

Free Medical Care to the Poor: The Case of State Aided Charitable Hospitals in Mumbai

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Assisted by
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Centre for Enquiry into Health and Allied Themes

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PREFACE

The study report “Free Medical Care to the Poor: The Case of State Aided Charitable Hospitals in Mumbai” by CEHAT brings forth much needed evidence on the high degree of non-compliance to the legal obligations of these hospitals, to provide free and subsidised care to the poor and economically weaker sections. The charitable hospitals in Mumbai get various benefits from the government such as land, electricity at subsidised rates, concessions on import duty and income tax. In return, they have to reserve 10 per cent of their sanctioned operational beds for indigent patients and provide them free services, and also reserve an additional 10 per cent for economically weaker sections. These rules were laid down by the Bombay High Court in 2004.

The study is based on the data procured from the Charity Commissioners office, which is official data being submitted by these hospitals. The results show that the norms laid down by the High Court in 2004 are blatantly being flouted. What has emerged are the ways in which the hospitals are circumventing their obligations. For instance, the hospitals are reporting total number of patients availing of free services which includes outpatient and inpatient, when most of the free care being given is in the form of outpatient care. This is serious as the obligation is to provide free beds which essentially means inpatient care.

This report comes at a time when the Government of Maharashtra has admitted that charitable hospitals flout norms, despite the existing monitoring system in place. That these hospitals are getting away without offering service to the poor has been acknowledged. One of the measures recommended by the GoM is to set up and maintain an online database in all these hospitals that provides updated information about number of beds reserved for the poor and number of beds available. This would ensure that the indigent and EWS can avail of health care. This is an important step as there is no such information available as of now. The lack of information is further accentuated by the fact that there is no referral system in place thus making it really difficult for the poor to access services.

In the current policy scenario, where the country is moving towards Universal Health Care, it is pertinent that the GoM acknowledges that these resources are available to the state for provisioning of public health services. In Mumbai itself, 1600 such beds are available across the charitable hospitals in the city, which could well be brought under an organised system with clear mechanisms for referral and monitoring.

We hope that the study findings will be useful for ensuring accountability of the charitable hospitals and for improving the implementation of the High Court Scheme.

Padma Bhate-Deosthali
Coordinator, CEHAT

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EXECUTIVE SUMMARY

In 2004, a Public Interest Litigation was filed in the High Court of Mumbai, challenging the state aided charitable hospitals that were not providing free treatment to the poor and weaker sections of society. The High Court formed a committee consisting of the Charity Commissioner, Government Officials and representatives of Association of Hospitals (AOH) to probe the matter and come up with uniform guidelines. The Committee submitted the final report, following which, a scheme was framed by the High Court of Maharashtra which gave detailed guidelines on how free treatment should be operationalised by the hospitals that come under the Bombay Public Trust Act (BPTA) 1950.

An earlier survey undertaken by CEHAT revealed that there were no transparent monitoring mechanisms in place that guaranteed accountability. Many hospitals refused to share data on grounds of confidentiality. Notices about such schemes were often not posted prominently in hospitals and poor people remained unaware. In this context, the present study was proposed to examine the history of charitable hospitals in Mumbai and their degree of compliance to the scheme prepared by the High Court with the help of data procured from the Charity Commissioner's office. A brief outline of the scheme is given below:

Scheme framed under section 41AA of the Bombay Public Trust Act 1950 (BPTA Scheme)
Scheme for charitable hospitals
Obligation by law for various benefirs as part of not-for-profit status, including free land, income tax exemptions, etc.
10% free beds and 10% subsidised beds set aside for poor patients
Monitored by the Charity Commissioner
Any health condition will be treated

This study by CEHAT intended to

- Review literature on the history of state aided charitable hospitals in Maharashtra, with special focus on Mumbai, and appraise the nature of engagement between the private sector and the state aided hospitals.
- Review the data submitted by the state aided charitable hospitals of Mumbai to the Charity Commissioner on free and subsidised patients, to estimate the degree of compliance to the High Court scheme and also to monitor the scheme.

This study substantiates what the public has known for long through a review based on data submitted by the state aided charitable hospitals. The findings have reinforced what the state government committee found through "surprise inspections" in February 2013. It has comprehensively invalidated the repeated claim by the Association of Hospitals (AOH) that its members are doing enough charity. Given this situation where AOH and its member hospitals are failing to fulfill the legal mandate, a strong message needs to be sent, and proper systems put in place for the active implementation of court orders. The scheme itself needs to be streamlined in the light of the experience of the last six years, so that access is maximised and 20% of the beds in the state aided charitable hospitals become a resource that the poor people of Maharashtra can count on, along with government hospitals.

Key Findings

1. A substantial number of state aided charitable hospitals do not comply with the scheme and the degree of non compliance is quite high.
2. Most state aided charitable hospitals never allotted the mandatory 20% beds for treating the poor and instead complained that they were treating too many patients.
3. Data reported to the Charity Commission by the state aided charitable hospitals is inadequate, inconsistent and unsystematic. Many hospitals do not even submit the required data.
4. State aided charitable hospitals predominantly treat indigent or weaker section patients at the outpatient level because outpatient (OP) admissions can be passed off as in patient (IP) admissions in the current scheme of things. There is a strong economic incentive in doing so, as the money spent is meager, and for most hospitals, each such case frees an extra bed that can earn thousands of rupees per day.
5. The Indigent Patients' Fund (IPF) is unutilised by hospitals. On treating all the 42 largest hospitals as one single entity, over the last three years, it was seen that the IPF has always been in surplus, in fact, to the extent of crores of rupees.
6. State aided charitable hospitals invariably underreported donations and bed numbers at the office of the Charity Commissioner.
7. State aided charitable hospitals create an impression that they are facing financial loss because of treating the poor. But a look at the growth of these charitable hospitals in terms of gross revenue and growth of bed numbers reveals a different picture.
8. The existing monitoring mechanism is ineffective and the hospitals use their 'autonomy' as a shield against any demand of accountability. Visits by inspectors were very few; between January 2009 and August 2009, and again between November 2010 and December 2011, no inspection was conducted. Even when inspections were conducted, they seemed to focus largely on the small hospitals, and not on the large ones.
9. No matter how serious the allegations were, no kind of penalties were levied on the offending hospitals. The action by the monitoring committee often involved only rolling back the wrong decision by the hospital in question. There was not a single instance where disciplinary action was taken against an offending hospital in Mumbai.

A review of the data revealed that only two per cent of the large charitable hospitals in Mumbai (that is, only one out of 42 hospitals) have provided indigent patients with the mandated 10% bed days. The study findings reveal that only a microscopic minority of the state aided charitable hospitals comply with the guidelines of the mandated scheme. While the scheme itself may need some modifications for its effective implementation, like the formation of a referral system between public and state aided charitable hospitals, the degree of non-compliance is so high that proper implementation and monitoring of the scheme will cause considerable equity gains.

ACROMNYMS

AGM	- Administrator General of Maharashtra
AIIMS	- All India Institute of Medical Sciences
AOH	- Association of Hospitals
BPL	- Below Poverty Line
BPTA	- Bombay Public Trust Act
CAG	- Controller and Auditor General
CBHI	- Central Bureau of Health Intelligence
CDEC	- Customs Duty Exemption Certificate
CESTAT	- Customs, Excise and Service Tax Appellate Tribunal
DDA	- Delhi Development Authority
DGHS	- Directorate General of Health Services
EWS	- Economically Weaker Section
FCRA	- Foreign Contribution Regulation Act
FSI	- Floor Space Index
GoI	- Government of India
OP	- Outpatient
OPD	- Outpatient Department
IMR	- Infant Mortality Rate
IP	- Inpatient
IPD	- Inpatient Department
IPF	- Indigent Patients' Fund
IPO	- Initial Public Offering
MCGM	- Municipal Corporation of Greater Mumbai
MHADA	- Maharashtra Housing and Area Development Authority
NCT	- National Capital Territory
NHP	- National Health Policy
PAC	- Public Accounts Committee
PDC	- Programme Development Committee
PIL	- Public Interest Litigation
PSU	- Public Sector Units
PTAF	- Public Trust Administration Fund
RGJAY	- Rajeev Gandhi Jeevandayi Arogya Yojana

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INTRODUCTION

[The allotment of land at concessional rates to certain institutions] with the primary objective of providing free treatment to poor patients was a laudable step towards making modern medical facilities accessible to economically weaker sections of the society. If successfully implemented, the policy could have provided life saving opportunities to some of those, at least, who are afflicted with complicated and deadly diseases but are practically beyond the realm of the costly medical treatment. Unfortunately however, the policy itself suffered from serious inadequacies right from the beginning and instead of providing succour to its targeted sections of the society, it became a victim of its own deficiency. Ultimately, what was started with a grand idea of benefiting the poor turned out to be a hunting ground for the rich in the garb of public charitable institutions.

-Public Accounts Committee, Fourteenth Lok Sabha, (PAC, 2005, p. 26)

Transformation of Charitable Hospitals as Commercial Entities

India has a history of planned development of health services and the state has played a key role in the finance, supply and management of these services. Although the post independence state played a central part, private interests were never curbed and as a result, they have grown over the years (Baru, 1998). It was during the nineteen eighties that the Indian state formally recognised the role that the private sector could play in provisioning health care services for the masses. The National Health Policy of 1983, which followed the Alma Ata Declaration of 1978, marked a departure from the earlier policy in that it favoured nongovernmental provision of curative services. (Lefebvre, 2010; Duggal, 2001).

With a view to reducing governmental expenditure and fully utilizing untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professionals, increased investment by non-governmental agencies in establishing curative centers and by offering organized logistical, financial and technical support to voluntary agencies active in the health field (National Health Policy 1983 as cited in Duggal, n.d.).

At the time of independence, there were very few private hospitals in India apart from charitable institutions funded by big business families or missionaries (Lefebvre, 2010). However, the policy shift saw subsidies being offered to the private sector by the government by way of land (leased or otherwise) at nominal rates, granting medical care the status of industry which guaranteed cheap credit, reduction of import duties on high technology equipment, and a whole array of other benefits like exemption from property taxes, water and electricity charges and so on, which benefitted the private health sector substantially (Ramu et al., 2001). Lefebvre (2010) observes that while genuinely charitable organisations have previously been the main beneficiaries of such policies of state subsidies, a newer generation of trust societies with sometimes less-than-clear charitable objectives and private corporations were granted access to extensive resources in Delhi, Hyderabad and other locations across India.

The last three decades marked a stark shift in the policy approach and as a result, the private curative industry experienced tremendous growth. This unregulated growth has had its impact on non-profit

hospitals, which were traditionally run with a charitable objective. A study conducted as part of the Commission of Macroeconomics and Health in India noted that in the wake of increased privatisation and corporatisation of health services, many charitable trust hospitals across the country had become more commercial in their operations, thereby altering their character from a charitable institution to a private for-profit/corporate one. The study called for greater transparency and accountability so that the conditions of cross-subsidisation such as free admissions and free outpatient services for the poor, prescribed by the law were adhered to (Nundy, 2005).

Mumbai - A Case Study

The era of transformation of a large proportion of today's charitable hospitals into commercial entities, which was an outcome of the unregulated expansion of the private sector, saw some interesting developments such as the corporate hospital sector taking the "charitable route" of expansion. This particular shift, however, is well documented and during the past two decades, many of the old trust hospitals have made explicit arrangements with the private corporate sector. Invariably, the founders' objective of being charitable, providing considerable relief to the poor is being completely overlooked. Mumbai has been a goldmine for the private corporates, where they could piggyback on existing charities and have access to resources including land that was given at low rates by the government. The profit seeking behaviour that followed had an inevitable impact on the hospitals' attitude to the non-rich, not to speak of the poor. For example, Wockhardt Hospitals Ltd., is opening a 350 bedded hospital on the same plot where Adams Wylie Memorial Hospital, a hospital run for the poor by the Red Cross Society stood. It was clear that once the new hospital came up, the poor would not have access to the expensive treatment. When the Administrator General of Maharashtra (AGM) raised an objection based on this fact, the Wockhardt group moved the Bombay High Court asking that the AGM be restrained from interfering in the functioning or day-to-day progress of the hospital (Deedwania 2007).

The attitude of the new management to philanthropy -or even the poor themselves- was evident when the Wockhardt Hospitals Limited during their planned initial public offering (IPO) had identified the Mumbai High Court scheme mandating free beds to the poor under the head of "Internal Risk Factors" (Khorakiwala et al, 2008). In 2012, the chief operating officer of Wockhardt Hospitals, Dr VP Kamat reportedly told the press about the upcoming facility on the land owned by the Wylie Trust: "Everyone wants quality care now and there is propensity to pay for good services." He also informed the press that the new hospital would have a specialised institute of aesthetics (Pinglay, 2012). Another story of the sudden transformation of a hospital run by a charitable trust to an out and out commercial enterprise is that of Kokilaben Dhirubhai Ambani Hospital.

The booming real estate market in cities like Mumbai is the driving force behind the corporate link up with charitable trusts in order to have access to land at low rates besides other benefits (Lefebvre, 2008). The entry of state aided charitable hospitals into these networks of purely profit seeking medical entrepreneurs and the medical technology race between such hospitals to attract patients and doctors have been driving the medical cost up for the patients besides acting as an entry barrier to medical care in the cities (Lefebver, 2010). The corporate infiltration into the charitable sector and the aggressive expansion plans of hospital chains has transformed the sector resulting in a reduction of care that the poor have been accessing for free and at reasonable rates from the state aided charitable hospitals, which is cause for concern.

In 2004, a Public Interest Litigation (PIL) was filed in the High Court of Mumbai, challenging the state aided charitable hospitals that were not providing free treatment to the poor and weaker sections. The High Court formed a committee consisting of the Charity Commissioner, Government officials and representatives of the Association of Hospitals to probe into the matter and come up with uniform

guidelines. The Committee submitted the final report, in the light of which, the High Court framed a scheme with guidelines on how free treatment should be operationalised by the state aided charitable hospitals that come under BPTA 1950 ¹.

The latest available data reveal that there are about 80 state aided charitable hospitals registered with the Charity Commission in Mumbai. Data on bed strength is available for about 60 of them. Together, they constitute more than 8,000 beds. These state aided charitable hospitals are by no means homogenous as statistics reveal: the largest 25 among these state aided charitable hospitals account for about 6400 beds, indicating that a considerable number of these state aided charitable hospitals are large institutions. Overall, it means that about 800 beds are available for the poor for free and another 800 beds at subsidised rates ².

Recently, around fourteen state aided charitable hospitals, including Lilavati, Breach Candy, Jaslok, Bombay, Hiranandani, and Saifee Hospitals, have appealed to the Charity Commissioner stating that they are currently overspending in order to treat the poor and are thus incurring losses. Recent developments indicate that there has been a first-of-its-kind directive, and the Charity Commissioner has allowed four state aided charitable hospitals - Jaslok, Hiranandani, Breach Candy and Lilavati - to stop treating poor patients temporarily (Deb-Roy, 2012). Investigations that followed the exemption however indicated that Jaslok, Breach Candy and Bombay Hospital used only 4%-4.5% of the 10% beds they had committed to use to treat the poor ("Top hospitals didn't use even half of the beds marked for poor", 2012)

An earlier survey undertaken earlier by CEHAT (Fernandes & Pai, 2007) had revealed that there were no transparent monitoring mechanisms in place that guarantee accountability. Many hospitals refused to share data under the veil of confidentiality. It was also observed that prominent notices about such schemes were often absent in hospitals and poor people remained unaware. In this context, a study was proposed to examine the history of state aided charitable hospitals in Mumbai and their degree of compliance to the scheme prepared by the High Court with the help of data procured from the Charity Commissioner's office.

The Study

This study by CEHAT conducted an extensive literature survey on the history of state aided charitable hospitals in Mumbai using academic works, policy documents and various available reports. The study also intended to prepare a typology of state aided charitable hospitals in Mumbai across different parameters. This was followed by a review of the High Court scheme data, submitted by the state aided charitable hospitals of Mumbai to the Charity Commission in order to estimate their degree of compliance to the scheme. The main objectives of the study were to

- Conduct a review of literature on the history of state aided charitable hospitals in Maharashtra, with special reference to Mumbai, and also look at the nature of engagement between the private sector and the state.
- Review the implementation of the High Court scheme based on hospital level data across three years.

¹ The scheme, the way it was conceptualised by the court is attached as Annexure 1.

² Based on data from Charity Commissioner's Office.

Methodology

This study relied on secondary sources, such as academic studies, policy documents, scheme data from the Charity Commission, and various available reports. An extensive literature survey was conducted. For the review of the scheme, data for the preceding three years were procured from the Charity Commissioner's office with permission. This data was based on the monthly submission by state aided charitable hospitals to the Commissionerate. The data thus collected were analysed using MS Excel to evaluate the degree of compliance by the state aided charitable hospitals to the High Court scheme. Out of the seventy four state aided charitable hospitals in Mumbai for which data was available, 42 relatively bigger hospitals with more than 50 beds were selected for further analysis based on convenience and manageability. Monthly data for three years for all these 42 state aided charitable hospitals was converted into six six-monthly periods ³.

Limitations of the Study

Since this study is based on data submitted by the state aided charitable hospitals, incomplete data was a problem, which limited the scope of data analysis. Ironically, the high degree of non-compliance has helped overcome this limitation to an extent in that the flouting of norms is evident even without advanced data analysis. The voluntary nature of data submission by the hospitals has affected the preparation of a typology of hospitals which was initially planned, as data on only a subsection of the 81 state aided charitable hospitals were available in the public domain and at the Commissionerate. When hospitals were contacted to collect the missing parameters, the response was not positive. However, a brief statistical and diagrammatic illustration on the nature, numbers and spread of such hospitals in Mumbai (based on available data) is presented in Annexure 2. Despite these limitations, it is hoped that this report presents the findings in a manner useful to health researchers, journalists, policymakers and activists.

Chapterisation

The first three chapters following the introduction track the history of state aided charitable hospitals, concluding with the legal intervention in Mumbai High Court in the form of a PIL that resulted in the free bed scheme. These chapters present the extensive literature survey that was conducted as part of the study. The next chapter presents the findings from the review of scheme data procured from the Charity Commissionerate. This is followed by conclusion and recommendations.

³ However, out of these 42 big hospitals, only 29 had given the number of total patients for any six month period across 2009, 2010 or 2011.

HISTORY OF CHARITABLE HOSPITALS IN THE COLONIAL ERA

(The British were) superior to subject peoples in natural ability, integrity and science ... They [had] introduced honesty, law, justice, order, roads, posts, railways, irrigation, hospitals ... and what was necessary for civilisation, a final superior authority.

- Sir Ronald Ross, who identified the mosquito vector of malaria, on British Rule in India (as cited in Harrison, 1998, p. 151).

"This Edifice was erected as a testimony of devoted loyalty to the Young Queen of the British Isles, and of unmingled respect for the just and paternal British Government in India ; also, in affectionate and patriotic solicitude for the welfare of the poor classes of all races among his countrymen, the British Subjects of Bombay, by Sir Jamsetjee Jeejeebhoy, Knight, the first Native of India honoured with British Knighthood, who thus hoped to perform a pleasing duty towards his government, his country, and his people : and, in solemn remembrance of blessings bestowed, to present this, his offering of religious gratitude to Almighty God, the Father in Heaven of the Christian, the Hindoo, the Mahommedan, and the Parsee; with humble, earnest prayer for His continued care and blessing upon his Children, his Family, his Tribe, and his Country."

-Inscription on the Foundation stone of JJ Hospital, Bombay (As cited in Moore, 1845, p 47).

Bombay city, the beginnings of which are traced to the seventeenth century, was known among the Europeans to be "extremely non-conducive to health" (Ramanna, 2002). Indeed it was described as a place where "two monsoons were the age of a man" (Da Cunha, 1900). The first Western hospital in India, the Royal Hospital, was established by the Portuguese in Goa during the early sixteenth century. It was reported that between 1604 and 1634, some 25,000 soldiers died from cholera and malaria in the Royal Hospital, Goa, adding to the region's reputation as a "graveyard", although the hospital would have helped bring down the deaths (Bruijn, 2007). However, as John Fryer observed, there was no western hospital in Bombay, until the late seventeenth century (Ramanna, 2002).

The British East India Company had founded small hospitals in its factories in the early 1670s and by the end of the century there were modest, though more or less permanent, establishments in Calcutta, Bombay and Madras. (Mark Harrison 2008). The first hospital in Bombay was built in 1677, converting an old court building near Cooperage. The cost was financed by imposing a half per cent duty on trade (Solicitor to Government, 1910). The health situation remained the same, with English trading posts usually being short of surgeons, who "died as often as their patients". The fact that it took more than a year before a European replacement could arrive led to the employment of Indian physicians (Harrison, 2009). However, as David Arnold (1993) observes, Western medicine had made few inroads into India before 1800 and was largely limited to European enclaves and ports like Bombay, Surat, Goa, Calcutta, Dhaka, Madras and Pondicherry.

The Nineteenth Century and Later

The British East India Company, however, was reluctant to social spending and municipal bodies were not able to raise the revenue required for such spending "on account of a general reluctance among

Indian ratepayers to countenance taxation for sanitary and medical purposes" (Harrison, 1998). Mark Harrison (1998) observes that a major part in the growth of medical institutions such as hospitals was played by military considerations of the colonizing West. By 1784, there were three large hospitals in Bombay, two for British troops and one for Indians. The need for such hospitals was acutely felt by the British as the incidence of illness and mortality amongst European troops in India was extremely high. According to Harrison, while Dragoon guards stationed in the United Kingdom had an average annual mortality of 14 per 1000 in 1830-6, the British troops in Bombay suffered an annual mortality of over 47 per 1000 between 1830 and 1849. The death of troops in Bombay was mostly caused by disease (Harrison 1998).

According to Harrison, even if the British East India Company was generally reluctant to provide funds for municipal sanitation and hospitals, some governors "of a philanthropic bent" made some minor contributions from local revenues specifically for interventions like vaccination against smallpox (Harrison, 1998). Most of these concerted actions on the medical front became inevitable due to the vulnerabilities that were faced largely by the Europeans themselves. This is evident from the case of smallpox vaccination, which was introduced in Bombay in June 1802. Even after a century, in 1893, one of the main arguments favouring compulsory vaccination in Pune was "in consideration of the proximity of the city to the large European population of the cantonment and the constant intercommunication which exists between the city and the cantonment" (Arnold, 1993) As some degree of contact with the natives was unavoidable, the priority of Western medicine was to target groups of Indians like domestic servants, soldiers, plantation labourers so that a "sanitary cordon" existed around the white community. But such measures were not governed by an enclavist mentality mindset alone, and as David Arnold observes, for the regime that was recently established by force and with an ongoing struggle against the Marathas, such measures offered a welcome opportunity to give "fresh proof" of the East India Company's "humane and benevolent" intentions toward its subjects, "an additional mark of the fostering care of the British Government" in India (Arnold, 1993).

Philanthropy by Indians

The picture often presented by colonial literature that initiatives behind medicine and public health came almost entirely from the British colonizers, while the Indians were merely unenthusiastic recipients if not outright resisters, has been challenged by later scholars. David Arnold, for example, observes that while "It is certainly important to recognize the extent to which Western medicine in India relied upon state action for its propagation and to take into account the influence of Indian resistance on its development, it is also necessary to appreciate the role of Indian leadership and indigenous strategies of accommodation and appropriation in this process. One largely neglected aspect of this wider process is the role of Indian patronage" (Arnold, 1993).

Health care provisioning for the civilian Indian population when compared to that for soldiers remained scanty till the end of the nineteenth century, although there were some initiatives in medical care from the initial nineteenth century. These were usually initiatives by Company employees themselves and some Indians acting on their own. They got only occasional support from municipal bodies and the British East India Company. An illustration of "Fever Hospitals" in the cities, provided by Harrison offers an interesting window into those times. The construction of Calcutta Fever Hospital which was planned in 1836 was expected to be funded largely by private individuals, mostly Europeans and a few wealthy Indians. Calcutta's municipal body agreed to co-fund it making a small contribution to its running costs. However, the Government of Bombay declined to co-operate with the scheme. This was based on the reluctance of residents to have what they regarded as a 'fever nest' close to their homes (Harrison, 1993).

In colonies like Bombay, where Western ideas and ideals of science and progress had begun to influence local culture, indigenous philanthropy was seen to play an incrementally important part in the creation of hospitals and dispensaries. Prominent members of the Indian elite such as Jamsetjee Jeejeebhoy and Goculdas Tejpal helped establish large hospitals in Bombay in the nineteenth century. Mark Harrison quotes Roy Porter who argued (about English voluntary hospitals) that "such institutions put an idealized gloss on the relations between rich donors and the poor, and threw a "cloak of charity" over naked repression" (Harrison et al., 2009). He infers that such acts of philanthropy exercised in establishing a hospital performed similar functions in India as it did in other countries undergoing industrialisation that is, creating a "sense of social solidarity in situations where bonds of customary obligation were becoming strained". Financing hospitals served as a distinctive way to prove the donors' intent of benevolence and also to cement their credentials as community leaders (Harrison, 1998).

Philanthropic interventions in the area of healthcare in India, according to David Arnold, took a multiplicity of forms and were based on a variety of motives. One of these was the kind of patronage that resulted directly from the interaction of wealthy Indians with the British rulers, often as a result of pressure from the colonial authorities. Taking inspiration from their own social history where philanthropy and charity had played a major role in healthcare structures including hospitals, the British looked to the leaders of Indian society, to take up colonialism's 'hegemonic project'. The great wealth that was accumulated by the Indian elite comprising the merchant classes and the rulers, made them obvious candidates to take upon a similar role in India, according to the British. Besides, the colonial power took a somewhat narrow view of its own responsibility towards the health and welfare of the Indian population. It followed that they expected Indians to bear at least part of the finances for their own healthcare provisions. As a result, individual philanthropists from India were often pressed to finance the establishment of hospitals and dispensaries (Arnold 1993) However, although the contributions by the Indians were substantial, they seldom matched colonial expectations. There were frequent complaints that promised donations never materialised, or that "Indians gave more money for the care of sick animals than for needy humans" (Arnold 1993).

Medical Philanthropy as Political Agenda

Medical philanthropy had its role in political agenda too, as it was assumed that the promotion of western medicine would be easier if the Indian elite and 'notables' would be associated with it, as it would attenuate the coercive and alien elements of colonial medicine and public health. However, David Arnold maintains that aided in no small measure by the strong cultural tradition of philanthropy and charitable activities in India, the colonial project was "often taken over -one might say hijacked- by Indians, particularly the new urban elites, and made part of indigenous networks of patronage and authority" (Arnold, 1993). The traditions of charity and religious duty, which ranged from feeding and giving alms to the poor to building rest houses, continued and found ways to adapt under colonial rule.

Understandably, medical charity in the colonial era also had a strategic element of accommodation, whereby acts of philanthropy bought influence, prestige or even at times political recognition from the colonial regime. The reward from the regime "might be a personal message of thanks from Queen Victoria, the award of a title or some other honour in the state's gift, or simply the good offices of the local Collector or Resident" (Arnold, 1993). Medical patronage has also served as the public celebration of an individual's successful association with the ruling colonial power, at a time when the colonial government was seeking a closer association with India's old ruling and landed elite, in an effort to consolidate their position in the post-mutiny era (Arnold, 1993).

Parsee Philanthropy

It is said that in those times, most public buildings in Bombay were built with substantial support from philanthropists and through public subscriptions (Chopra, 2011). Hospitals were no different; the first major institution to provide Western medicine in Bombay, the Bombay Native Dispensary which opened in 1834, was maintained by public subscriptions. It was run in a building that was given rent-free by the colonial government (Ramanna, 2002). A Parsee business magnate, Jamsetjee Jeejeebhoy's large donations established JJ Hospital in 1845, which became the "largest hospital in western India in the nineteenth century"(Ramanna, 2002). More dispensaries were established in Mumbai in the mid-nineteenth century with private endowments.

Acts of philanthropy often had multiple objectives such as eternalise the memory of the donor or his/her family, strengthen community bonds and boost the stature and reputation of the community leaders. Many hospitals and dispensaries like JJ hospital and Cama hospital had separate provisions for patients who were Parsees (Arnold, 1993). It was in response to requests from the East India Company to fund a hospital that Parsee business magnate, Jamsetjee Jeejeebhoy gave huge donations. JJ Hospital was established in 1845, which became the "largest hospital in western India in the nineteenth century" (Arnold, 1993). A small community, the Parsees who were "initially very dependent upon British favour and overseas trading connections" found establishment of dispensaries and hospitals as a "way of cementing a close and mutually beneficial relationship with the ruling power." The hospital's foundation stone carries proof of the donor's "unmingled respect for the just and paternal British Government in India" (Arnold, 1993).

This was followed by a period in which Parsee philanthropy flourished with the opening of Sir Cowasji Jehangir Ophthalmic Hospital in 1866, Jehangir Nusserwanji Wadia Dispensary at Mahim in 1874, Nasarwanji Petit Charitable Dispensary in 1885, Cama Hospital for Women and Children- funded largely by Pestanji Hormusji Cama in 1886, Bomanji Edalji Albless Obstetric Hospital in 1890, and a plague hospital which was funded by Parsees. It has been noted that of the first group of eight thousand of Bombay's population to be inoculated against plague, almost half were Parsees and also that the plague epidemic did not affect the Parsee community the way it affected others (Arnold, 1993). In addition, there were other dispensaries too like Mithibai Hormusji Dispensary in Kurla which was established in 1856 (Ramanna, 2002).

An Era of '*Competitive Civic Philanthropy*'

Parallel to these developments, other communities also followed suit, triggering what is often seen as a "competitive civic philanthropy" which the state actively encouraged (Arnold, 1993). Nagdevi Charitable Dispensary established and maintained by Dr. Bhau Daji and his brother Dr. Narayan Daji was one of the early efforts. Jagannath Shankar Sheth Dispensary was founded 1858 in Girgaum which offered free medical aid (Ramanna, 2002). This was followed by the establishment of the Gokuldas Tejpal Native General Hospital in 1865, the Jaffer Suleman Dispensary in 1886, the Dwarkadas Lallubhai Dispensary for women and children in 1892 and a new leper asylum funded by Aga Khan (Arnold, 1993).

At the turn of the nineteenth century, in Bombay Presidency there were mainly provincial hospitals and municipal-managed local dispensaries funded by some grants from the government that were irregular and inadequate, leading to financial constraints and distress resulting in poor and shoddy services and consequently poor public health. The government was anxious to reduce its financial commitment and its responsibilities by bringing in external donors (Ramanna, 2012).

The social repercussions of the narrow focus and the bias against the health and welfare of the "locals" by the colonial administration along with the rising concern of the health conditions, especially maternal and public health, led to many initiatives by local reformers and philanthropists. They founded institutions to cater to the specific needs of the population and funded them. Many donors stepped in to pay for the building, furniture or staff salaries of the existing municipal-run dispensaries or to set up new institutions. With the active support of the government, a large number hospitals, sanatoriums and dispensaries were started through individual charities. The government, however, monitored all institutions, whether they were government-aided or not, through routine inspections (Ramanna, 2012).

These new private-funded institutions, started mainly on religious and community lines, catered to specific groups like Parsis, Christians, Memons, Hindus and Jews and so on. They looked at two specific health issues considered most critical then: maternal health and hygiene, promotional activities to prevent infectious diseases and epidemics. The training of nurses, dais (traditional birth attendants) and other medical-attendants were undertaken as part of charitable work by private donors or institutions. By the 1920s, many welfare societies had come into the foray backed by government support, which carried forward health issues and institutions through both private and public funds. The health initiatives were extended to target vulnerable groups like port-workers, mill-workers and labourers. Thus by the early twentieth century there was a distinct interaction and collaboration between public and private actors in health, be it through collaboration, partnerships or complementing each other's work (Ramanna, 2012).

Financing of Hospitals in Bombay

According to Mridula Ramanna (2002), initial health care institutions established in Bombay could be classified into three categories - ones where the cost was borne entirely by the community, where there was some cost sharing between the community and the government, and those entirely financed by the government. In the second model, which could be termed as a rudimentary public-private partnership, the community's contribution consisted of taking care of the infrastructure, "providing the building and the furniture, while the government supplied the medical and surgical instruments and defrayed the salaries of the sub-assistant surgeons." All these dispensaries provided free health care services and medicines to patients, while some had patients coming from distant places like Sind, Kutch, Kathiawar, Khandesh, Nasik and Hyderabad (Ramanna, 2002).

However, the philanthropic support was often viewed cynically by the colonial administration. There were members of the senior staff who felt that such institutions "originated too often in the desire of richer men to obtain for their families and dependants medical treatment at a nominal cost, and for themselves, formal recognition as public benefactors" (Ramanna, 2002). It was observed that as soon as hospitals were built, often with considerable government support, the interests of the philanthropists declined, and subscribers refused to pay and expected free medication at the same time (Ramanna, 2002).

It is in this context that the government decided to change the existing rules for charitable dispensaries in Bombay and introduced a payment system that came into being in March 1872, which required that "subscribers to dispensaries and well-to-do persons not subscribing, should pay for medical advice and medicines received at the dispensaries, and that the indigent poor only were to receive the same gratuitously" (IMD, 1874). However, the implementation of the rule was done in a very relaxed manner, and the focus was strictly on rich people who visited the hospitals. An annual administrative report observes that all the staff involved were clearly instructed on the rules and who should pay, and that "not only the poor but also those in a better position but still not exactly well-to-do, were one and all to receive advice and medicine gratis" (IMD, 1874). It was observed by officials who evaluated the scheme

that in many hospitals, the information regarding the payment system was not disseminated well, and the poor believed that they also were required to pay for their medicines. As a result, in some dispensaries, the number of patient admissions and attendance "fell considerably" although the numbers improved later (IMD, 1874).

It is interesting to note that even in the eighteen-seventies, in some hospitals where the salaries and other expenses were funded by the government, there were often complaints by the British doctors that the rich were availing themselves of free treatment. However, the local press tended to brush it aside while arguing for free care for all, stating that the donor had meant the hospital to be available to all classes of patients (Ramanna, 2002). In addition to these hospitals, the Bombay municipality opened free Municipal Dispensaries, like the ones in Kumbharwada in 1898, and in Dongri in 1899. These two free dispensaries were largely attended by the poor (Michael, 1902). A note published in the nineteen thirties regarding the maternity homes in Bombay summed up the health care infrastructure as follows:

The position today is that in the City of Bombay there are 14 public and free institutions with 486 beds, and 8 private semi-charity institutions with 155 beds, while paying nursing homes are 61 in number with 667 beds. The total number of maternity institutions both public, private charity with free beds, and nursing homes come to 83 with 1,308 beds (Bradfield, 1938).

Despite some access to health care services, the morbidity and mortality rates in Mumbai continued to be among the worst in the world in the early twentieth century. Comparative Infant Mortality Rates (IMR) published by the Registrar General of Great Britain showed that the respective Infant Mortality Rates for Amsterdam, Stockholm, Copenhagen, London, Berlin and Bombay were 42, 47, 48, 93, 146 and 630 deaths per 1000 births respectively. The Bombay figure was the highest recorded figure for any city (Public Health Notes, 1922). Chandavarkar (1994) notes that the mortality rate in the working-class districts in the city was particularly high. Medical attention remained expensive and sometimes unattainable. Workers who fell sick and were lucky enough to survive often returned to their respective villages to recuperate. Lack of maternity hospitals and scarcity of cheap and accessible health facilities forced working-class families to return to their villages for childbirth. Another reason for getting admitted into hospitals for childbirth was that the people believed "that either the mother or the child dies". This belief, according to him was based on "sound reason and tragic experience."

Post independence, the terms of engagement between the government and charitable institutions changed. Government support was now mostly in terms of infrastructural support, mostly in the form of free or subsidised land, electricity and water. The charitable trusts took care of the salaries, and controlled the revenues, which were substantial as the nature of the hospitals itself underwent a change. These developments will be explored in the next chapter.

TRANSFORMATION OF CHARITABLE HOSPITALS IN THE POST INDEPENDENCE ERA

The hospital industry is undergoing massive change. Partly because of modifications in payment practices, demand for hospital inpatient care is shrinking, leading to hospital closures and mergers as well as some conversions to for-profit status. Hospitals are integrating not only horizontally but also vertically, the latter including combinations with other types of health-care providers and, mainly through contracting, the establishment of links to health-insurance plans..... By virtue of their ownership status, it is also expected that at least some nonprofit hospitals will engage in these noncommercial activities. Important for public-policy purposes is the question whether nonprofit hospitals are becoming less committed to such "noncommercial" activities and whether these activities cease almost entirely when nonprofits convert to for-profits.

- Sloan (1998)

The Bombay Plan and the Bhore Committee

Brutal suppression of the Quit India Movement, appointment of Sir Joseph Bhore as the head of the Health Survey and Development Committee and the publication of proposals by the industrial leaders, which came to be known as the 'Bombay Plan' happened almost simultaneously. The Bombay Plan, which was prepared by a set of leading industrialists and philanthropists, was termed by Amrith et al., (2006) as "an economic plan which used socialist language carefully to 'preserve what was essential in capitalism.'" Qadeer (2001) observed that the Bombay Plan focused on urban services, and while it held the state responsible for health infrastructure, it envisioned no role for the state to control the private sector. Even in the nineteen forties, there was considerable support to the private sector by the government. The Bhore Committee Report (1946) observes that out of a total of 61 private medical institutions in the urban areas of Bombay province, 16 were supported by public funds. At the same time, the report notes that the government had undertaken the major share in the provision of medical relief, unlike in other countries where voluntary organisations took the initiative. In order to encourage voluntary efforts, the Bhore committee recommended that the government and the local authorities encourage charitable initiatives "in every possible manner" citing the specific case of Charitable Building Trusts in Bombay that helped the "less fortunate members of the community". The Bhore Committee (1946) went on to state that

There is abundant scope for voluntary effort to supplement what governments can do in practically all branches of health service, and every available agency should be utilized in the endeavour to bring effective health services within the reach of all. But the responsibility for providing such services rests upon the governments, and they cannot relieve themselves of any part of that responsibility by making grants to voluntary organisations over whose activities they have very little control. ..(While voluntary effort should be welcomed and encouraged) there must be regular inspection and the governments should have power to take whatever steps may be necessary to ensure that the health activities of voluntary organisations are maintained at a satisfactory level.

Even though the history of charitable hospitals providing western medicine dates back to the early colonial period, in terms of absolute numbers and in comparison with government infrastructure, charitable hospitals did not constitute a large number at the time of independence. But as if in keeping with some of the Bhore Committee recommendations, the hospitals with direct and indirect support from the government seem to have flourished in the later period. Mool Chand hospital in Delhi was given nine acres of prime land situated at Lajpat Nagar in South Delhi in 1951. In 1957, the Lahore Hospital Society was allotted five acres of land at Pusa Road, Delhi to construct a charitable hospital in the memory of Dr BL Kapoor (Quershi, 2001). In Delhi alone, between 1951 and 1976, land was allotted to five different charitable hospitals, with the condition that considerable proportion of treatment would be given to poor patients (Jha, 2012). In fact, the Land and Development Office of Delhi had imposed conditions on some hospitals that required them to provide 70% of the total number of beds for free treatment (Quershi, 2001). Apollo Hospital was allotted 15 acres of prime land in South Delhi in 1988, for a token rent of Rs 1 per annum, in return for 33% of free beds (Shah, 2009).

However, there are no studies that analyse the financing aspects of hospitals run by charitable trusts. Some state level studies that had intended such analysis were not encouraged by the trusts and there is lack of information on the sector (Khan & Parsad, 1986). Though there is no specific historical data on all trust hospitals, some historical data on medical colleges do exist. This data may throw up broad trends since other than the government, only charitable trusts and societies were allowed to establish medical colleges in India under the establishment of the Medical College Regulations Act. This effectively made all medical colleges "charitable trusts" by definition. However, an amendment had been incorporated in 2010, which allowed that Companies registered under the Company Act may also be allowed to open private medical colleges. Interestingly, the Act states that permission for colleges that "resort to commercialization" will be withdrawn (Establishment of Medical College Regulations, 1999). When one looks at the national level data for inpatient care between 1986 and 1996, there is an increase in the utilisation of charitable institutions in rural and urban areas. However, this does not mean that free care has increased. According to a study published by the National Commission for Macroeconomics and Health in 2005, there was a decrease nationally in access to free care from 19% of all care to 10% of all care between 1986 and 1996. This also reflects the fact that user fees have been introduced in several public and not-for-profit health institutions during this period (Nundy, 2005).

Growth of the Private Sector

It was noted that at the time of independence there were 28 medical colleges in the country for training in western medicine of which only 3.6% was from the private sector. By 1986, there were 123 medical colleges for western medicine, and of them, 17% were from the private sector, which showed some expansion of the private sector, but still its size was not substantial. This increase was despite the emphatic admission in the Fifth, Sixth and the Seventh Five Year Plans (1974-1990) that no more medical colleges need be established as doctors were 'overproduced' (Jesani & Anantharaman, 1989). Figures indicate that as of 2012, 161 colleges exist in the public sector and 56 of them came up after 1990; 194 colleges with 23905 seats exist in the private sector. Of these, 160 were established after 1990. Currently, 55% of the medical colleges are in the private sector, and more than 80% of these were established after 1990 (Medical Council of India, 2012). Although all these new private sector entities are registered as Charitable Trusts, Societies or Non-profit companies registered under Section 25 of the Companies Act, it is a well-established fact that these act as any other commercial entity.

A similar pattern can be perceived with the larger group of charitable hospitals too. A study by the Planning Commission in 2004 grouped hospitals along with schools and colleges as the "types of organisations which are held most guilty of abusing the charitable provisions". The study clearly brought out the issues related to "misuse of tax provisions, fraud, and poor governance by some sections of the

sector" and stated that ethics, values underlying voluntary work, and accountability of such organisations have to be relooked at. The report categorised hospitals as one group "which by claiming to be charitable, or promising to reserve a certain percentage of their services for the poor, have availed of benefits like land nominal or concessional rates, exemption from excise duties and the like, apart from exemption of income from tax, but have gone back on their promises". It noted that these institutions are run at present "as business ventures" (SICP, 2004).

India's health decision makers have rewarded its private and charitable sector in many ways right from the time of the Eighth Five Year Plan. Apart from provision of land, there have been other indirect and direct subsidies such as provision of water and electricity at lower costs and concessions on import duty on diagnostic equipment. The only condition was that the hospitals should provide a percentage of its inpatient facilities and outpatient/ diagnostic services free of cost for poor patients. Medical tourism was seen as yet another means of supporting private hospitals (Qadeer & Reddy, 2006). The Tenth Five Year Plan went further ahead in offering more concessions to medical institutions in the form of soft loans from financial institutions and the status of industrial activity for earning foreign exchange (Qadeer & Reddy, 2006). The Central Council of Health and Family Welfare passed a resolution in 1995 which said:

In keeping with the liberalization policy leading to health sector reforms, the PSUs be encouraged, if necessary with interest free financial assistance for a minimum period of five years, to participate in joint ventures through equity sharing, to facilitate the private sector to raise loans from financial institutions/banks etc. In return the private sector should provide a minimum of 30% beds and 40% outpatient/diagnostic services free for treatment of the poor in rural and urban sector (Government of India, 1995).

The state has been providing incentives to the private health sector in the form of land at subsidised prices, customs duty exemptions for the importation of medical equipment and drugs, loans at low interest rates, free or subsidised water and electricity, income tax exemptions and tax breaks, among other things (Nandraj et al., 2001 and Shukla & Duggal, 2006). According to a notification of the Customs Duty Act, imported hospital equipment becomes exempt from customs duty only when the hospital provides free care to 40% of the outpatients and 10% of the inpatients. Historically, there has been no periodic monitoring of whether this criterion is being fulfilled (Nandraj et al., 2001 and Shukla & Duggal, 2006). However, some hospitals got their exemptions rejected following what the media called a "Rs 5,000 crore medical equipment import scam"

Unbridled Growth of the Private Sector as a sign of Governance Failure

The Eleventh Five Year Plan (Planning Commission, 2008) admitted that the private sector is flourishing primarily because of a failing in the public sector. It also acknowledged that historically, the expansion of the private sector was actively encouraged by the state by offering tax exemptions and land at concessional rates, "in return for provision of free treatment for the poor as a certain proportion of outpatients and inpatients". However, the implementation of any such provision was never monitored by the state for a variety of reasons. In addition, private hospitals also receive financial support in the form of reimbursements from governments and public sector units (PSUs) for treating their employees (Planning Commission, 2008). However, studies have noted that the government had limited capacity to handle free care schemes, and that there are times when there was not even any provision in the contract between the private entity and the government for providing free care to the poor (Nandraj et al., 2001).

While lax implementation of such schemes is the norm, there have been committees that probed issues of implementation of such schemes. In Andhra Pradesh, a House Committee on Corporate Hospitals was set up by the Legislative Assembly and its report in 1996 found that the hospitals that are recipients of specific conditional concessions, were not providing the required free treatment to the poor. The same Committee also observed that systems to monitor the implementation of these agreed conditions were virtually absent. While such concessions act as incentives for expansion, equity issues linked to the compliance to the conditionalities are not monitored and hence such conditional schemes are not even implemented (Nair, 2004). In the nineties, in response to a Public Interest Litigation by Peoples Union for Civil Liberties, which maintained that profit seeking hospitals are making use of the import duty exemptions meant for 'charitable' hospitals with the help of corrupt officials in the Directorate General of Health Services (DGHS) and thus causing a loss amounting to almost five thousand crores of rupees to the government exchequer, a committee was formed for recovery of the customs duty from defaulting hospitals under the chairmanship of Padam A Rosha, to investigate into how many hospitals violated the Customs Duty Exemption Certificate (CDEC) norm (BSCAL, 1997). On the basis of the interim reported submitted by the committee, 112 applications, by hospitals claiming to be charitable, for the Customs Duty Exemption Certificate had been rejected (Apollo Hospitals Enterprises v. Union of India, 2001). Thereafter, a writ petition filed by the PUCL (W.P. (C) No. 2485 of 2001) in the Delhi High Court was heard and a detailed order was passed on 2nd May 2003 by a Division Bench. During the course of the court proceedings it was brought to the notice by the Central Board of Excise and Customs that a total of 396 hospitals were examined by DGHS. Out of those, CDEC has either been withdrawn or cancelled for 386 hospitals, as they did not comply with the requirements (M/S. R.G. Stone Urological v. Union Of India & Ors., 2010).

Quid Pro Quo Schemes between the Government and the Private Sector: The Case of Delhi

All through post-independence history, registered societies and trusts in Delhi have been allotted land by the Delhi Development Authority (DDA) as well as Government of India (GoI) on concessional rates for the establishment of hospitals. In return, the hospitals were mandated to reserve certain percentage of beds for poor patients in the IP as well as facilities in the OP Departments. Different hospitals in Delhi were asked to reserve between 10 to 70 per cent of beds in the IPD (SAMA, 2011). Over time, however, the difference in treatment costs between corporate hospitals and the charitable hospitals have been disappearing. As the following table regarding the Delhi case will show, the cost in corporate hospitals is twice as high as that in the All India Institute of Medical Sciences (AIIMS), the top-end public hospital in Delhi. For a single room, it is four times higher. However, between charitable and corporate hospitals, there is hardly any difference (Lefebvre, 2008).

Table 1: Coronary Angiography Prices (in Rupees) in Delhi for one day Hospital Stay (2006)

Management	Hospital	General Ward	Shared Room	Single Room
Corporate	Max Devki Devi	13,000	16,000	21,000
Corporate	Indraprastha Apollo	14,000	15,500	19,000
Trust	Sir Ganga Ram Hospital	13,000	13,500	19,000
Corporate	Fortis	10,000	11,000	12,000
Public	AIIMS	5,000		5,000

Source: (Lefebvre, 2008).

According to the report by the Public Accounts Committee (PAC), in November 1999, the Government of Delhi constituted a Committee to review the compliance of the hospitals to the free treatment facility clause. The Committee's review report in 2000 confirmed what the public knew all along, that beneficiary hospitals were not fulfilling their obligations of providing free treatment to poor patients. In the same year, a high level committee headed by Justice A.S. Qureshi also recommended that allotment of land at concessional rates to such institutions must be cancelled for non-compliance with the terms of allotment. Based on the findings of these committees, the DDA sought a report in 2001 from fourteen hospitals regarding the fulfilment of their obligations. It is noteworthy that only five institutions responded to the DDA's notice. However, as the PAC report notes, "no action was initiated against the defaulters, nor was any action taken to verify the correctness of the report furnished by the five institutions" (Lok Sabha Secretariat, 2005).

In response to a Starred Question on Sondhi Charitable Hospital in Delhi raised in the Assembly in March 2001, it was stated that the hospital was functioning like a private nursing home and charging exorbitant fees, and the Health Secretary directed the DDA to take appropriate action against the hospital for violating the terms and conditions of allotment. No action was taken despite orders from higher authorities to initiate cancellation proceedings against the hospital. No responsibility for the inaction has been fixed (Lok Sabha Secretariat, 2005).

Interestingly, various hospital managements of Delhi put forward different arguments in front of the high level committee headed by Justice Qureshi in order to escape the financial burden posed by the substantial proportion of inpatient beds for free patients, which amounted to 70% for hospitals like Veeranwali Hospital and VIMHANS, and would make these hospitals financially unviable, if implemented. Other hospitals, who had to earmark 25% per cent of the beds for the poor, also felt that the provision is "excessive" and affects the "financial viability of the hospitals". However, after deliberations within the leading voices of the Delhi private health care industry, a group consisting of Dr Naresh Trehan of the Escorts Hospital, Dr Sama and Dr KC Mahajan of Sir Ganga Ram Hospital, Shri AL Batra of Batra Hospital, Dr S Khanna of Dharmashila Cancer Hospital and Dr Prathap C Reddy of Apollo Hospitals, conveyed to the high level committee that the proportion of free beds to the poor needs to be 15%, so as to keep the hospitals financially viable. According to the industry leaders, the "ideal" would be 10%. The threshold percentage of 15% was based on the argument that the cost of medicines and medical consumables is so high that it is difficult to give totally free care beyond this (Qureshi, 2001).

The high level committee, took a very bleak view of the nature of the hospitals that claim to be charitable. Its final report concluded that "most of the charitable hospitals are no more charitable", although the founders had intended them to be charitable hospitals, providing considerable relief to the poor, needy and deserving patients. In a scathing indictment, the report says that the successors, however have been "selfish, greedy and exploitative" and have converted these charitable hospitals to moneymaking machines (Quershi, 2001). Incidentally, Dr RK Takkar, MD of Indraprastha Apollo hospital in Delhi, who was also part of the committee representing the hospitals, had suggested as part of the high level committee's deliberations in 2000 that provision of free care would be feasible through a health insurance scheme. He also had "serious reservations" about some comments in the report about Apollo Hospital, and chose to submit a note of dissent to the final report (Quershi, 2001)

As detailed in the (Sama, 2011) study, following many such instances of flouting of norms, a lawyers group named Social Jurist filed a Public Interest Litigation (PIL) writ petition in 2002 stating that conditions of allotment of land to hospitals, particularly with regard to free treatment for the poor were not being fulfilled. The final judgment was pronounced by the High Court of Delhi in 2007. It took into consideration the recommendations of the Justice Qureshi Committee report and decreed that 10% of the total beds in

the inpatient department (IPD) must be reserved and 25% of the patients in the OPD should be treated free of cost if the patient belonged to the economically weaker section EWS. The monitoring and the implementing body for the provision of free treatment is the Nursing Home Cell of the Directorate of Health Services, Government of the National Capital Territory (NCT) of Delhi (Sama, 2011). However in 2012, it emerged that out of a total of 43 hospitals which were required to comply with the scheme, most were in fact flouting the conditions. Delhi Government issued notices to 34 defaulting private hospitals for not complying with the directions of the Supreme Court and Delhi High Court ("Delhi: Notice to 34 hospitals for not treating poor for free," 2012). In short, compliance to these conditions remains as big a challenge today as ever.

As Nandraj et al. (2001) observed incentives provided by state governments all across India have not been used to influence private care provision favourably vis-à-vis equity. The government often provided incentives to the private sector without ensuring any returns for the poor and disadvantaged people of the country. Such incentives "have been put in place reactively to private sector interests, and have not been monitorable" (Nandraj et al, 2001). However, some of these commissions and the resulting legislations have had some impact in many states, including Maharashtra. The Customs Department's action against hospitals who did not fulfil the required conditions when they imported duty-free equipment in Maharashtra, Gujarat and Madhya Pradesh during 1988-94, was upheld by the Customs, Excise and Service Tax Appellate Tribunal (CESTAT), Mumbai, at the end of long court proceedings which started with a PIL in 1996 (Mehra, 2008).

Charitable Hospitals in Mumbai

According to state Gazeteers (1986), various religious and charitable trusts in Maharashtra prior to 1950 were governed under various central and provincial level enactments based on religion. In 1950, in a major reform, a composite legislation called the Bombay Public Trusts Act of 1950 was passed which was made applicable to all public trusts without any distinction of religion. The Charity Commissioner, with headquarters in Bombay, was appointed to administer the Act. The Deputy Charity Commissioner, with the assistance of two Assistant Charity Commissioners, looks after the Greater Bombay region (Maharashtra State Gazeteers 1986). Clause 41AA of the Act which was included later, gave power to the Charity Commissioner and the State Government to issue directions with respect to hospitals to earmark certain beds and facilities for poor patients to be treated free of charge or at concessional rates (BPT Act, 1950).

Charitable hospitals in Mumbai have been historically receiving various benefits from different government agencies. First, trust hospitals were exempt from paying the Public Trust Administration Fund (PTAF) amounting to five per cent of the gross annual income, which is otherwise mandatory for all trusts registered under BPTA, according to Section 58, Clause 1. Charitable trust hospitals have been exempt from paying PTAF from 1972. Besides getting exemptions from payment of contribution towards 'PTA Fund', public charitable trusts which are running hospitals, nursing homes, dispensaries are getting other facilities and concessions like land on concessional rates and land on lease at concessional rates from Government of Maharashtra and Local Authorities. The charitable hospitals are also registered under the provisions of Income Tax Act, 1961 and are getting exemptions in payment of Income Tax on the ground that they are providing medical aid/relief at free or concessional rates to the poor and needy persons in furtherance of the objectives of their trusts. Charitable hospitals had received concessions/exemption in payment of Octroi on import of hospital equipment vide notification No.279/82-Cus-FN0.460/96/83-Cus. V. (G.S.R. 767-E), dated 30th September, 1983. A Trust namely 'Sadhu Vaswani Mission Trust' which runs medical facilities in Mumbai and Pune received under customs duty exemption certificate with notification 64/88-Cus dated 1st March, 1988 an amount of Rs. 1,02,85,744/- upto January, 1993. They also received exemption from payment of customs duty on

the import of a CT Scan Machine through Ad-hoc Exemption order No.170 dated 22nd June, 1995. The amount of customs duty exemption received under this exemption order was Rs.83,73,102/- .

Information based on affidavits submitted to the committee by a small subset of the total hospitals that come under BPTA 1950, revealed that many charitable hospitals got land either free or at concessional rates from the Government or local authorities. For instance, the Government of Maharashtra allotted a plot of land admeasuring 7200 sq. m. to Bombay Hospital Trust on lease for a period of 99 years on concessional rate vide order dated 7/1/1970. Similarly, Sir Harkisandas Narottamdas Hospital and Research Center has received a plot of land on lease from the Municipal Corporation of Bombay. The National Health and Education Society, which is running Hinduja Hospital has received 22073 sq. m plot of land in the year 1978 on lease for period of 99 years from the Government of Manarashtra. Hinduja Hospital has also received additional Floor Space Index (FSI). Breach Candy & Bacchubai Hospital has received a plot of Government land on lease. The Diabetic Association of India, which runs SL Raheja Hospital, has received two acres of land from the Government of Maharashtra free of cost and revenue. Gurunanak Memorial Hospital, Bandra has received land on lease for 999 years from the Government of Maharashtra at a concessional rate. Maharashtra Housing and Area Development Authority (MHADA) has granted a piece of land to Lilavati Hospital on lease from the Government of Maharashtra. MGM Vaidya College, Kamothe, Navi Mumbai received four hectares of land on concessional rate. Terna Medical College, New Bombay received four hectares of land on lease at a concessional rent. Dr. DY Patil Medical College, Nerul, Navi Mumbai has received 8 hectares and 5650 sq. m. of land at a concessional rate. Similarly, Thane Municipal Corporation has granted land to Kaushalya Trust. Collector of Bombay has granted pieces of lands to Gauri Mittal Hospital and Saifee Hospital on concessional rent on lease.

Based on the affidavits, it was seen that twelve charitable hospitals have got extra FSI benefits by way of concession. During financial year 2002-03, the Government of Maharashtra granted Grant-in-aid to 23 hospitals Charitable Hospitals totally amounting to Rs. 1,02,58,500/-. During the financial year 2003-04, a total grant in Aid of Rs. 2,86.90,100/- was given to four charitable hospitals by the Government of Maharashtra. Charitable Hospitals situated within the limits of Mumbai Mahanagar Palika were getting concession in payment of Property Tax, Electricity Bill, Water charges. According to the Dhumal Committee Report, the aforesaid concessions given by the Local Authorities have been withdrawn from 2001-2002 (Dhumal Committee Report, 2006). This observation by the Dhumal Committee, however, was based on wrong information submitted to the committee by the private hospitals themselves, as we will see in later chapters.

In addition to this, many hospitals have applied for and were recipients of large import duty concessions. Interestingly, Nanavati Hospital and Jaslok Hospital were among the hospitals whose import concessions were revoked following the Rosha Committee recommendations. Nanavati Hospital and Jaslok Hospital were part of long legal proceedings challenging the verdict regarding their status as charitable hospitals. However, both the Supreme Court as well as the High Court upheld the argument of the DGHS that these hospitals were guilty of "non-fulfilment of the free treatment obligation" (Dr Balabhai Nanavati Hospital v. Union Of India & Ors., 2011; Jaslok Hospital & Research Centre v. Union Of India & Ors., 2007). The custom import exemption notification had stipulated that the hospitals have to provide free treatment to at least 40 per cent of the outdoor patients and to all indoor patients whose income is less than Rs.500/- per month, "keeping for this purpose at least 10 per cent of all the hospital beds reserved for such patients" (Jaslok Hospital & Research Centre v. Union Of India & Ors., 2007). All such charitable hospitals were to provide medical, surgical or diagnostic treatment without any distinction of caste, creed, race, religion or language "at reasonable charges, either on the basis of the income of the patients concerned or otherwise, to patients other than those specified," that means all the other patients (Dr Balabhai Nanavati Hospital v. Union Of India & Ors., 2011). For the sake of comparison with the

conditions that are in place for a hospital to be considered "charitable", the tariffs of both the hospitals are attached. Even the lowest tier room has a daily tariff which is multiple times the per capita per day income limit for the patients in order to access free care, which speaks volumes of the purported affordability of the hospitals. Additionally, the deposits demanded at the beginning are so restrictive that it virtually renders treatment for even the lower middle class at these charitable hospitals unaffordable⁴.

BPTA as an Entry Strategy for Private Hospitals

From the exorbitant rates at which patients are charged, it is clear that the specific comment on hospitals in Bombay made by Gilson et al (1994) - that almost all private hospitals are registered under the Charitable Trust Act with the sole purpose of availing tax and other benefits from the government - still holds true. The only requirement of provision of free services to some patients in return for such benefits is not monitored (Gilson et al., 1994).

According to Yesudian (1993), in Bombay, "every non-public sector hospital is a voluntary sector hospital because it is registered under the Charitable Trust Act". The private hospitals are registered under the BPTA as voluntary institutions, in order to access tax rebates and direct and indirect subsidies. It was also observed that all the major private hospitals in the city are registered as Research Centres although "hardly any research is carried out" and papers written by consultants are passed off as research work. This too was aimed at accessing tax and other concessions like import duty waiver for purchasing expensive medical equipment. The mushrooming of private health facilities in Bombay can be attributed in part to the cutbacks in government investments and resultant paucity of funds causing deterioration of services at the public hospitals. These hospitals cater mainly to upper and upper middle class patients, and even in the nineties, it was observed that medical tourism was the main source of income at least to some of these hospitals, indicating the socioeconomic categories these hospitals largely catered to (Yesudian, 1993).

The report of the working group headed by Dr Rindani (1976) on the medical facilities in Bombay observed that of the total 19335 beds in Greater Bombay, 5174 (26%) were in the private sector. By 1990, there were 602 hospitals in Bombay of which 88% were private although they were providing only 40% of the total 29162 beds (Yesudian, 1993). An analysis of the data on hospitals with valid Nursing Home License Certificates available with the Municipal Corporation of Greater Mumbai (MCGM) under the Bombay Nursing Home Registration Act (1949) shows that of a total of 156 hospitals, 112 got registered after 1990 (MCGM, n.d.). Available data specific to charitable hospitals indicate that of a total of 37 hospitals for which year of establishment is available, 23 or about two thirds were established after independence (HOSMAC, n.d.).

According to Dhumal (2006), even prior to enactment of the Bombay Public Trusts Act, 1950, a number of charitable hospitals existed in Mumbai as well as in other parts of Maharashtra, and the stated objective of these hospitals was to provide medical treatment to the needy and the poor. These hospitals received assistance from the government or from local authorities, like lease of land at nominal or concessional price, exemption or concession in payment of income tax, customs duty, property tax, water tax, electricity bills, or other kind of financial and administrative assistance (Dhumal Committee Report, 2006).

⁴ Refer to Annexure 6

Introduction of 41AA Clause in BPTA

It was noticed by the Government of Maharashtra that Charitable hospitals and nursing homes did not generally provide sufficient or cheaper facilities to the poorer class of people although they have received or are receiving assistance from the state, and the state has no appropriate control over their activities. Therefore, it was felt necessary to introduce provisions of Section 41AA in the mid-nineteen eighties. The statement of objects and reasons for the introduction published in the Government Gazette on March 15 1984, read, "According to the terms of the trusts, the medical centres are to be run by them for charitable purposes, but some of them are having very big and flourishing business. It has been noticed that they do not generally provide sufficient or cheaper facilities for the poorer classes of the people and although they have received or are receiving assistance from the State, the State has no appropriate control over their activities." Failure to comply with any directions issued under section 44A, without any reasonable cause, is proposed to be made an offence punishable with fine, which may extend to Rs 2000 (Rindani et al., 1976).

Section 41AA of the Bombay Public Trusts Act 1950, which was introduced in August 1985, specified that "State aided public trust" means a public trust exclusively for medical relief or for medical relief and other charitable purposes, which maintains a hospital, including any nursing home or maternity home, dispensary or any other centre for medical relief, and which has received any grant of land or building, either on ownership basis or on lease or leave and license, at a nominal or concessional rate, from the State Government or the Central Government or any local authority (B.P.T. Act, 1950). The definition also includes bodies that have been given any exemption or permission to continue to hold any vacant land under Section 20 or 21 of the Urban Land (Ceiling and Regulation) Act, 1976 (XXXIII of 1976) by the State Government. Any entity that was given any concession or exemption or relaxation of a substantial nature from the Development Control Rules by any competent authority for the purpose of the trust is also included in the definition of "State Aided Public Trust". Additionally, trusts that have received any loan or guarantee or any nonrecurring grant in aid or other financial assistance or is receiving any recurring grant in aid or other financial assistance from the State Government, the Central Government or any local authority, were added into the purview of the definition.

Having thus defined the "state aided public trusts", Section 41AA which formalised the power of the Charity Commissioner and the State Government to issue directions with respect to hospitals in order to earmark certain beds and facilities for poorer patients to be treated free of charge or at concessional rates, went on to define those entitlements in the following manner. First, it was mandated that such medical facilities must reserve and earmark ten percent of the total number of operational beds and ten per cent of the total capacity of patients treated at such medical centres, for medical examination and treatment in each department of the medical centre, in such manner as may be specified in the directions, of the indigent patients seeking admission or treatment, who shall be medically examined and treated and admitted , as the case may be, free of charge. In addition, Section 41AA mandated that hospitals run by state aided public trusts must reserve and earmark ten per cent of the total number of operational beds and ten per cent of the total capacity of patients' treatment at such medical centre, for medical examination and treatment in each department of the medical centre in such manner as may be specified in the directions for the weaker sections of the people seeking admission for medical examination and treatment, who shall be charged according to such rates as the State Government may, by general or special order , determine from time to time, with regard to the rates charged by the State Government in the corresponding medical centres maintained by it. Section 41AA of the BPT Act also made it clear that in addition, such hospitals are bound to comply with any such other incidental or supplemental requirements as may be specified in the direction or in any general or special orders issued there under.

The Act did not leave any room for doubt that 10 per cent of the hospital's treatment capacity is to be put aside, free of cost for poor patients, and an additional 10 per cent needs to be put aside for poor patients at subsidised rates determined by the state government from time to time. However, the introduction of the new section of the Act did not mean that the trust hospitals complied with it. The hospitals, as already observed by Nandraj et al. (2001), Gilson (2002) and Yesudian (1993), took undue advantage of the lack of monitoring by the government, and routinely flouted the 20% norm for free and concessional care put forth by the BPTA. While there have been efforts by the government to use the health care capacity in the charitable hospitals, they proved ineffective, for a variety of reasons - the most important being the reluctance of the hospitals themselves, who became more interested in attracting well off patients and earning profits, rather than helping the poor. There are academic studies that show that foreigners account for about 12 per cent of all patients in top hospitals of Mumbai, like Lilavati, Jaslok, Breach Candy, Bombay Hospital, Hinduja Hospital, Apollo and Wockhardt (Puri, Singh & Yashik, 2010). It is notable that just two out of seven hospitals mentioned are private corporate hospitals. The first five happen to be charitable hospitals. It also happens that these are the hospitals that got themselves exempted from the scheme citing large losses. The origin of this free bed scheme and the PIL in the High Court, which resulted in the framing of the scheme, will be explored in the next chapter.

PUBLIC INTEREST LITIGATION AND ITS AFTERMATH

A Policy Environment of State Support for Private Charitable Hospitals

Despite the consistent failure in monitoring conditions that purportedly offered free care for the poor in return for huge subsidies, the central as well as the state governments continued with the policy of handing out direct as well as indirect subsidies to the private sector to the for-profit and the not-for-profit variants. The Central Council of Health and Family Welfare, the apex advisory body of the Ministry of Health and Family Welfare of India, in its fourth meeting in 1995, passed a resolution titled, 'Directing resources for developing Public Private Partnership and joint sector approach in favour of the poor,' which called for harnessing all the available resources for the health care, especially for the poor and the disadvantaged.

The aforesaid resolution stated that it was imperative to make efforts to develop public private partnerships, and called upon the State as well as Central Governments to consider provision of free/subsidised land, electricity, water, roads, exemption of customs duty on the imported equipment to the extent possible and fiscal incentives, where necessary (Government of India, 2005). The resolution also recommended that, in keeping with the liberalisation policy leading to health sector reforms, the financial public sector units (PSUs) are encouraged to provide interest free financial assistance for a minimum period of five years to the private sector to raise loans from financial institutions/banks. In return, the private sector should provide a minimum of 30% beds and 40% outpatient/diagnostic services free for treatment of the poor in the rural and urban sectors (Government of India, 2005).

This policy environment certainly contributed to the private charitable hospitals' receiving substantial benefits in many states including Maharashtra. It was more so in Mumbai. A study conducted to evaluate the status and functioning of charitable hospitals in three major cities, Mumbai, Delhi and Bangalore, by a leading hospital consultancy firm observed, a "paradigmatic change" took place among charitable hospitals, which brought "businesslike attitudes and strategies" (Shah & Bhatt, n.d). As a result, there was a newfound resistance from within state aided charitable hospitals to any effort by the state to provide care through their infrastructure, which added on to the existing lack of monitoring vis-à-vis the existing legally mandated provisions as part of section 41AA of the BPT Act. Along with direct and indirect benefits from the government, there was a growing demand within the state administration that the health care resources that such trusts are bound to keep aside for the poor by legal mandate need to be used by the state for the benefit of poor patients. This demand grew as part of the discontent about the administration and implementation of the Bombay Public Trust Act, 1950 among the public, the political leadership, and also among the officers who administer the Act (SCIP, 2004).

Weak Consolidation Efforts by the State

This resulted in some sporadic efforts by the state government to consolidate and use the capacity in charitable hospitals run by state aided trusts, partly in recognition of the fact that the state aided charitable hospitals were unwilling to fulfill the legal provisions of BPTA, like free provision of beds to the poor, voluntarily. The attempt to get state aided charitable hospitals to be part of Rajiv Gandhi Jeevandayee Arogya Yojana was one among these. The Maharashtra Government has implemented

Rajiv Gandhi Jeevandayee Arogya Yojana in the state from October, 1997 to provide financial help to financially weaker sections focusing on below the poverty line (BPL) population, for treatment of serious diseases of heart, kidney, brain and the spinal cord. These patients can avail themselves of medical services for these ailments in both public and private hospitals which are part of the scheme (Government of Maharashtra, 2012). It provided full financial aid for treatment of eligible patients, including surgeries and implants. It was reported that the budget for 1998 had allocated Rs 250 crores for the scheme ("Maharashtra budget hikes prices of cigarettes and liquor", 1998). In 2010-11, with a budget of Rs 111 crore, 13,616 surgeries were performed at the designated network of government and recognised private/trust hospitals, and reimbursed later (Kurian, 2012).

Since monitoring of the 41AA has been an issue, there was an effort by the state government to make state aided charitable hospitals a part of the Jeevandayi Scheme by invoking the provisions of the Bombay Public Trust Act. However, from 1997 itself, the state aided charitable hospitals have refused to treat the patients referred to them by the government, in blatant violation of BPTA provisions. A high-level meeting to review the scheme presided by the health minister found that out of the 800 odd cases referred to the state aided charitable hospitals for treatment, only nine patients were treated, and the rest were turned away (Marpakwar, 1999). It was observed that since the scheme was launched, the health department had recommended 100 patients to the Bombay Hospital, twenty-seven to P D Hinduja Hospital, ten to Jaslok Hospital, eight to Harkisandas Hospital, four to Leelavati Hospital, one to Breach Candy Hospital, among others. As per the official records of the health department, out of a total of around 800 cases, only nine - one by Lilavati Hospital, five by Bombay Hospital, two by Hinduja Hospital and one by Ruby Hall Clinic, Pune were provided treatment. The state aided charitable hospitals initially demanded that the scheme should be routed through the Charity Commissioner. However, when the government conceded this demand the hospitals failed to respond (Marpakwar, 1999). The then health minister had taken note of the complete non-cooperation by the state aided charitable hospitals and requested the Charity Commissioner to ensure that the charitable hospitals implement the scheme in letter and spirit (Marpakwar, 1999).

Soon, the Association of Hospitals termed as "an umbrella organisation of disgruntled hospitals," filed a petition in the High Court challenging the validity of the Jeevandayi scheme. It was argued that the state aided charitable hospitals anyway reserve 10% of their beds for poor patients as laid down under Section 41 AA. It was said that if any more patients were given free treatment, it would affect their financial health adversely. The division bench of Chief Justice M B Shah and A Y Sakhare admitted the petition, and stayed Jeevandayi Yojana's implementation in 30-odd hospitals for six weeks. The state government however rejected the AOH's claim and alleged that the state aided charitable hospitals do not follow the guidelines laid down under the Bombay Public Trust Act ("HC Stays Jeevandayi Yojana", 1998). Interestingly, the state aided charitable hospitals had also objected to the procedure involved in referring patients to them. As per the government resolution, patients below the poverty line need to approach a district hospital, which in consultation with a competent reference committee, would refer them to a private/state aided charitable hospital. AOH maintained that such reference system does not allow the private/ state aided charitable hospitals to have a say in the matter and as such obstructs its functioning ("HC stays Jeevandayi Yojana", 1998).

This volte face by the state aided charitable hospitals came as a surprise to the health ministry, as according to the minister, the representatives of the hospitals had expressed no reservations when the scheme was discussed initially. "All of a sudden, they are challenging the scheme despite the government giving them tax concessions and additional floor space index in return", the minister informed the press. The Maharashtra state government soon moved the Supreme Court against the Bombay High Court's order staying the Jeevandayi scheme (Mhasawade, 1998). The Supreme Court vacated the stay by the High Court, based on the Special Leave Petition, filed by the Maharashtra government ("SC

Vacates Stay on Jeevandayee Scheme", 1998). After the year long legal battle, the government made plans to be stricter. Public statements were made by the health minister that state aided charitable hospitals refusing to treat patients under the scheme will face legal action, and even a bill providing fine up to Rs 2 lakh for erring state aided charitable hospital managements was to be introduced in the winter session of the state legislature in 1999 ("Aher Threatens Action Against Jeevandayi Violators", 1998). However, there has not been any follow up on any such bill. There were also reports that Bombay Hospital and Jaslok Hospital had begun treating patients following the Supreme Court ruling against their parent organisation, AOH ("Stiff Penalty Mooted For Erring Pvt Hospitals", 1998).

Public Discontent against Flouting of Norms

Interestingly, persistent flouting of the rules by the charitable organisations also triggered various state agencies to take note of the situation. In Maharashtra, there were serious attempts to review the functioning of charities, and as a result, the Bombay Public Trust Act was amended 25 times between 1950 and 1997 (SCIP, 2004). Each amendment made the Charity Commissioner progressively more powerful, at least in theory, to check maladministration, misappropriation and misuse of trust funds, and abuse of powers by the trustees. Each successive amendment added more provisions at the Maharashtra Charity Commissioner's disposal for removal, dismissal, suspension of trustees, for issuing injunctions and directions to them and to appoint receivers, etc.¹⁴⁴. Following these amendments, which introduced provisions like 41AA that mandated free medical care to the poor, the Bombay Public Trust Act was again reviewed by the Maharashtra Law Commission constituted in 2001, on grounds that there was general public discontent about the way the Bombay Public Trust Act was being implemented. Such discontent was not only in the minds of the public, but also in the minds of the political class and in the administrative departments as well. The Commission submitted its report in 2004 titled, 'The 13th Report of the Law Commission on the revision of the Bombay Public Trust Act, 1950' to the Maharashtra government, which recommended the introduction of a new Bill. The report had many new provisions, including those for improving the performance of the Charity Commissioner's office by strengthening its capacity to monitor trusts effectively.

The Report of the Law Commission on the revision of the Bombay Public Trust Act, 1950 had painted a gloomy picture of how charitable organisations were run in Maharashtra. According to a representation to the Law and Judiciary Department of the Government of Maharashtra by the Bombay Chartered Accountants' Society, the report contended that most charitable institutions did not serve the cause of charity but were run as business centres, and recommended that there was need to bring them under effective control and regulation. The report also found that most charitable institutions received direct or indirect benefits from the government because of which they were in a position to amass considerable wealth disproportionate to the original contribution by the founders of the trust. Lastly, the Law Commission report observed that most charitable institutions work for the benefit of a family or the close relatives of the Trustees (Bombay Chartered Accountants' Society, 2004). The recommendations of the commission were justifiably strict as they endeavoured to bring in elements of effective control and regulation.

Understandably, the Association of Hospitals, which represents state aided charitable hospitals in Maharashtra, was one of the first bodies to raise objections to the recommendations of the Law Commission. The Association of Hospitals (AOH) insisted that any such amendments will prevent generous philanthropists from coming forward. It was argued that as a result of the recommendations, the quality of healthcare was likely to suffer. AOH also expressed its fear that the move would completely discourage corporates from investing in the social sector ("Amendment to Trusts Act to Hit hospitals", 2004). In their complaint to the Chief Minister, AOH said that while the "recommendation appears to be innocent, (but) a careful study shows that the move is motivated by the idea to empower the

Government to acquire indirect control over public charitable trusts in the State" (Datta, 2004). Supporting the objections by the hospital lobby, the Bombay Chartered Accountants' Society, in a separate representation to the Law and Judiciary Department of the Government of Maharashtra, contended that the proposals in the report "effectively gives authority to the government to issue directions to hospitals etc to earmark certain beds etc for poorer patients to be treated free of charge or at concessional rates," and that it was "tantamount to interfering with the independent functioning of such charitable trusts which are in reality not obtaining any significant monetary benefit from the government". The Bombay Chartered Accountants' Society urged that the government should not interfere in the management and functioning of hospitals and similar institutions which are well-managed by non-government organisations (NGOs). It was advised that the government should concentrate in providing more hospitals and managing the existing hospitals under their control more efficiently and effectively (Bombay Chartered Accountants' Society, 2004).

The Centre for Advancement of Philanthropy, an organisation established in 1986 consisting of powerful corporate houses such as HDFC, the Tatas and the Forbes Marshall Group threw their weight behind the protestors. The centre has considerable clout, with a strength of over 500 representing most of the corporate foundations and voluntary organisations. Managements of state aided charitable hospitals like Kokilaben Dhirubhai Ambani, Sir Harkisandas Narrotamdas Jaslok, PD Hinduja, KJ Somaiya, and Lilavati also happen to be members of this powerful organisation. In June 2004, a formal memorandum was submitted to the Minister of Law and Judiciary by the centre, which sought to address the "disturbing recommendations" made by the Law Commission (Centre for Advancement of Philanthropy, 2004). The memorandum requested the minister to "dismiss these undesirable recommendations of the Maharashtra Law Commission" and argued against efforts of control and regulation. The centre cited the case of the United Kingdom, and insisted that the "Charity Commissioner (must be) more a friend, philosopher and guide to charities than a judicial or quasi-judicial authority" (Centre for Advancement of Philanthropy, 2004). The pressure on the government was enormous, and the idea of a new bill was shelved (SCIP, 2004). Despite "a general public discontent about the administration and implementation of the Bombay Public Trust Act, 1950", the private sector interests preferred status quo and as the campaign gained momentum, it needed to be granted.

PIL in the Bombay High Court on Refusal of Treatment

It is in this situation that Sanjiv G Punalekar, a Mumbai based lawyer filed an application in the Bombay High Court in December 2004, based on the refusal of treatment for his father in a state aided charitable hospital. Not taking into account the hospitals' argument that the Punalekars came nowhere near the categories of 'poor' or 'weaker section', the High Court converted the application into a PIL (CEHAT, 2006). The division bench consisting of Chief Justice Dalveer Bhandari and SA Bobde passed an interim order dated 14/10/2005 constituting an Expert Committee under the chairmanship of the Charity Commissioner, Maharashtra. The Expert Committee was to look into various aspects of Section 41AA of BPTA for the effective implementation of the provisions contained therein (Dhumal Committee Report, 2006). Based on the deliberations of the Committee, a report was submitted to the court in 2006. Recommendations from the report were used by the court to frame a scheme which stipulated inter alia that 10% of the beds in such hospitals should be reserved for indigent patients (with income less than 25,000) for free and 10% on concessional rates for economically weaker sections (with income less than 50,000). Also, 2% of gross revenue would be earmarked to create an Indigent Patients' Fund (IPF) to be spent on poor patients. All the state aided charitable hospitals would report to the Charity Commissioner, who was appointed to monitor the compliance and implementation of this scheme.

As part of the court procedure, the Charity Commissioner reported in 2005 in the High Court that his office had conducted an inspection of Bhatia Hospital, Jaslok Hospital and Bombay Hospital. In the

light of the inspection, the Assistant Charity Commissioners observed in their report that none of the hospitals run by the Public Charitable Trusts had provided treatment free of cost to the Indigent patients and that only Bombay Hospital provided some treatment to the patients of economically weaker sections at concessional rates. It reported that an inspection of Breach Candy Hospital was carried out in November 2003 and that of Lilavati Hospital in July 2004. The inspection reports also indicated that these state aided charitable hospitals did not provide medical facilities in accordance with the provisions of Section 41 AA of the Bombay Public Trusts Act, 1950 that is, free treatment to poor patients ⁵.

Punalekar had in fact sought the High Court's order for formulating a scheme of centralised admissions to provide free treatment to patients up to a statutory quota in view of the concessions availed by them. This was opposed by the state aided charitable hospitals who maintained that there should be no centralised admission and that admission of patients would be at their own discretion. The state aided charitable hospitals had also expressed their inability to provide completely free treatment and raised objections over the definition of free treatment. They contended that free medicines would not be provided to the patients (Fernandes & Rai, 2006). A scheme that neither covered medicines/consumables nor had a centralised referral system as the one in Delhi was framed. The Maharashtra scheme remained a much watered down version of the Delhi Scheme, which was more equitable ⁶. This happened even as the terms of reference defined by the High Court for the expert committee had suggested, "a proper referral system and admission policy" as the main objective (Dhumal Committee Report, 2006).

Role Played by AOH within and outside the Expert Committee

The State Legislature had constituted a Legislative Committee to monitor the functioning of the state aided charitable hospitals under the court scheme, and this elicited considerable resistance from the state aided trust hospitals. However, the court found that the apprehension expressed by the Association of Hospitals that the two committees, one by the government and the other by the court, were overlapping and in conflict over the subject of the petition was incorrect ⁷. There have been cases where (as reported in the court by the state authorities), action was to be taken on one hospital- Jaslok in this case- for alleged "misbehaviour" with the members of the Legislative Council who tried visiting the hospital and verifying the running of the scheme ⁸.

It came to light over court proceedings that one of the members of AOH had warned partner hospitals and other members of the association that no "outsider" ⁹ that no person other than a resident of Maharashtra should be provided health facilities that are meant for indigent persons and weaker sections of the society. Responding to this, the High Court took an unambiguous position that every citizen of this country who was within the said two categories was eligible for availing the benefit of medical treatment. The bench also said that people not only from all over the country but also from the neighbouring countries should be welcomed. The court stated that it failed to understand why a human being should be deprived of the best medical treatment available and within their means, leave aside restricting it to citizens.¹⁰ In 2009, the court felt that since the Scheme was in operation, no further orders need be passed, and the petition was disposed off. Now, the responsibility of monitoring the scheme was with the Charity Commissioner's office.

⁵ Judgment of the Bombay High Court, dated March 16, 2005 by the bench comprising of Dalveer Bhandari and S. A. Bobde.

⁶ This Delhi Scheme will be discussed later.

⁷ Judgment of the Bombay High Court, dated March 12, 2008 by the bench comprising of J. N. Patel and Nishita Mhatre.

⁸ Judgment of the Bombay High Court, dated February 27, 2008 by the bench comprising of J. N. Patel and Nishita Mhatre.

⁹ It has to be noted here that Mumbai is known for the parochial brand of politics of the Shiv Sena.

¹⁰ Judgment of the Bombay High Court, dated March 12, 2008 by the bench comprising of J. N. Patel and Nishita Mhatre.

It has to be mentioned that many of the design features of the free bed scheme in Maharashtra were tweaked at the instance of AOH, during the deliberations of the Dhumal Committee, which had two AOH representatives as members. For example, a referral system which the Committee had initially considered in line with the one existing in Delhi was shot down by AOH, on grounds that it would amount to "interference in the internal management of the hospitals" (Dhumal Committee Report 2006). Likewise, it opposed raising IPF to anything more than 2% of the revenue although by virtue of being "charitable", these state aided charitable hospitals save 5% of the revenue which would have to be paid as PTAF, which trusts pay. Added to other benefits that Dhumal Committee report explains, 2% of IPF is a very small amount. It needs to be borne in mind that a similar scheme is in place in Delhi which mandates 10% IP and 25% OP services to the poor, absolutely free. Unlike the Maharashtra scheme, this scheme includes medicines and consumables too.

Interestingly, the Qureshi Committee of Delhi had many stalwarts of the private hospital industry as members. The leading voices of the Delhi private health care industry, a group consisting of Dr Naresh Trehan of the Escorts Hospital, Dr Sama and Dr KC Mahajan of Sir Ganga Ram Hospital, Shri AL Batra of Batra Hospital, Dr S Khanna of Dharmashila Cancer Hospital and Dr Prathap C Reddy of Apollo Hospitals, had conveyed to the high level Committee that the proportion of completely free beds to the poor (including drugs and other consumables) needed to be at the maximum of 15%, so as to keep the hospitals "financially viable" (Qureshi Committee Report, 2001).

In spirit, a watered down version of this recommendation of the private hospitals in Delhi is what the free bed scheme in Maharashtra tried to implement with 10% of the beds free and 10% of the beds at half the cost. It was possibly assumed that since medicines and consumables which constitute more than half of the expenditure are excluded in the scheme, it would be voluntarily complied with by the state aided charitable hospitals. This is the only possible explanation, why the monitoring mechanisms remained lax. The resultant non-compliance however, was huge and upsetting.

AOH appealed to the Bombay High Court earlier in an effort to get rid of the BPTA Scheme as it exists, but was unsuccessful. In response to arguments by the AOH, which has been trying constantly to undermine the validity of the scheme, the court stated that there are sufficient safeguards for the state aided charitable hospitals who may feel aggrieved by any action under the Scheme against them ¹¹. There is a review petition by one of the state aided charitable hospitals under consideration but the legality of the scheme was established despite considerable efforts by the AOH and state aided charitable hospitals to sabotage it. AOH hit a dead end as far as getting rid of the BPTA Scheme per se was concerned (Kurien, 2012). At the same time, all through the court procedure, on record and off the court, AOH has been maintaining that all the concessions to the state aided charitable hospitals have been withdrawn, and the High Court seemed to have taken this argument in good faith ¹².

Lying to the High Court and Appellate Tribunals

Alongside claiming that the state aided charitable hospitals do "enough charity" and that they do not get enough concession from the state, the state aided charitable hospitals and AOH have been part of elaborate legal proceedings to maximize the subsidies that they can extract from the state and its agencies. The acts of misinforming the public and the authorities that the Association of Hospitals (AOH) and its member state aided charitable hospitals, who have been at the forefront of the fight to make the High Court scheme ineffective, should be brought to notice. An impression is created that these state aided charitable hospitals no longer get any subsidies or exemptions from the government or other agencies.

¹¹ Judgment of the Bombay High Court, dated April 15, 2009 by the bench comprising of Bilal Nazki and V.K. Tahilramani.

¹² Judgment of the Bombay High Court, dated April 15, 2009 by the bench comprising of Bilal Nazki and V.K. Tahilramani.

Even in their submission to the Charity Commissioner recently, after which four state aided charitable hospitals (Jaslok, Hiranandani, Breach Candy and Lilavati) were allowed to stop treating poor patients temporarily, they have been arguing that the scheme affects their viability and there is "financial difficulty in treating poor patients" (Deb-Roy, 2012). It is clear that state aided charitable hospitals that have been physically expanding (in terms of bed strength and specialities) over the last five years¹³, and have profited a lot from foreign patients via medical tourism, show no sign of any such grave "financial difficulties."

These arguments are all linked also to the initial submission by the AOH to the Dhumal Committee Report (2006) that the quid-pro-quo of free beds to subsidies is no longer valid as the "trust hospitals do not have any benefit whatsoever" which was factually incorrect. This was made after listing the benefits as "octroi, electricity, property tax etc."¹⁴ It is seen that this falsehood is oft repeated in the press and the media, and AOH has never been brought to justice for misleading a court appointed committee. The case of subsidies on electricity offers an illustrative example. Parallel to the PIL which resulted in the High Court scheme, in which the AOH and state aided charitable hospitals were trying hard to convince the court that they do not receive any benefits, another case was being fought by AOH and others with the electricity provider in the Maharashtra Electricity Regulatory Commission for "more" benefits. The proceedings of this case clearly brings out that state aided charitable hospitals (like Hiranandani and Raheja) are already being given clear subsidies vis-à-vis electricity tariff. Strangely, the lawyer representing AOH which refuses to treat a miniscule 10% for free patients stating that it affects its "financial viability", argues in the Regulatory Commission that these very state aided charitable hospitals are "institutions run without any motive for profits" and that "the purpose of a Government hospital and charitable hospital is the same". The AOH argued that state aided charitable hospitals should be treated at par with Government hospitals and that the tariff for both should be the same. AOH argued that "all the charitable hospitals render yeoman service to the Society and general public and play a vital role in supplementing the Governmental facilities for health care"¹⁵. Failing to get a favourable order at the state level, AOH took the fight to the Appellate Tribunal for Electricity in Delhi, which rebuking the state commission, noted that state aided charitable hospitals "utilise electricity for *benevolent objectives of providing health care, human life saving and for relief from health hazard and not making any profit for any one* (emphasis added).¹⁶ Assisted by the best lawyers of the country, AOH has been very successful with its negotiations with the state, inside courtrooms and outside. In 2009, Maharashtra government authorities issued a notification increasing the Floor Space Index (FSI) for private hospitals in the city and suburbs by 300% and 400% respectively, which was a longstanding demand by the hospitals. Here too, the hospitals were required to "continue to provide" free medical treatment to the extent of 10% of the total number of beds to those below the poverty line ("State extends FSI benefit to private hospitals", 2009).

Though self-regulation of the charities sector is necessary along with state regulation in the non profit sector to ensure good governance and accountability, there is still need for an effective state mechanism to enforce the law in case of transgression of a code of good conduct (SCIP, 2004). This has been particularly true for the medical care sector. While lately, the Charity Commissioner of Pune has been taking proactive measures like filing criminal cases against state aided charitable hospitals flouting the

¹³ This will be explored in the next chapter in detail.

¹⁴ Submission by AOH to Dhumal Committee Report (2006) Annexure G of the Report.

¹⁵ Maharashtra Electricity Regulatory Commission, CASE NO. 19, 2012, <<http://www.mercindia.org.in/pdf/Order%2058%2042/Final%20Order%20Supplemental%20Order%20Case%20No%202019%20of%202012.pdf>> (accessed May 13, 2013).

¹⁶ Appellate Tribunal for Electricity by the Association of Hospitals, C/o Bombay Hospital Versus Maharashtra Electricity Regulatory Commission & Ors., Appeal No.110,111,170,171,201 & 202 of 2009 & Appeal No. 70,71,78,79,80,81 & 82 of 2010, October 10, 2011. New Delhi.

High Court Scheme's norms, Mumbai has been lagging far behind with very lax implementation of the scheme (Isalkar, 2011). A brief description of the nature of state aided charitable hospitals in Mumbai is given in the next chapter along with a review of the working of the scheme.

WORKING OF THE HIGH COURT SCHEME

The state aided charitable hospitals in Mumbai are mostly large hospitals offering secondary and tertiary level care. Over the past two decades, many of the old state aided charitable hospitals have made explicit arrangements with the private corporate sector. Invariably, the founders' objective of being charitable and providing considerable relief to the poor is completely being overlooked. Mumbai has been a goldmine for private corporates, where they could piggyback on existing charities and have access to resources including land that was given cheap by the government, which would otherwise cost a fortune.

Given this context and the lack of human resources of the Charity Commissionerate to monitor the state aided charitable hospitals' compliance to the High Court mandated scheme has been a contentious issue. The large number of state aided charitable hospitals in Mumbai has compounded the issues related to the implementation of the scheme and its monitoring¹⁷. This chapter, with the help of data procured from the Charity Commissionerate, will review the working of the scheme. The case study of Kokilaben Dhirubhai Ambani Hospital reflects the transformation of the state aided charitable hospitals in Mumbai.

The Case of Kokilaben Dhirubhai Ambani Hospital¹⁸

In an incident which has interesting similarities to the Delhi case in 2004 where allotment of land to three ineligible institutions deprived DDA of revenue of Rs. 38.54 crore¹⁹, a recent CAG Report (2011) on Maharashtra revealed that Kokilaben Dhirubhai Ambani Hospital received land that belonged to a medical charity in fraudulent ways which caused a huge loss to the state exchequer. Most of the case study is extracted from the CAG report which exposed it. Ownership of land originally allotted free of cost to Malti Vasant Heart Trust (Nitu Mandke and family) for a hospital at Andheri, Mumbai was changed by agreements with the Reliance Dhirubhai Ambani Group of Industries, a corporate Group, without prior approval of the Government. The Trust was liable to pay unearned income of Rs 174.88 crore, which was not recovered by the Government in the absence of an independent mechanism to enquire about changes in the ownership of the original allotment of land and commercialisation of activities.

It was noticed by the government auditors that a plot of land measuring 12,050 square metres was allotted to the hospital and research centre at lease rent of just one rupee per year for a period of thirty years to Malti Vasant Heart Trust vide Government order dated 29 December 1997. At the time of allotment of land, the trustees were Shri Nityanand Vasant Mandke, Smt. Alka Nityanand Mandke and Smt. Jyotsna Vasant Mandke.

Scrutiny of records in 2010 revealed that only Smt. Alka Nityanand Mandke remained of the original trustees and in place of the two other original trustees, three new trustees were brought in. The

¹⁷ An annexure which will briefly describe the spread of state funded private charitable hospitals in Mumbai is attached.

¹⁸ Information taken from CAG (2011) Audit Report (Revenue) Maharashtra 2010-2011, Chapter 4: Land Revenues, Comptroller and Auditor General, New Delhi.

¹⁹ Department of Urban Development http://www.cag.gov.in/reports/reports/civil/2004_4/chapter3.htm "chapter - III Ministry Of Urban Development And Poverty Alleviation" 2013, (accessed June 02, 2013).

hospital building was constructed in January 2009 on the allotted land and named Kokilaben Dhirubhai Ambani Hospital and Research Institute. There were seven share/stake holders of the hospital. One of the trustees, namely Smt. Tina Ambani informed the Chief Minister in 2009 that it was a flagship hospital of Reliance Anil Dhirubhai Ambani Group. The business group had invested Rs 291 crore in the hospital venture. Three more trustees were subsequently added to the trust and decision making was now with the new trustees.

However, no prior permission was taken from the Government for change/ownership in the trustees. Effecting such changes without the knowledge of the Government is illegal and as the ownership had been changed without prior approval of the Government, the Trust was liable to pay unearned income of 75 per cent of the market value of 2009 which worked out to Rs 174.88 crore.

According to a circular issued by the Government in February 1983, when land is allotted by the Government at concessional rate, 40 per cent of the total/ available operational beds should be available to the general public on payment of fees which is fixed by the hospital with prior approval of the Public Health Department. Information independently collected by CAG's office revealed that the bed charges in the hospital ranged between Rs 15,000 to Rs 20,000 per day. The Collector confirmed that the rates for bed charges were not approved by the Government.

As per the agreement between the Chairman of Malti Vasant Heart Trust and the Collector, MSD, Mumbai in April 2003, the fees and rates to be charged in the Outpatient Department (OPD) of the hospital shall be in accordance with the rates charged in the Government Hospital in the Municipal Corporation area. Information independently collected revealed that the OPD charges of the hospital were Rs 600 whereas the OPD charges in Government hospitals in the municipal area were Rs 10. The data collected from the hospital revealed that the building is put to use for commercial activities such as - gift shop, spa, beauty salon, food court, office of Reliance Company and business centre comprising of video conference facility, ready to use office blocks, in stark violation of the conditions of the agreement.

Another seriously disturbing trend has been the blatant under-reporting by Kokilaben Ambani Hospital to the Charity Commission about their bed-strength. In April 2009 it reported to the Charity Commissioner a total bed strength of 160, when actually, there were 750 beds. Till June 2012, Kokilaben Ambani Hospital never reported more than 400 beds. To add, enormous amounts of money have been accumulating in the IPF account, and in June 2012, the account had around Rs 3 crores of unspent money. Over the last three years, the proportion of scheme related patients to total patients has never been more than 2.5%.

In an interesting replay of sorts, Sir H N Hospital and Research Centre, another hospital which Reliance has been "supporting" with the objective of "making philanthropic interventions for the welfare of the Indian society" is undergoing a transformation²⁰. It just so happens that within 15 years of its joining the management of the hospital run by a charitable trust established in 1925, "with the objective to rehabilitate and modernize the heritage hospital serving the poor and middle classes of society", Reliance Foundation's chairperson, Mrs. Nita M. Ambani has become now the President of Sir H N Hospital & Research Centre. According to its website, the Reliance Foundation is expanding its heritage hospital, Dr. H N Hospital and Research Centre, Mumbai by building a 19 storey, 800,000 sq. ft. world class health facility²¹.

²⁰ India Heart Beat.com, "Sir H N Hospital & Resaerch Centre's Profile". 2013, <<http://www.indiaheartbeat.com/hospital/profile/11457/Sir-H-N-Hospital-Resaerch-Centre.html>> (accessed June 02, 2013).

²¹ Reliance Foundation, 2013, <<http://reliancefoundation.org/>> (accessed June 02, 2013).

The working of the High Court Scheme

This section reviews the working of the legally mandated free bed scheme as well as the monitoring committee using data available with the Charity Commissioner, data that the state aided charitable hospitals submit to Charity Commissioner as well as from the monitoring committee. The hospitals under BPTA 1950 were exempt from 1972 from any contribution towards the mandatory Public Trusts Administration Fund of Maharashtra which amounted to five percent of the gross annual income, or of the gross annual collection or receipt because these trusts were taken to be set up "exclusively for the purpose of medical relief"²². Over the years, the quantum of other concessions and subsidies received by such trusts has also been substantial. As part of the court scheme, state aided charitable hospitals have been mandated by the High Court committee to retain the copies of papers proving the 'indigent/weaker section' status of the patient for a period of three years to facilitate the cross checking of the same by the office of the Charity Commissioner, if necessary. The state aided charitable hospitals were also asked to keep proper records and at the end of the year file a report, along with the audited accounts, to the Charity Commissioner.

The initial analysis was based on data submitted by the state aided charitable hospitals to the Charity Commissioner's office on a monthly basis. The form of reporting mandated by the BPT Act is a monthly register (Form X AAA-Vide Rule 25 A) for each hospital which records the billing number, date and amount, patient address, contact details and income, the department the patient is admitted to and dates of admission and discharge. This is to be sent to the Charity Commissionerate along with the financial details of the amounts credited and debited from the IPF Account of the state aided charitable hospitals. The data is then compiled and filed by the Commissionerate into individual hospital folders and the financial information fed into a computerized data sheet for each hospital.

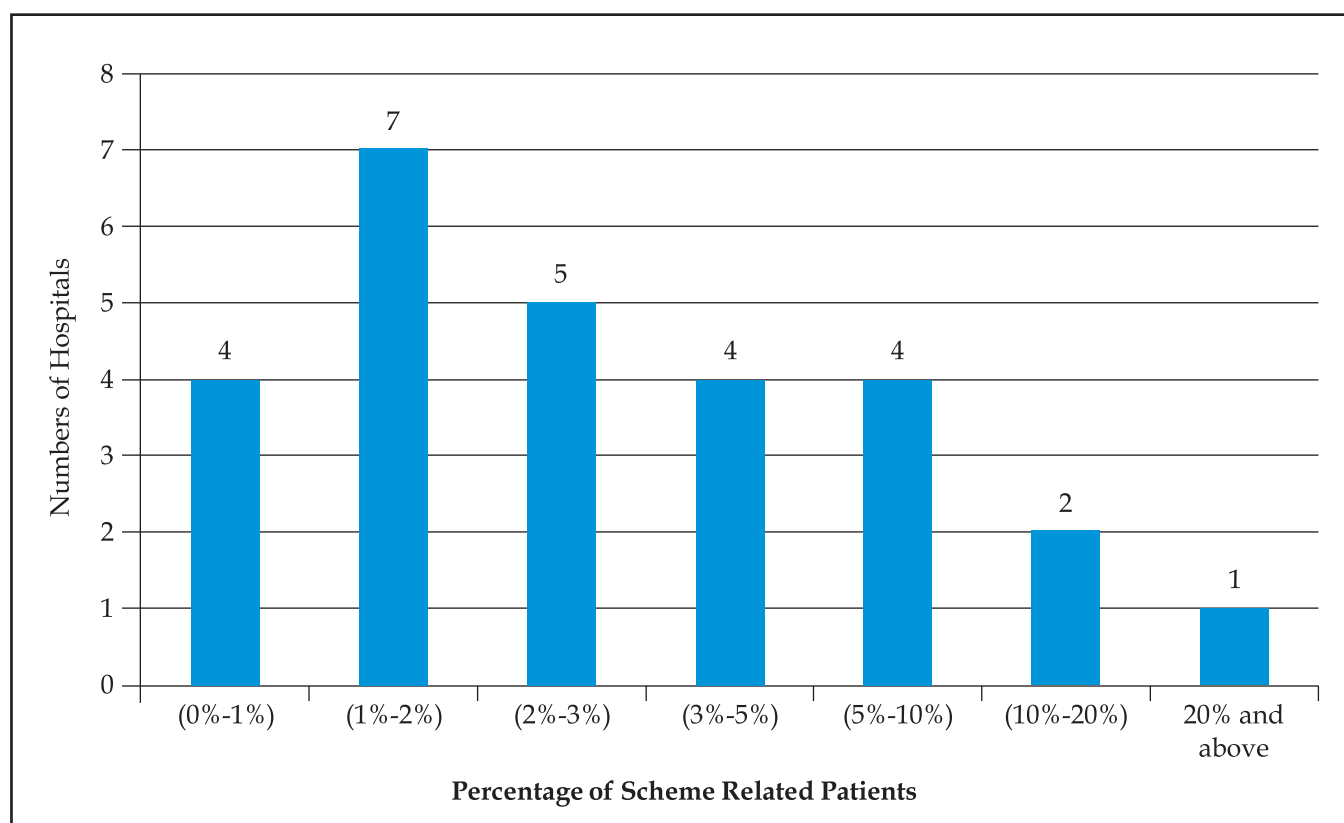
Scheme patients as a proportion of total paying patients

Out of the seventy four state aided charitable hospitals in Mumbai for whom such data were available, 42 relatively bigger hospitals with more than 50 beds, were selected for further analysis. For convenience, monthly data for three years for all these 42 hospitals were converted to six six-monthly periods. Analysis of the compiled data revealed that a substantial number of state aided charitable hospitals did not comply with the scheme and that the degree of non compliance was high. Out of the 42 big state aided charitable hospitals, only 29 had given the number of total patients for any six month period across 2009, 2010 or 2011. Our analysis has shown that out of 27²³ hospitals with data for total patients, only one hospital had at least 20% of scheme related (indigent + weaker section) patients. Figure 1 gives a distribution of 27 large state aided charitable hospitals according to the proportion of patients treated under the scheme. For this, data from the latest available six-monthly period was taken.

²² BPTA (1950)

²³ Two hospitals that show more than 100% due to reporting error were excluded.

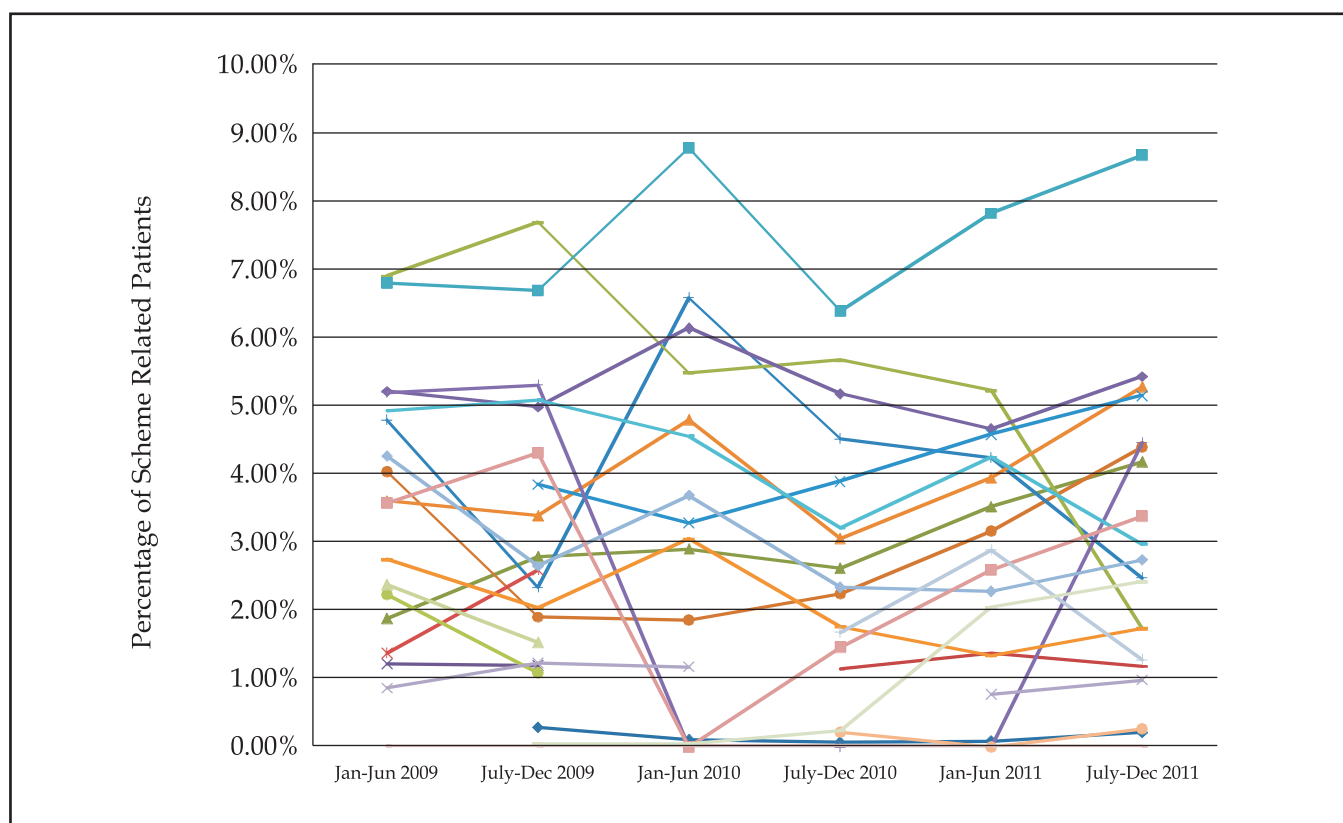
Figure 1: Distribution of Hospitals according to the Percentage of Scheme Related Patients (IP + OP)



As the above figure is based on data for the latest available six monthly period between 2011 December and 2009 January, it is interesting to note that data for all the three hospitals that show a high proportion of poor patients- two hospitals showing 10%-20% and one hospital showing more than 20%- are from 2009. After the court scheme came under increased media and civil society scrutiny, things changed. After 2009 December, all these three state aided charitable hospitals that have reported more than 10% of their patients being given benefit of the scheme have stopped reporting the total number of patients.

Once we remove the three state aided charitable hospitals with 'suspiciously' high numbers, who stopped reporting the total for unknown reasons, we have a more detailed chart (Figure 2) where it is clear that of the big state aided charitable hospitals that have reported total patient numbers, none have given care to even 10% and only one- fourth has served at least close to 5% of the scheme related patients. It has to be borne in mind that since our analysis involves both IP and OP patients put together, our calculation is an overestimate when comparing it with the mandated 20% beds. However, to start with, these broad numbers bring forth the very high degree of non compliance to the scheme even when OP and IP are treated on par. Data across the last three years were analysed and hospitals showing consistently low numbers bear out the systematic undermining of the scheme guidelines by the state aided charitable hospitals. It rules out the conjecture, which often hospitals bring up in order to seek exemption from the scheme, that the present low numbers are a result of past high numbers and the resultant financial pressure. The scheme patients' numbers have been historically very low.

Figure 2: Six-Monthly Trend: Percentage of Scheme Related Patients (IP + OP)

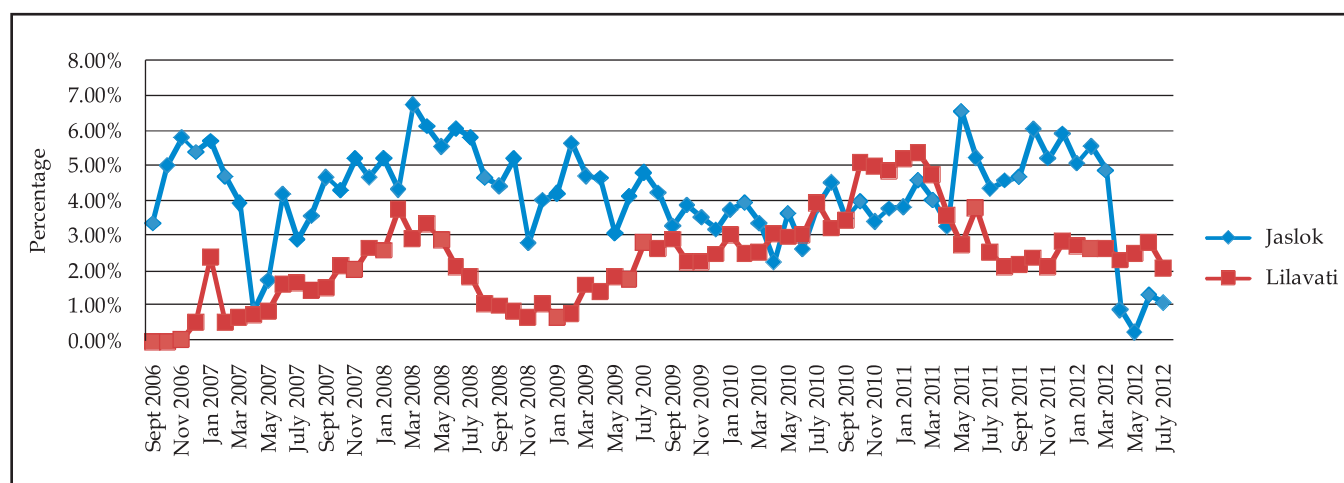


The historical trend, going beyond the last three years of low patient numbers are specifically examined for two state aided charitable hospitals that sought exemption from the scheme.

Proportion of poor patients treated: A Case Study of two state aided charitable hospitals that complained of over-provisioning

A survey of the state aided charitable hospitals that went to the Charity Commissioner for exemption from the scheme stating that they are treating too many patients, throws up some interesting statistics. According to our analysis, which is based on self-reported data (from Jaslok and Lilavati hospitals) regarding total patients and scheme patients (Breach Candy and Hiranandani do not submit total patients data at all), it is clear that these state aided charitable hospitals, when looked at month-wise patient inflow, have never treated more than 7% poor patients over the last six years. If it were to be taken as an average, the figure would be much lower, as is evident from the figure.

Figure 3: Proportion of Poor Patients treated in Jaslok and Lilavati Hospitals across the last six years



The data available with Charity Commissionerate: Is it consistent? Is it used?

Indeed this level of analysis only gives us a broad picture. Since the Charity Commissioner's office did not compile or analyse details like bed days, OP/IP disaggregation, or average expenditures between OP and IP for each state aided charitable hospital, it was decided to access the hospital folders and calculate monthly bed days for three months from the separate case records submitted by 19 big state aided charitable hospitals, for whom some data was available. Findings from this analysis would help bring out a more accurate picture of the overall situation. A detailed analysis of case records submitted by 19 hospitals showed that:

- Only eight state aided charitable hospitals have submitted detailed segregation of data into IP and OP categories.
- Only two state aided charitable hospitals provided billing data clearly classified into billable and non-billable.
- Apart from one state aided charitable hospital, no hospital has provided any separate information on the bed-days for inpatient cases.
- Four state aided charitable hospitals gave incomplete reports and included no patient-information, billing-details or discharge and admission dates.

An examination of the folders revealed that most state aided charitable hospitals submitted some of the required data, and some reported information in their own formats. For example, some state aided charitable hospitals presented bank account statements of the IPF accounts, the billing-rate-cards, details of billable and non-billable services, segregated patients-lists into OP and IP, bed-days and so on, while some state aided charitable hospitals left out patient contacts, billing details, departments, dates of admission and discharge in their monthly reports. This lack of consistency arises from the imbalance in the nature and degree of data being made available for monitoring. Instead of this confusion, use of the standard format that has been provided in the scheme would enable effective reporting and aid efficient monitoring. A stricter enforcement of submitting all the data as mandated is essential.

Some state aided charitable hospitals submit details of one or two cases where all the bills, income verification details are maintained, which while giving a glimpse into the processes followed and services provided by the state aided charitable hospitals, is inadequate to judge the implementation of the scheme. While most of the big hospitals have completely computerized MIS, it is not clear what is preventing

them from submitting electronic data to the Charity Commission.

Are there incentives in the system for hospitals to predominantly provide OP?

We were at all practical purposes, left with the overall bed numbers and overall monthly patient numbers under the indigent as well as the weaker section patients, as most of the 42 big state aided charitable hospitals in the city do not submit patient data disaggregated between IP and OP, to start with. Since the numbers are reported as a composite of IP and OP, it is necessary to explore how much OP is being provided as part of the scheme and the reasons. This inevitably had to be done with a smaller subset of state aided charitable hospitals who submitted information on financials disaggregated between IP and OP cases. An interesting result that emerged from the analysis was about the average money per day spent by the hospital on an indigent OP patient as a percentage to that on an **indigent IP patient for the latest month: it was found that an indigent OP visit cost 10.67% of an average indigent IP bed day**. This was based on data from six hospitals for whom IP/OP data was available.

Figure 4: Average Bed Days for different Conditions: TAC Estimates 08).

Cause Group	India (TAC)15
Infections	3.81
Digestive	4.05
Other	3.40
Urology	4.36
Eye	1.03
Circulatory	5.35
Respiratory	3.76
Injury	4.92
Pregnancy	4.61
Neoplasm	5.48
Musculoskeletal & Connective Tissue	6.13
Endocrine	4.67
Skin	4.08
Nervous	5.61
Ear	2.43
Blood Diseases	4.75
Overall	4.04

Source: The Tariff Advisory Committee (2008). Summary Reports from TAC Data - Health (2007 -

This shows that there is a strong incentive for state aided charitable hospitals to treat OP since the Charity Commission does not disaggregate data and analyse it, if/when checking compliance. However, this needed to be verified by analysing data from state aided charitable hospitals that have provided data on patients disaggregated between OP and IP. Further analysis proved that the state aided charitable hospitals are predominantly treating OP patients. In both cases, that of indigent patients for whom 10% beds are to be provided for free and that of weaker section patients for whom 10% beds are to be provided at 50% cost, it was seen that **on the average only about one-fourth of the total number of patients were given IP treatment**²⁴. This result is very important because the Charity Commission treats the total patient numbers provided by the state aided charitable hospitals to calculate proportion of beds, and not IP patients alone. More seriously, a look at the disaggregated data for the last three months instead of one, shows that the proportion for some state aided charitable hospitals can be as low as around 5% of IP cases. This calculation, for the hospitals for which such disaggregated data is available, is presented in Annexure 3 as Table 3.

Health Care provided as Bed days instead of Numbers

In order to assist further analysis, it was decided that total bed days at the state aided charitable hospitals disposal would be calculated and both indigent and weaker section bed days provided for a six monthly

²⁴ Based on 8 hospitals for whom disaggregated data for indigent patients was available and based on 7 hospitals for whom disaggregated data for weaker section patients was available.

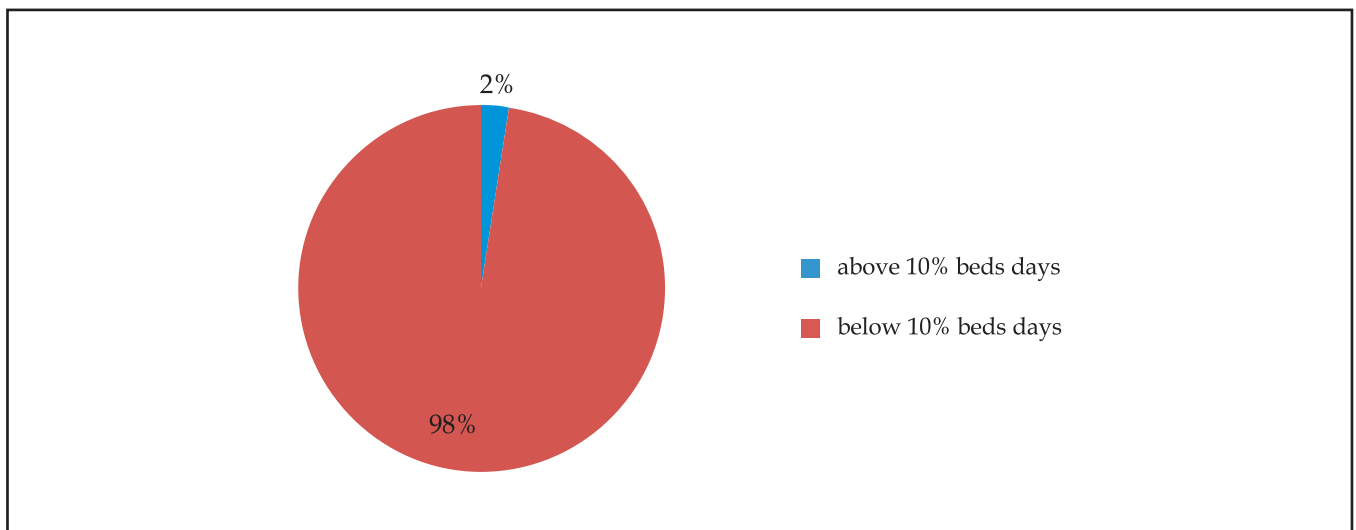
period, as a percentage of the overall would be calculated for all the 42 state aided charitable hospitals. In order to achieve that, average bed days per patient was arrived at first. This data was taken from the Charity Commissioner's data folders for the latest month available. Disaggregated data also include figures from the state aided charitable hospitals that were granted exemption after they complained to the Charity Commissioner that they were treating too many patients and that it was not economically feasible. Hence, any chance of this average based on a sample of 15 state aided charitable hospitals for indigent IP and 12 state aided charitable hospitals for weaker section IP being an underestimate is ruled out. Average bed days per indigent patient as well as weaker section patients were 4.21 and 3.76 days respectively²⁵. Tables with disaggregated figures for the individual hospitals vis-a vis indigent as well as weaker section patients are attached in Annexure 3 as Table 4 and 5.

Owing to data limitations and in order to rule out the possibility of underestimation or overestimation and limit margin for error, average bed days figures were again validated using similar figures arrived at by the Insurance Tariff Advisory Committee report of 2008-09. The average bed day figures for both categories were quite close to the TAC estimate.

The average bed day figures that emerged from the analysis were used in all the 42 hospitals to arrive at approximations of the situation, with respect to big state aided charitable hospitals in Mumbai. For looking at the compliance, we converted the available indigent and weaker patient numbers into bed days based on the average bed days that were arrived at. This exercise was done for all the 42 hospitals under study and the detailed trends can be looked at in the following diagrams.

Between July-December 2011, it was seen that only two per cent of the large charitable hospitals have provided indigent patients with the mandated 10% bed days; (Figure 6) only one out of 42 hospitals in Mumbai! A disaggregated look at the profile of hospitals is also given in the table. Majority of big charitable hospitals (almost three-fourths) in Mumbai fail to set aside even 2% of beds for indigent patients, while they are supposed to keep 10% of beds for such patients. Disaggregated table giving a percentage wise distribution of hospitals is given in Annexure 3 as Table 6).

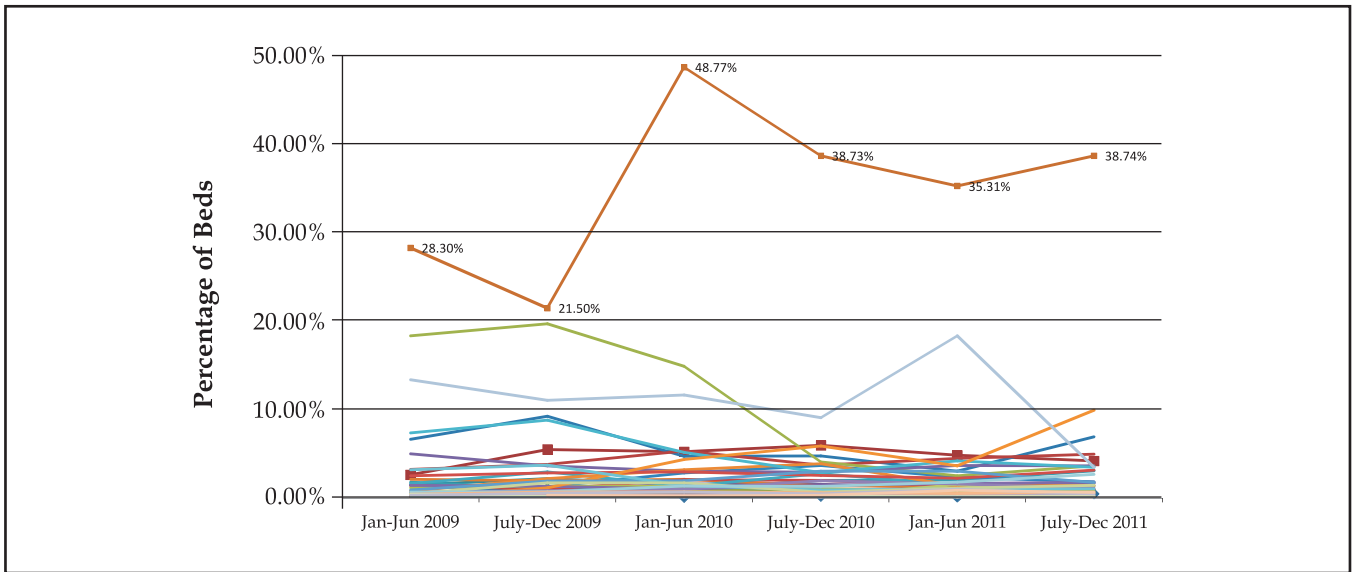
Figure 5: Proportion of large Charitable Hospitals in Mumbai that provide 10% Beds to Indigent Patients



²⁵ Each OP patient visit was treated at par with an IP patient visit for want of disaggregated data. These numbers were verified by using data from a large hospital for which disaggregated data for a year was available.

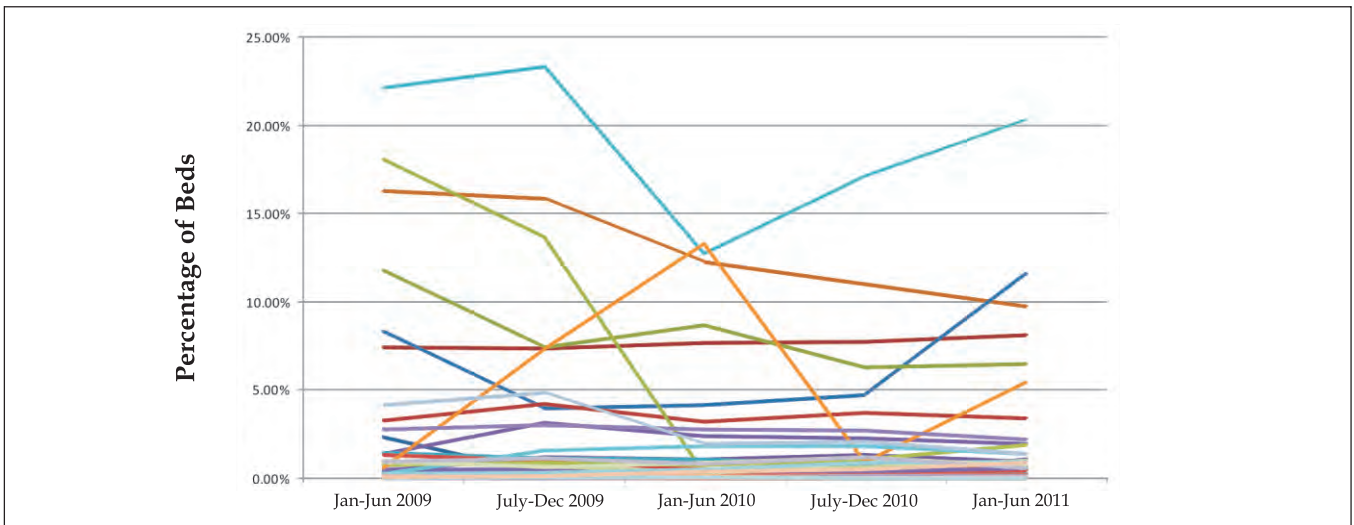
While 10 percent of bed days are mandated by the High Court scheme to indigent patients, it is clear that out of the 42 state aided charitable hospitals with 50 or more beds in Mumbai, only one spends more than 10% bed days, and only three spend 5 % or more bed days for poor patients. This number in itself is an overestimation, as our calculations treat one Outpatient visit on par with one Inpatient day and then club together IP, OP data to arrive at average bed days of 4.21 for indigent and 3.76 for weaker section patients. Even with such extremely liberal benchmarks, charity hospitals are flouting the norms to a high degree. The following figure has trends across the last three years, which does not paint a different picture for these 42 big hospitals.

Figure 6: Proportion of Beds provided to Indigent Patients by 42 hospitals across the last three years



Coming to patients from weaker sections, we have a similar situation where only 4.76% of the 42 large charitable hospitals in Mumbai have complied with the court directive. A disaggregated look at the situation across the last three years follows. This figure has trends across the last three years for bed days set aside for patients from weaker sections. However, it does not paint a different picture.

Figure 7: Proportion of Beds provided to Weaker Section Patients by 42 Hospitals across the last three years



It is clear from the analysis that only less than one-fifth hospitals offer even at least 5% of bed days to both indigent and weaker section patients. As we have already seen, these percentages are still overestimations since we treat one OP visit on par with one IP day and put a 4.21 weightage on any reported OP case, which is about three fourths of the total. But since the initial analysis has proved that the degree of non-compliance is so high, even these overestimations prove to fall short of the mandated 20%. The results of the analysis, where not just the proportional numbers of patients, but estimated proportion of bed days were looked at, comprehensively prove that flouting of the scheme rules is highly prevalent and is practised by almost all hospitals.

Case of a Positive Outlier

The fact that these numbers are exceedingly inflated can be explained by the case of a hospital which appears as a positive outlier in our study. According to our analysis, this particular hospital spent more than 20 per cent bed days for the indigent patients and more than ten per cent bed days for patients from weaker section patients almost consistently over the last three years. We have already seen that on the average, the percentage of Inpatients in total indigent patients was 26.08%, and for weaker section patients the percentage was 22.46. However, for this particular hospital which reported a very high proportion, higher than the mandated 10% each for indigent and weaker section patients, the figures for IP patients as a proportion of total patients were just 7.93% in the case of total indigent patients and 10.96% in the case of total weaker section patients. In other words, this hospital is giving more than 90% care to low cost OP patients!

Also, for the same state aided charitable hospital, average spending from the IPF per bed day for an indigent patient was Rs 5748/-, while the average spending from the IPF per OP visit was just Rs 731/-. Interestingly, we found that, while average revenue per patient for this particular hospital would be around a lakh of rupees, average spending on indigent and weaker section patients was around 6,000 and 4,000 rupees per patient respectively. There is certainly an incentive for the hospitals to prefer OP patients, and thus inflate the numbers and the existing monitoring mechanism is inadequate. Every OP reported as an indigent/weaker section patient also means that an 'earning bed' is freed for revenue generation, as the summary data submitted to the Charity Commission does not differentiate between OP and IP. Incidentally, this was a state aided charitable hospital that applied for exemption from the scheme due to over spending.

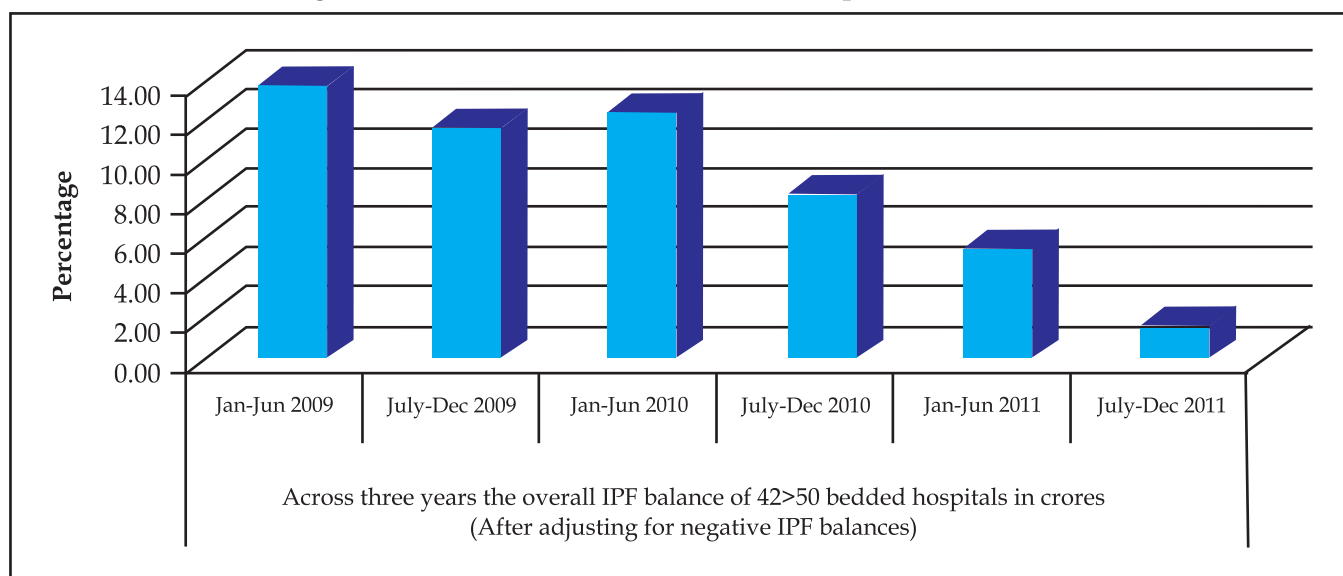
Such analysis is not possible for all the state aided charitable hospitals or for all the years as such IP/OP data is not submitted by all hospitals nor is it compiled or analysed by the Charity Commissionerate. However, it is clear from our analysis that there is a distinct possibility that even the very few state aided charitable hospitals that are better performing in terms of patient volumes may be focusing on low cost, OP patients and the so-called "high spenders" in terms of IPF, may be focusing on just a few high cost patients. In both instances, the proportion of 20% beds that actually go to poor patients is kept at a minimum. None other than the Maharashtra Labour Minister himself has alleged in August 2012 that some hospitals were reporting high expenditure without spending much on the poor. Also, in a positive development, it was reported in 2012 that the Advocate General's office opined to the Health Ministry that the 2% revenue provision should not be used as a cap to refrain from observing the provision for reservation of beds.²⁶

²⁶ *Times of India* (2012), "New law to rein in hospitals flouting bed quota norm?" 2012, <http://articles.timesofindia.indiatimes.com/2012-07-24/mumbai/32826757_1_charitable-hospitals-errant-hospitals-beds>(accessed June 02, 2013).

IPF Spending on Scheme Patients: Unutilised Funds

One has to keep in mind that even beyond subsidies and income tax benefits, all these state aided charitable hospitals under BPTA 1950 are also exempt from 1972 from any contribution towards the mandatory Public Trusts Administration Fund of Maharashtra, which amounted to 5% of the gross annual income. The Indigent Patient Fund, on the other hand is just 2% of the income. As evident from the analysis, many of the state aided charitable hospitals have been reluctant to spend even this amount. If we treat all the 42 largest hospitals as a single entity, over the last three years, it can be seen that the IPF has always been in surplus - to the extent of crores of rupees. If we removed the hospitals that are showing negative balances, the amount will go up multiple times.

Figure 8 : Overall IPF Balance of 42 Hospitals (> 50 beds)



When no method of verification exists, the reported figures by the hospitals on the amount they spend do not carry much credibility, particularly in a situation when the health minister of the state has expressed concerns on the reliability of data. However, our analysis of the last three years six monthly IPF balances brought out the following results:

Table 2: IPF spending across three years

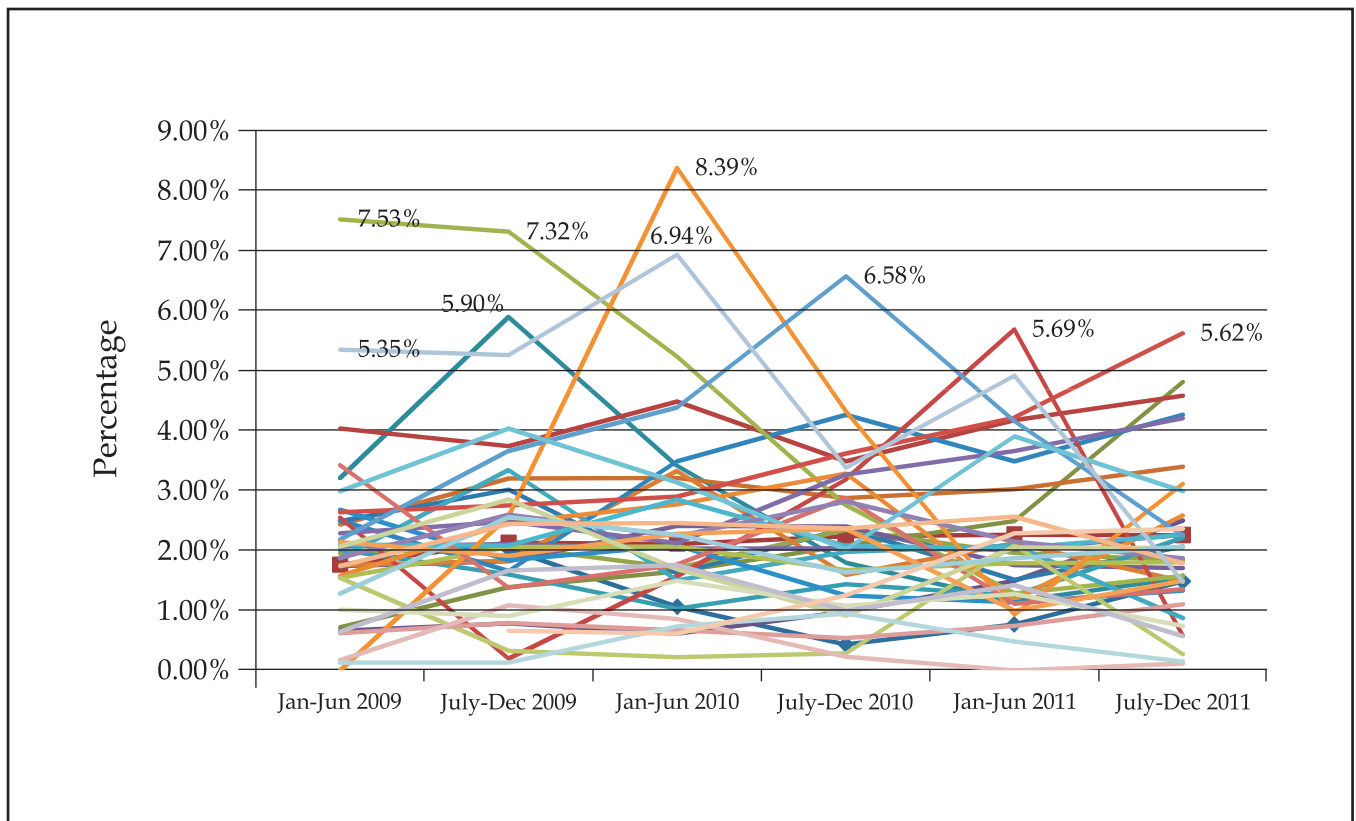
Periods for which IPF spending was under 2% (out of 6 six-monthly periods across 3 years)		
Months	No of hospitals	Percentage of expected IPF funding (2%)
0 out of 6 *	9	21.43%
1 out of 6	4	9.52%
2 out of 6	6	14.29%
3 out of 6	7	16.67%
4 out of 6	9	21.43%
5 out of 6	2	4.76%
6 out of 6	5	11.90%

*This means that out of the six six-monthly periods across three years, IPF spending never went under 2%. It is, in other words, the best case scenario.

In the context of the recommendation by the Advocate General's office that the 2% revenue provision is just one sub-component and should not be used as a cap to refrain from observing the provision for reservation of beds, it is disturbing that many hospitals are not even spending the 2% of IPF funds that they are supposed to, which leads to substantial amounts being left in the IPF. Some hospitals are able to show negative IPF balances. However, the fact remains that most of these have completely become commercial entities, and the beds that they save by offering only OP services to the poor, are earning very high returns which would exceed any 'extra' spending over the mandated 2%. It is clear that 2% IPF limit is being used cleverly by some hospitals to save beds earmarked for the scheme patients. This earns them extra profits. However, despite the Advocate General's intervention, no further action has been taken. Charitable hospitals even cite the High Court scheme to justify their not joining the Rajeev Gandhi Jeevandayi Arogya Yojana (RGJAY).

In the following figure, once the outliers are removed, it becomes clear that a substantial number of hospitals have been spending consistently under the mandated 2% across the last three years.

Figure 9: IPF Trends across the last three years



Innovative Flouting: Underreporting of donations and bed numbers Even with regard to the hospitals that were supposed to be spending more than 2% of IPF, many relevant questions exist. Many of these hospitals receive substantial amounts in donations etc, which is supposed to flow into IPF. Also, many of these hospitals in the list of negative IPF have been receiving large foreign donations amounting to crores. Curiously, at least some of them have not reported any donations at the office of the Charity Commissioner.

For example, Prince Aly Khan Hospital, which has not shown any donations for a single month after 2007 September, according to the hospital related data submitted at the Charity Commissionerate, has received more than Rs 6 crores in 2011-12 alone, about Rs 3 crores in 2010-11, and about Rs 14 crores in 2009-10 by way of foreign donations, according to data provided in the Foreign Contribution Regulation Act (FCRA) web portal. Bandra Holy Family Hospital, which has not reported any donations after 2007 January, according to the hospital related data submitted at the Charity Commissionerate, has received more than Rs 1.5 crores in 2010-11 alone by way of foreign donations according to data provided in the FCRA web portal. BSES Hospital, whose reported donation is Rs 1192/- which was received in March 2011 according to submitted data, has in fact received almost Rs 7 crores by way of foreign donations in 2010-11 and more than Rs 5 crores in 2009-10. Similarly, Holy Spirit Hospital, which has till date reported only Rs 7634 which it received in June 2010, received foreign donations which exceeded Rs 6 crores in 2009-10.²⁷ Saifee Hospital, which has never reported any donations as mandated in the scheme to the Commissionerate, received foreign donations of almost Rs 2 crores in 2009-10. It is clear that most of the hospital trusts receive donations, and from the above examples it is clear that the IPF amount is grossly underreported.

Another seriously disturbing trend has been the blatant under reporting to the Charity Commission about their bed strength. This pushes the mandated number of beds to the poor downwards. As discussed earlier, Kokilaben Ambani Hospital has been a paradigm case of such fraud. Even till June 2012, Kokilaben Ambani Hospital never reported more than 400 beds any month. In addition, enormous amounts of money have been accumulating in the IPF account, and in June 2012, the account had around Rs 3 crores of unspent money. Over the last three years, the proportion of scheme related patients to total patients has never been more than 2.5%. SL Raheja Hospital is another example of blatant under reporting of beds. Raheja Hospital reported 176 beds to the Charity Commission in September 2006, when the process of reporting began. By March 2010, they reported 108 beds, and in October 2011, the latest month for which reported data is available, they reported 121 beds. At the same time, the website of the hospitals states that "In 2003, our services were expanded to multi-specialties (and) the bed capacity in our hospital was also increased to 170. Currently, our bed capacity is 230."²⁸ It is very clear that the hospital is not reporting to the Charity Commissioner, half of its beds. Similarly, K.J. Somaiya Medical Trust has been reporting 500 beds for the last six years with 100 beds earmarked for the scheme. The website of the medical college, however, says:

In accordance with current rules which stipulate 7 beds per students, the K.J. Somaiya Hospital and Research Centre has a total of 700 beds. These beds are provided on a free medical basis, i.e. the cost to the patient will only cover room and board. Presently, these facilities come free of cost. As the strength of the students increase, the number of beds will also increase to 1050-1400 beds in the near future.²⁹

Interestingly, an examination of the webpage shows that this page was online since January 31, 2002! In the current situation, where there is a clear absence of a mechanism to verify if the state aided charitable hospitals are not exaggerating the bills as with insurance, if the IPF reductions are worked out at the lowest charges in the hospital, or if the set of non-billable are strictly adhered to by all state aided charitable hospitals, there is a constant risk of hospitals inflating the bill as well as shifting to OP care as the saved IP beds yield much more than what is spent on the scheme. This is particularly true for Mumbai, a health tourism hub, as most of the state aided charitable hospitals have state of the art

²⁷ Ministry of Home Affairs, Foreigners Division, "Foreign Contribution Regulation Act, 2010" (n.d.), <<http://mha.nic.in/fcra.htm>> (accessed June 02, 2013).

²⁸ S. L. Raheja Hospital, 2013, <http://www.dairaheja.org/raheja_hospital.html> (accessed June 02, 2013) Subsequently this webpage has been taken off & a new webpage has been created which shows only 140 beds.

²⁹ Somaiya Health Care, (n.d.), <<http://www.somaiya.com/products/health/health.htm>> (accessed June 02, 2013).

equipment and technology. These hospitals are progressively integrating themselves with the booming healthcare market. As we have already seen, there are academic studies that show that foreigners account for about 12 per cent of all patients in the top hospitals of Mumbai, like Lilavati, Jaslok, Breach Candy, Bombay Hospital, Hinduja Hospital, Apollo and Wockhardt, most of which also happen to be state funded private charitable hospitals.

The Popular Myth of Loss-making Charitable Hospitals

Many of these also happen to be the ones who constantly complain to the Charity Commissioner that they are currently overspending to treat the poor and thereby incurring losses. A look at the growth of these 42 Mumbai state aided charitable hospitals in terms gross revenue across the last three years, and in terms of growth of bed numbers for 33 of these state aided charitable hospitals for which data for the last six years was available, will quell this myth. Figures which are self-explanatory follow:

Figure 10: Growth in Monthly Revenue of 42 Hospitals in Mumbai across the last three years

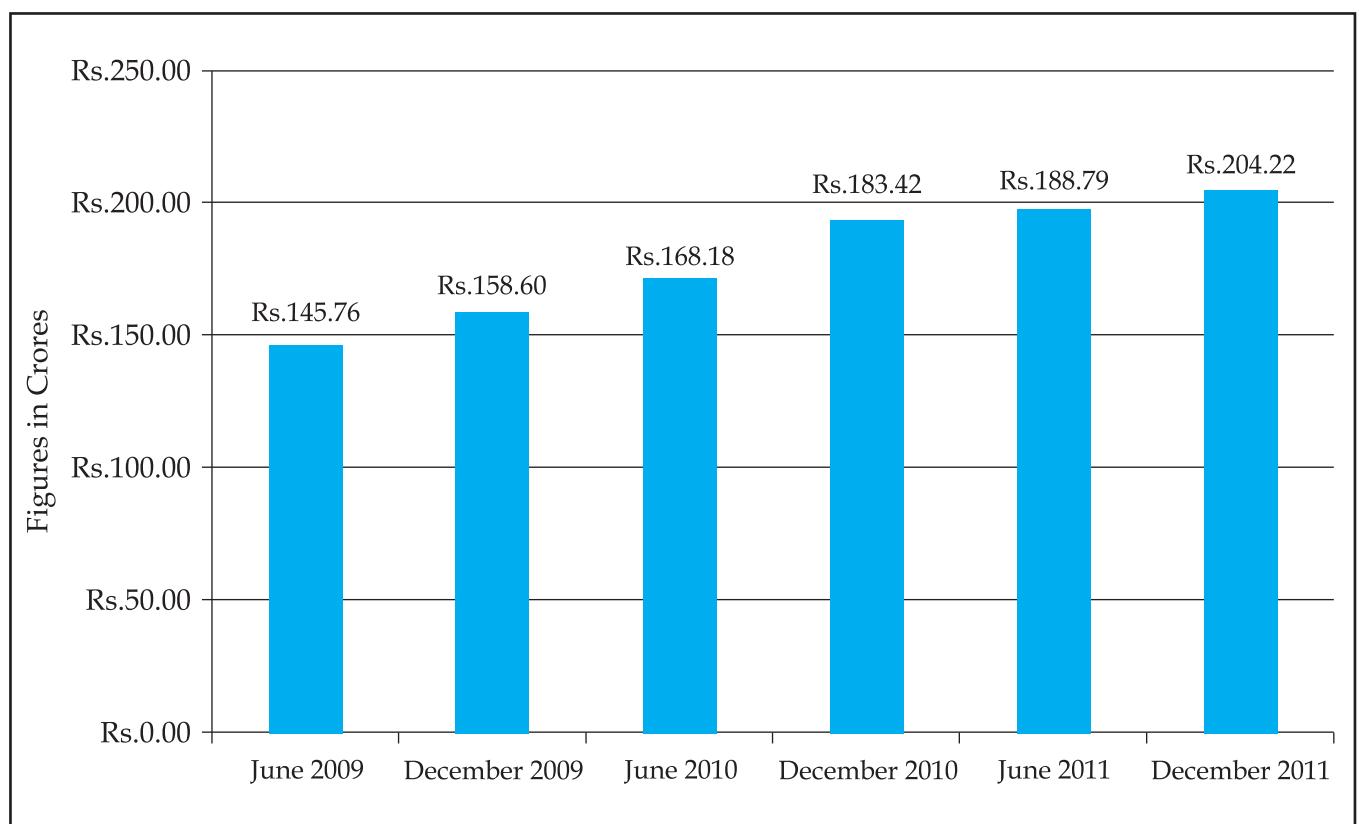
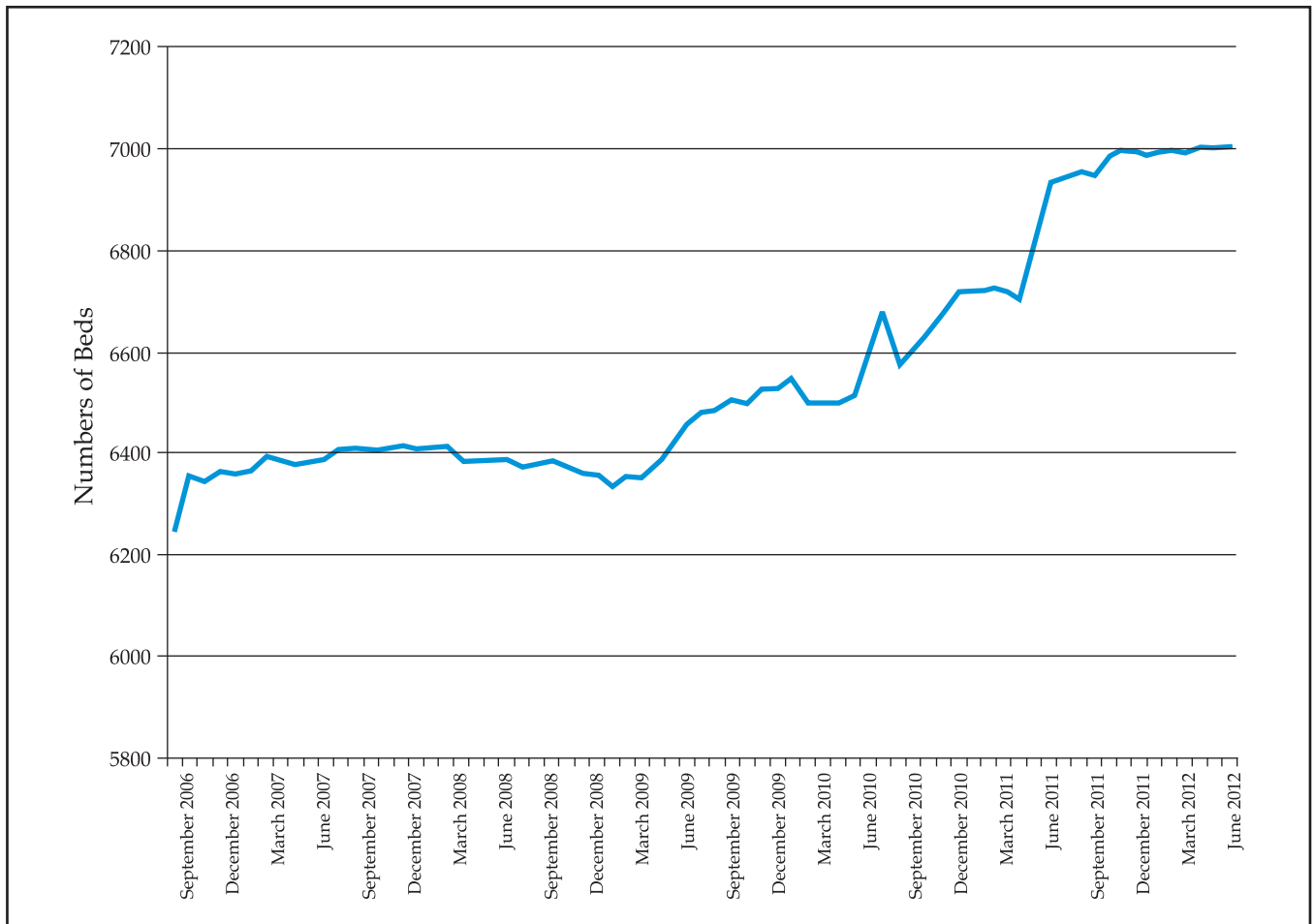
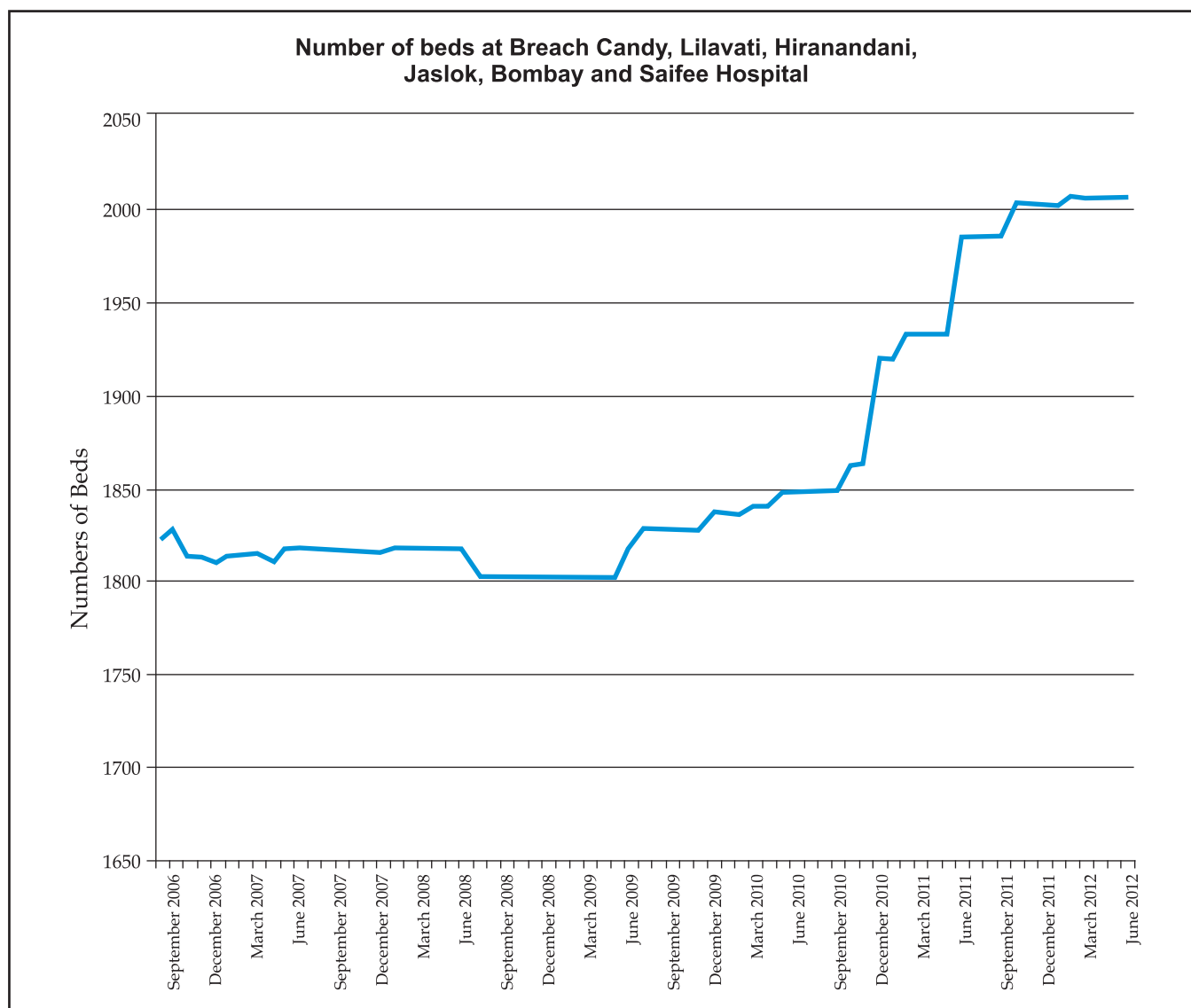


Figure 11: Total Bed Capacity of 33 State aided Charitable Hospitals in Mumbai (2006-2012)



Interestingly, if one were to look at the expansion in terms of bed capacity of hospitals Breach Candy, Lilavati, Hiranandani, Jaslok, Bombay and Saifee,- who reportedly complained they are currently overspending to treat the poor and thereby incurring losses, one would witness a faster pace than the overall group. In fact, as the following figure shows, the pace of expansion was the fastest when these hospitals claimed to be incurring losses.

Figure 12: Expansion in terms of Bed Capacity- Six Hospitals



It is evident that hospitals that have been physically expanding (in terms of bed strength and specialties) over last five years, and which profit a lot from foreign patients via medical tourism, show no sign of any such grave "financial difficulties. "

Insufficient Monitoring and Oversight

It is clearly also a case of hospitals using their 'autonomy' as a shield against any demands of accountability. To compound the problem, the existing monitoring mechanism remains ineffective. A review conducted as part of the study showed that according to the data kept at the Commissionerate, visits by inspectors were very few, and between January 2009 and August 2009, there were no inspections. Similarly, as per information available from the documentation at the Commissionerate, between November 2010 and December 2011, no inspection was conducted. Even when inspections were conducted, they seem to be focused largely on the small hospitals, and not on the big ones.

The Monitoring Committee meets every month presided by the Charity Commissioner or the Deputy Charity Commissioner held at the Commissionerate. The members include representatives from the Association of Hospitals (AOH), an umbrella body of private hospitals in Mumbai and health officials from the BrihanMumbai Municipal Corporation. The Inspectors of the Commissionerate are also frequently part of the proceedings and they submit their reports and findings and are delegated duties by the committee. The agenda for the monthly meetings is more or less fixed, which includes passing of previous month's minutes and discussion of complaints by patients and concerns raised by hospitals. Applications for exemption under Clause 19 of the Scheme for hospitals showing more than six months of negative IPF balance are also tabled and forwarded to the Charity Commissioner for his/her consideration.

A review of minutes of the monitoring committee meetings conducted across three years (2009-2011) showed that while complaints by patients are taken up, the action that follows investigation is to send the patient back to the hospital, with a recommendation by the committee that the patient be admitted. When financial issues such as overcharging are involved, the action by the committee often involves only rolling back the wrong decision by the hospital in question. No penalties are invoked, however serious the violation may be. The research team could not come across even one instance where a hospital in Mumbai was taken to task.

The situation is grave and it emphasises the need to implement the scheme with certain modifications that will improve its efficiency and monitorability. These recommendations based on the findings of the study will be discussed in the last chapter.

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Conclusion and Recommendations

Historically, there was resistance to fulfil the terms of the BPTA Scheme from the so called charitable hospitals, many of which have become for-profit entities over time. As Duggal (2012) discussed recently, the Charity Commissioner's office has not been able to monitor the functioning of the scheme effectively, and for a long time, it was suspected that conditions regarding free beds to the poor patients or IPF were not being adhered to. Recently, around fourteen hospitals, including Lilavati, Breach Candy, Jaslok, Bombay, Hiranandani, and Saifee Hospitals, have appealed to the Charity Commissioner stating that they were incurring losses in order to treat the poor. Four of these state aided charitable hospitals in fact got exempted from the scheme (Deb-Roy, 2012). However, a sample survey by the state health department that followed indicated that Jaslok, Breach Candy and Bombay Hospital used only 4%-4.5% of the 10% beds they had committed to use to treat the poor ("Top hospitals didn't use even half of the beds marked for poor, 2012). The state aided charitable hospitals and their organisation, the Association of Hospitals (AOH), have also been trying through court interventions to stall the scheme over last many years.

However, this doublespeak by the state aided charitable hospitals and Association of Hospitals (AOH) which represents them was further proven by the report of a recent committee set up by the Maharashtra government to review the performance of state aided charitable hospitals. It found that the court directive to treat the poor patients is not being followed. The committee report says that on an average only 4.03% of the earmarked beds out of a mandated 20% are being used. The Bombay Hospital here has 142 beds earmarked out of the total 701. It was seen that only 42 were admitted in April and May 2011, in June 2011 the number went down to 38. The report concluded that the state aided charitable hospitals were not complying with the scheme ("Hospitals not following diktat to admit poor patients: Report", 2012). However, in the absence of strong monitoring and information systems, even the veracity of such statistics is subject to question, although they prove beyond doubt that the scheme is not being complied with and that there are gross violations of law. For example, there is no way to verify if 4.03% of the 20% earmarked beds went really to the people who ought to be covered by the Act. This puts even the very limited claims of these state aided charitable hospitals under a cloud of doubt.

As the country endeavours to move towards Universal Health Care, Maharashtra health planners would do well to acknowledge beds earmarked under the BPTA Scheme as unutilised resources available with the government. This becomes all the more important as private beds available 'on paper' for the poor in the state are substantial. According to the Central Bureau of Health Intelligence (CBHI 2010) figures, Maharashtra has 50,000 government hospital beds -central government, state government and local government bodies put together. Data received by the Charity Commission (incomplete as only 25 out of 35 districts of Maharashtra have reported data, and not all state aided charitable hospitals in reported districts have reported data) suggests that there are more than 7000 hospital beds reserved for the poor across 407 hospitals.³⁰ Thus, a conservative estimate would be that there are around 10,000 extra beds under government control available across the state, reserved for 'indigent patients' and patients from the 'weaker sections', making an extra 20% beds available for the public sector. Given that most of these charitable hospitals are ones offering specialised services, the real quantum will be in fact much more. There is grave need for designing a formal referral system between public hospitals

³⁰ Charity Commissioner of Maharashtra, "Statistics" 2013, <http://mahacharity.gov.in/static_pages/statistics.php> (accessed December 1, 2013).

and state aided charitable hospitals whereby these grossly underutilised beds become available to the public. Delhi has already put in place such a scheme, following a similar court directive.³¹

However, AOH has used the launch of RGJAY as a window of opportunity, a convenient excuse to further their efforts at stalling the High Court Scheme of 10% free beds, which they in any case did not comply with as evidenced by the latest review report by the government panel discussed. In its meeting with state authorities, the AOH expressed its reservation in joining the scheme, pointing out that it 'already' provides charity in the form of free or subsidised treatment to the poor (Rao & Vora, 2013). In a cunning move, AOH is using it to achieve what they have been wanting for half a decade. In order to make enrolment to these schemes an either/or proposition, AOH is trying to present the purely business practice of bulk purchases at 10%-15% lower prices as 'charity'.

AOH and the member hospitals are trying to hijack the situation by apparently misleading the government on the legal status of the scheme, and hiding the fact that RGJAY is a business opportunity at competitive rates, while the BPTA Scheme is a legally mandated service guarantee in return for subsidies received in the past and currently. AOH, which represents a set of hospitals that call themselves charitable while practicing profit maximization, should not be allowed to sabotage the legally mandated scheme by manipulating the government's enthusiasm to 'launch' yet another popular insurance scheme with fanfare, whatever may be the welfare costs. Recent news coverage reveals that AOH's ultimate aim is to use empanelment to RGJAY scheme as a negotiating point in their efforts to back out of the provisions of BPT Act, which could force the government to make a formal request to the court.

However, in a recent development, a state government report has found out that 49 state aided charitable hospitals registered with the Charity Commissioner that were surveyed by a committee including officials from the health and sales tax departments and Charity Commissioners' office, none were following the guidelines, including reserving 20% of beds for the poor. It was found that most hospitals do not follow the rule to reserve 2% of their revenue for treatment as IPF. The report also found that some state aided charitable hospitals are charging fees that have been waived by doctors ("49 registered hospitals flout charity rules: Govt report", 2012). Despite large-scale flouting by the hospitals being exposed at this level, AOH remains as adamant as ever. Dr Pramod Lele, who is the CEO of Hinduja Hospital and also the president of AOH representing over 50 private hospitals in the city maintained: "The hospitals are meeting the requirements of the Charity Commissioner. We are doing enough charity at present" (Shelar, 2013). In other words, his point is that the state government committee is mistaken. This study has substantiated what the public has known for long through a review based on data submitted by the state aided charitable hospitals. The findings have reinforced what the state government committee found through "surprise inspections" in February 2013. It has comprehensively invalidated AOH's repeated and often absurd claim that its members are doing enough charity.

The scheme itself needs to be streamlined using the last six years experience, so that access is maximized and 20% of beds in the state aided charitable hospitals become a resource that the poor people of Maharashtra can count on, along with government hospitals. According to the AOH's own counsel, "The purpose of a Government hospital and a charitable hospital is the same".

In the light of the findings emerging from our study in Mumbai, the following recommendations can be made:

³¹ Health & Family Welfare, Government of Delhi, 2013, <http://delhi.gov.in/wps/wcm/connect/DoIT_Health/health/related+links/information+regarding+free+treatment> (accessed June 02, 2013).

Recommendations	Rationale
1. A similar study should be sponsored by the Charity Commissioner/Health Dept for all state aided charitable hospitals in Maharashtra to look at the degree of compliance by the hospitals.	The CEHAT study brings out high degree of non compliance to the scheme guidelines in terms of beds set aside for poor patients. It was also found that most of the care being given is in the form of OP care. At the time of reporting the numbers to the Charity Commissioner, IP and OP numbers are clubbed together.
2. The Charity Commissioner should do verification on points like charges for medicines and other consumables. The Charity Commissioner should direct that the billing for all investigations should be at the cost incurred by the state aided charitable hospitals for these investigations.	Currently no such mechanism of verification of prices exists, although the scheme guidelines mandate that these are to be charged at purchase prices.
3. Exemption given to some state aided charitable hospitals must be revoked.	In the light of this study and also the findings of the recent health department enquiry, it is clear that these exemptions are not based on an objective consideration of facts.
4. The current eligibility criterion of Rs 25,000 annual income must be revised at least on par with RGJAY norm, and be linked to inflation.	In view of the inadequacy of that amount, other government schemes targeting similar population like RGJAY have already revised it to Rs 1 lakh. MCGM recently changed the income limit for welfare schemes to Rs 1 lakh from Rs 60,000.
5. As envisaged by the Dhumal Committee, there should be a referral system between government and state aided charitable hospitals, and availability of beds in each hospital updated on a daily basis.	Such a system will bring in efficiency as well as reduce the burden on public hospitals. The study found out that most of the 20% beds are not provided to the poor.
6. The Charity Commissioner should direct the hospitals to follow the reporting format strictly so that separate Reporting of IP and OP cases along with total number and bed days, which is verifiable, are available for monitoring.	The study shows that state aided charitable hospitals focus on OP instead of IP cases and flout the scheme rules. Each OP case reported as IP frees up a bed - or 30 bed days- that earns revenue for the hospital.
7. Including Medicines and Consumables in the set of entitlements	This is highly feasible as the Delhi government managed to do it at the recommendation of the large private hospital owners themselves. The hospital owners were of the view informed by their experience that 15% of patients receiving completely free treatment will be financially feasible.

<p>8. De-linking IPF and proportion of free bed, and like practiced in Delhi, making the provision as 10% of IP, and 25% of OP for free, inclusive of medicines and consumables.</p>	<p>The study shows that currently IPF is used as an excuse to minimise the number of beds given to the poor. Also, currently, more than three-fourths of the patients are given access to only low cost OP care. The advocate general's office has already given its opinion to the health department that the 2% revenue provision should not be used as a cap to refrain from observing the provision for reservation of beds. This needs to be implemented soon.</p>
<p>9. Like practiced in Delhi, a self declaration by way of a mandated undertaking must be sufficient to access the scheme, if the poor patient does not have BPL card or Tahasildar's certificate.</p>	<p>The literature survey revealed that such a scheme was being practiced in Delhi successfully.</p>
<p>10. The government does not know the extent of subsidies given/being given to these state aided charitable hospitals. An inventory must be prepared whereby the government has information on subsidies given by government agencies. State aided charitable hospitals that do not comply with the scheme should be penalized in proportion to the subsidies they received, in addition to 5% PTA fund.</p>	<p>Our research has found that currently there is no source of information for the government to estimate the extent of direct and indirect subsidies given to state aided charitable hospitals by different departments and agencies. Such a source is necessary so that state aided charitable hospitals, which refuse to be part of the scheme and treat patients can be penalised proportion to what they received from the government. The penalty provision in the existing scheme has never been implemented.</p>
<p>11. All the state aided charitable hospitals should be mandated to be part of RGJAY, but RGJAY provisions must be over and above the 10% inpatient and 25% outpatient care(or any proportion that the court deem fit) that they provide for free, including medicines and consumables.</p>	<p>In order to be outside the purview of RGJAY, state aided charitable hospitals have repeatedly argued that they are complying with the court mandated free bed scheme. Our research has found that this is wrong. The court scheme is a quid-pro-quo, while in RGJAY , the government reimburses the hospitals for procedures at market rates. The only explanation for such reluctance on the part of some state aided charitable hospitals to join, may be the monitoring mechanisms that RGJAY may have. Both these schemes should be part of the mandate of the hospitals since both serve the needy and BPTA gives the state the power to mandate such schemes. One should not be used to get rid of the other.</p>

In line with the recommendation of the study, an indicative referral system involving ward-wise health posts, dispensaries and the state aided charitable hospitals is attached in Annexure 4. To this network, the 16 Peripheral Municipal Hospitals (Kasturba hospital for infectious diseases, Arthor Road, Bhabha Hospital, Bandra (W), Kurla Bhabha Hospital, MAA Hospital, Chembur, Rajawadi, Ghatkopar Barve Nagar, Ghatkopar (W), Kannamwar Nagar, Vikhroli (E), Mulund (East), Mulund(West), S.K.Patil, Malad, V.N. Desai Hosp. Santacruz (E), Cooper Hospital, Vile-parle (W), Kandivali Centenary, Govandi Centenary and Bhagwati Hospital, Borivali) can be integrated according to location and need. The suggested ward-wise network can be fine tuned by involving parameters of physical accessibility instead of ward labels. Going beyond just the peripheral hospitals, all the public hospitals can be integrated into this referral network as well. A list of all the public hospitals in Mumbai is attached in Annexure 5. However, this elaborate exercise is beyond the scope of this study, and can be designed by an expert group based on the idea originally proposed in the Dhumal report. Hence, this proposed ward-wise referral system can be taken as indicative at best.

References

Aher threatens action against Jeevandayi violators. (1998, October 1). Indian Express. Retrieved from <http://expressindia.indianexpress.com/ie/daily/19981001/27450984.html>.

Amendment to Trusts Act to hit hospitals. (2004, June 15). Mid Day. Retrieved from <http://www.mid-day.com/news/2004/jun/85660.htm>.

Amrith, S. (2006). *Decolonizing International Health: India and Southeast Asia, 1930-65* (p. 57). Hampshire: Palgrave Macmillan.

Apollo Hospitals Enterprises v. Union Of India (Uoi), (133) ELT 58 Mad (2001).

Arnold, D. (1993). *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-century India*, Berkeley Los Angeles, USA: University of California Press.

Baru, R. V. (1998). *Private Health Care in India: Social Characteristics and Trends*. New Delhi, India: Sage.

Baru, R. V. et al. (2001). *State and Private Sector in India: Some Policy Options in Private Health Sector in India: Review and Annotated Bibliography*. Mumbai, India: CEHAT.

Bhore, J. (1946). *Report of the Health Survey and Development Committee (Volume II)*. Simla: Government of India Press.

Bombay Chartered Accountants' Society. (2004). Representation to Law and Judiciary Department Government of Maharashtra in reply to the 13th Report on the Bombay Public Trusts Act, 1950 By the Maharashtra State Law Commission. Retrieved from <http://www.bcasonline.org/ContentType/Contentin.asp?508>.

Bombay Public Trusts. (B.P.T.) Act, 1950.

Bradfield, E. W. (1938). *An Indian Medical Review*, Manager of Publications. Delhi, India: Government of India Press.

Bruijn, I. (2009). *Ship's Surgeons of the Dutch East India Company: Commerce and the Progress of Medicine in the Eighteenth Century*. Leiden, Netherlands: Leiden University Press.

BSCAL. (1997, April 25). HC criticises Ministry in Medical Scam. Business Standard. Retrieved from http://www.business-standard.com/article/economy-policy/hc-criticises-ministry-in-medical-scam-197042501136_1.html.

CEHAT. (2006). *Activity Report: April 2005 to March 2006*. Mumbai, India: CEHAT. Retrieved from <http://www.cehat.org/go/uploads/Annualreports/ar05-06.pdf>.

Centre for Advancement of Philanthropy. (2004). Undesirable Recommendations of the Maharashtra Law Commission for Public Charitable Trusts. Submitted to the Law and Judiciary Ministry, Government of Maharashtra. Retrieved from http://theatreforum.in/static/upload/docs/Petition_Centre_Philanthropy.pdf

Chandavarkar, R. (1994). *The Origins of Industrial Capitalism in India: Business strategies and the working classes in Bombay, 1900-1940*. Cambridge, UK: Cambridge University Press.

Chopra, P. (2011). *A Joint Enterprise: Indian Elites and the Making of British Bombay*. Minneapolis, USA: University of Minnesota Press.

Da Cunha, J. G. (1900). *The Origin of Bombay*, *Journal of the Royal Asiatic Society*. Vol. 20. Bombay, India: Kraus Reprint.

Datta, P. T. J. (2004, June 10). Maharashtra 'involvement' has charitable trusts worried. *Hindu Business Line*. Retrieved from <http://www.thehindubusinessline.in/2004/06/10/stories/2004061000861900.htm>.

Deb-Roy, S. (2012, April 18). 4 private hospitals to stop treating patients temporarily. *The Times of India*. Retrieved from http://articles.timesofindia.indiatimes.com/2012-04-18/mumbai/31360858_1_charitable-hospitals-poor-patients-lilavati-hospital.

Deedwania, B. (2007, January 11). "New Wockhardt hospital caught in legal wrangle". *Mumbai Mirror*.

Delhi: Notice to 34 hospitals for not treating poor for free. (2012, October 12). *Zee News*. Retrieved from http://zeenews.india.com/news/delhi/delhi-notice-to-34-hospitals-for-not-treating-poor-for-free_805362.html.

Dhumal Committee Report. (2006). *Report of the Expert Committee Constituted by the High Court of Bombay for the Charitable Hospitals in the State of Maharashtra*. Mumbai, Maharashtra: S. B. Dhumal.

Dr. Balabhai Nanavati Hospital v. Union Of India & Ors. (2011, July 19). Retrieved from <http://indiankanoon.org/doc/12358644/>.

Duggal, R. (2001). *The Private Sector in India: Nature, Trends and a Critique*. Mumbai, India: CEHAT.

Duggal, R. (2012). *The Uncharitable Trust Hospitals*, *Economic and Political Weekly*, 47(25) 23-24.

Duggal, R. (n.d.). *Health Planning in India*. Retrieved from <http://www.cehat.org/go/uploads/Publications/a168.pdf>.

Establishment of Medical College Regulations (1999) under the Indian Medical Council Act, 1956. Jesani, A., & Anantharaman, S. (1989). *Private Sector and Privatisation in the Health Care Services*. Bombay, India: FRCH.

Fernandes, P. & Pai, R. (2007). *Report on implementation status of the High Court order on PIL on the scheme for indigent patients by charitable hospitals*. Mumbai, India: CEHAT.

Gilson, L., Sen, PD., Mohammed, S., & Mujinja P. (1994). The potential of health sector Non-Governmental Organisations: Policy Options, Health Policy and Planning (Vol.9, no. 1) (pp. 14-24). United Kingdom: Oxford University Press.

Government of India. (1995). Central Council of Health and Family Welfare: 4th Meeting, Proceedings and Resolutions. Directorate General of Health Services, Ministry of Health and Family Welfare, New Delhi. Retrieved from <http://nrhm.gov.in/images/pdf/media/publication/proc-central-council-hfw/fourth-conference.pdf>.

Government of Maharashtra. (2012). Jeevandai Arogya Yojana. Retrieved from <http://www.mahaarogya.gov.in/projectandschemes/Jeevandayiaarogya/default.htm>.

Harrison, M. (1998). Public health and medicine in British India: An assessment of the British contribution. Paper delivered to the Liverpool Medical History Society on 5 March.

Harrison, M. (1998). Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1941. New York, USA: Cambridge University Press.

Harrison, M. (2009). Racial pathologies: Morbid anatomy in British India, 1770-1850, in Biswamoy Pati and Mark Harrison (Eds.) The Social History of Health and Medicine in Colonial India. New Delhi, India: Routledge.

Harrison, M., Jones, M. & Sweet, H. (2009). From Western Medicine to Global Medicine: The Hospital beyond the West. New Delhi, India: Orient Blackswan.

HC stays Jeevandayi Yojana. (1998, April 30). Indian Express. Retrieved from <http://expressindia.indianexpress.com/ie/daily/19980501/12150484.html>.

HOSMAC. (n.d.). List of Hospitals in Mumbai. Retrieved from <http://www.karmayog.com/publichealth/publichealthindex.htm>.

Hospitals not following diktat to admit poor patients: Report. (2012, May 13). Daily News and Analysis. Retrieved from <http://www.dnaindia.com/mumbai/report-hospitals-not-following-diktat-to-admit-poor-patients-report-1688114>

Indian Medical Department. (1874). Annual administration and progress reports of the Indian Medical Department, Bombay for the year 1872-73. Bombay, India: Government Central Press.

Isalkar, U. (2011, March 9). Charity Commissioner files case against hospital. Times of India. Retrieved from http://articles.timesofindia.indiatimes.com/2011-03-09/pune/28672097_1_charitable-hospitals-poor-patients-charity-commissioner.

Jaslok Hospital & Research Centre v. Union Of India & Ors. (2007, October 31). Retrieved from <http://indiankanoon.org/doc/1605422/>.

Jha, D. N. (2012, Feb 10). Government orders 6 hospitals to treat poor for free. The Times of India. Retrieved from http://articles.timesofindia.indiatimes.com/2012-02-10/delhi/31045721_1_free-treatment-charitable-hospitals-poor-patients.

Khan, M. E. & Prasad, C. V. S. (1986). Health Financing in India: A case study of Gujarat and Maharashtra. Baroda, India: Operations Research Group.

Khorakiwala, H. F. et al. (2008), Red Herring Prospectus of Wockhardt Hospitals Limited. Mumbai, India.

Kurian, O. C. (2012). Charitable Hospitals: Charity at Market Rate. *Economic and Political Weekly*, 47(39), 23-25.

Lefebvre, B. (2008). The Indian Corporate Hospitals: Touching Middle Class Lives. In Jaffrelot, C. and van der Veer, P. (Eds.) *Patterns of middle class consumption in India and China* (pp. 88-109). New Delhi, India: Sage.

Lefebvre, B. (2010). *Hospital Chains in India: The Coming of Age?* New Delhi, India: Centre Asie, IFRI.

Lok Sabha Secretariat. (2005). Twelfth report: Public Accounts Committee (2004-2005) (Fourteenth Lok Sabha): Allotment of land to private hospitals and dispensaries by Delhi Development Authority. New Delhi: Ministry of Urban Development.

Maharashtra budget hikes prices of cigarettes and liquor. (1998, March 24). *Indian Express*. Retrieved from <http://expressindia.indianexpress.com/ie/daily/19980324/08350184.html>.

Maharashtra State Gazetteers (1986). *Greater Bombay District, Volume III*.

Marpakwar, P. (1999, May 14). Mumbai's pvt hospitals defeat a public cause. *Indian Express*. Retrieved from <http://expressindia.indianexpress.com/ie/daily/19990514/ige14050.html>.

Medical Council of India. (2012). List of Colleges teaching MBBS 2012. Retrieved from <http://www.mciindia.org/InformationDesk/ForStudents/ListofCollegesTeachingMBBS.aspx>.

Mehra, P. (2008, Aug 13). Hospitals to settle unpaid import duty on equipment: CESTAT. *The Times of India*. Retrieved from http://articles.timesofindia.indiatimes.com/2008-08-13/mumbai/27903689_1_import-duty-cestat-poor-patients.

Mhasawade, S. (1998, May 9). Jeevandayi stay to be challenged in SC. *Indian Express*. Retrieved from <http://expressindia.indianexpress.com/ie/daily/19980509/12950674.html>

Michael, L. W. (1902). *The history of the municipal corporation of the City of Bombay*. Bombay, India: Union Press

Moore C. W. (1845). *The Freemasons' Monthly Magazine: Volume 4*. Boston, USA: Tuttle and Dennett.

Municipal Corporation of Greater Mumbai (MCGM). (n.d.). Nursing Home Licenses. Retrieved from <http://www.mcgm.gov.in/irj/portal/anonymous/qldatalookup>.

M/S. R.G. Stone Urological v. Union Of India & Ors. (2010). Retrieved from <http://www.indiankanoon.org/doc/1672451/?type=print>.

Nair, P. (2004). *India: Desk study of Non- State Providers of Basic Services*. London, England: London School of Hygiene and Tropical Medicine.

Nandraj, S., Muraleedharan, V. R., Baru, R. V., Qadeer, I., & Priya, R. (2001). *Private Health Sector in India: Review and Annotated bibliography*. Mumbai, India: CEHAT.

Nundy, M. (2005). The not-for-profit sector in medical care. In Lal, P.G. & Byword Editorial Consultants (Eds.), *Financing and Delivery of Health Care Services in India: Background Papers for NCMH* (pp. 125-134). New Delhi, India: Government of India.

Planning Commission. (2008). *Eleventh Five Year Plan (2007-2012): Social Sector (Volume. II)*(p. 68). New Delhi, India: Government of India.

Prachi Piglay (2012, February 13). Specialty hospitals on the rise in city. *Hindustan Times*.

Public Health Notes. (1922). *American Journal of Public Health*. Volume 12.

SC vacates stay on Jeevandayee scheme. (1998, August 22). *Indian Express*. Retrieved from <http://expressindia.indianexpress.com/ie/daily/19980822/23450064.html>.

Puri, S., Singh, A., & Yashik (2010). Medical Tourism- A New Arena. *Iranian Journal of Public Health*, 29 (3), 16-19. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3481623/pdf/ijph-39-016.pdf>.

Qadeer, I. (2001). Impact of structural adjustment programme on concepts in public health. In I. Qadeer, K. Sen & K. R. Nayar (Eds.), *Public health and the poverty of reforms: The South Asian Predicament*. New Delhi: Sage.

Qadeer, I. & Reddy, S. (2006). Medical Care in the Shadow of Public Private Partnership. *Social Scientist*, Vol. 34, No. 9/10 (Sep. - Oct., 2006), pp. 4-20.

Qureshi, A. S. (2001). *High Level Committee for Hospitals in Delhi - Enquiry Report*. India: Government of Delhi.

Qureshi Committee Report. (2001). *High Level Committee for Hospitals in Delhi: An Enquiry Report*. New Delhi, India: A. S. Qureshi.

Ramanna, M. (2002). *Western Medicine and Public Health in Colonial Bombay 1845-1895*. New Delhi, India: Orient Longman.

Ramanna, M. (2012). *Health Care in Bombay Presidency, 1896-1930*. New Delhi, India: Primus Books.

Rao, M. & Vora, P. (2012, July 23). Govt scheme helps poor get treated for major ailments. *Hindustan Times*. Retrieved from <http://www.hindustantimes.com/India-news/Mumbai/Govt-scheme-helps-poor-get-treated-for-major-ailments/Article1-893908.aspx>.

Rindani, T.H. et al. (1976). *Report of the Working Group on the Existing Medical Facilities and Augmentation Thereof*. Mumbai, India: Municipal Corporation of Greater Bombay.

SAMA. (2011). *Free treatment in the Private Sector: Myth or Reality? A pilot study of private hospitals in Delhi: A report*. New Delhi: SAMA

Shah, A. P. (2009). Delhi High Court Judgement on case WP(C) No.5410/1997 (1997, Sept 22). New Delhi.

Shah, U. & Bhatt, D. (n.d.). Study of Status of Charitable Hospitals: Reviewing Options for Sustainable Partnership. HOSMAC Pvt. Ltd. and HOSMAC Foundation. Retrieved from <http://www.cii.in/webcms/Upload/Whitepaper%20on%20Partnership%20in%20Healthcare1.pdf>.

Shelar, J. (2013, March 4). 80% private charity hospitals in Mumbai are not poor-friendly: Audit. Mumbai Mirror. Retrieved from <http://www.mumbaimirror.com/mumbai/civic/80-private-charity-hospitals-in-Mumbai-are-not-poor-friendly-Audit/articleshow/18787661.cms>.

Shukla, A., & Duggal, R. (2006). Health System in India: Crisis & Alternatives. New Delhi, India: National Coordination Committee, Jan Swasthya Abhiyan.

SICP. (2004). A Review of Charities Administration in India. Sponsored by the Planning Commission, Government of India. Retrieved from http://planningcommission.nic.in/reports/sereport/ser/stdy_cai.pdf.

Sloan, F. A. (1998). Commercialism in nonprofit hospitals. In B. A. Weisbrod (Ed.), *To Profit or Not to Profit: The Commercial Transformation of the Nonprofit Sector* (p. 151). United Kingdom: Cambridge University Press.

Solicitor to Government. (1910). *The Gazeteer of Bombay City and Island*. Volume 3. Mumbai, India: Times Press.

State extends FSI benefit to pvt hospitals. (2009, May 12). Indian Express. Retrieved from <http://www.indianexpress.com/news/state-extends-fsi-benefit-to-pvt-hospitals/457723/>

Stiff penalty mooted for erring pvt hospitals. (1998, October 10). Indian Express. Retrieved from <http://expressindia.indianexpress.com/ie/daily/19981010/28351584.html>

The Bombay Public Trusts Act 1950. Retrieved from http://mahacharity.gov.in/static_pages/pdf/B.P.T.Act,1950.pdf.

Top hospitals didn't use even half of the beds marked for poor. (2012, May 10). Mumbai Mirror. Retrieved from <http://www.mumbaimirror.com/mumbai/cover-story/Top-hospitals-didnt-use-even-half-of-the-beds-marked-for-poor/articleshow/16221018.cms>.

Yesudian, C.A.K., (1993). *Nature of Private Sector Health Services in Bombay* (p. 2). Mumbai: Tata Institute Of Social Sciences.

49 registered hospitals flout charity rules: Govt report. (2012, February 27). Times of India. Retrieved from http://articles.timesofindia.indiatimes.com/2013-02-27/mumbai/37330204_1_govt-report-charity-rules-hospitals.

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Annexure 1

The High Court Scheme

1. The public Charitable Trusts registered under the provisions of the Bombay Publics Trusts Act, 1950 (for short 'BPTAct') which are running Charitable Hospitals, including nursing home or maternity home, dispensaries or any other center for medical relief and whose annual expenditure exceeds Rs.5 Lacs are "State aided public trust" within the meaning of clause 4 of section 41AA.
2. The public Charitable Trust covered by aforesaid clause 1 shall be under legal obligation to reserve and earmark 10% of the total number of operational beds for indigent patients and provide medical treatment to the indigent patients free of cost and reserve and earmark 10% of the total number of operational beds at concessional rate to the weaker section patients as per the provisions of section 41AA of the BPT Act.
3. In emergency, the Charitable Hospitals must admit the patient immediately and provide to the patient "Essential Medical Facilities" for all life saving emergency treatment and procedure till stabilization. Further transportation to the public hospital would be arranged by such Charitable Hospital, if necessary. The Charitable Hospital, shall not ask for any deposit in case of admission of emergency patients.
4. That each public Charitable hospital shall create separate fund which may be called Indigent Patients' Fund (for the sake of brevity, hereinafter referred to as "IPF") and shall credit two per cent of gross billing of all patients (other than indigent and weaker section patients) without any deduction.
5. Donations that may be received by the charitable hospitals from individuals or other charitable trusts or from any other source for providing medical treatment to the indigent and weaker section patients shall be credited to IPF Account.
6. The account of IPF shall have to be earmarked under the head of IPF and same shall be reflected under the earmarked fund in the annual balance Sheet (Schedule VIII Rules 7(1) of the B.P.T Rules).
7. The amount credited to the IPF Account shall remain at the disposal of the respective Charitable Hospital and that amount shall be utilized only for providing medical treatment to the indigent and weaker section patients as provided herein after.
8. The Charitable Hospitals shall provide following non billable services free to the indigent patients as well as weaker section patients
 - (a) Bed
 - (b) RMO Services
 - (c) Nursing Care
 - (d) Food (if provided by the hospital)
 - (e) Linen

- (f) Water
 - (g) Electricity and
 - (h) Routine Diagnostics as required for treatment of general specialties.
 - (i) House Keeping Services.
9. In case of indigent patients, the Charitable Hospitals shall provide medical examination and treatment in its each department totally free of cost. The indigent patient's bill of billable services shall be prepared at the rates applicable to the lowest class of the respective hospital. The medicines, consumables and implants are to be charged at the purchase price to the hospital. If Doctors forego their charges, then the same shall not be included in the final bill of the indigent patients. The bill so prepared shall be debited to IPF Account. The Charitable Hospitals shall not ask for any deposit in case of admission of indigent patients.
 10. In case of weaker section patients, the Charitable Hospitals shall provide medical examination and treatment in its each department at concessional rates. The weaker section patient's bill of billable services shall be prepared at the rates applicable to the lowest class of the respective hospital. The medicines, consumables and implants are to be charged at the purchase price to the hospital; however the weaker section patients shall pay at least 50% of the bills of medicines, consumables and implants. If Doctors forego their charges, then the same shall not be included in the final bill of the weaker section patients. The bill so prepared after deducting the payment made by the weaker section patients shall be debited to IPF Account.
 11. The Charitable Hospitals shall physically transfer 2% of the total patients' billing (excluding the bill of indigent and weaker section patients) in each month to IPF Account. The amount available in the IPF Account shall be spent to provide medical treatment to maximum number of indigent and weaker section patients. In case of surplus or shortfall in the IPF Account of the month, the same shall get adjusted in the subsequent months. In case there is imbalance in the credit of the IPF Account and the expenditure incurred in the treatment of indigent and weaker section patients for more than six months, such Charitable Hospital may bring this aspect to the notice of the Monitoring Committee who may issue appropriate directives to the concerned hospital.
 12. The Charitable Hospitals shall furnish information to the office of the Charity Commissioner regarding the amount collected in the IPF Account, treatment provided to the indigent patients and the weaker section patients and their profiles prepared by the Medical Social Worker and the amount spent for the respective patients along with the information required to be sent under Rule 25 A of the Bombay Public Trusts Rules, 1951.
 13. The Trustees of the charitable hospitals shall not provide medical facilities to their relatives, the employees of the Trust and their dependants in the category of "indigent and weaker section patients".
 14. The Charitable Hospitals shall admit indigent or weaker section patients coming to their hospitals from any source or through Government Hospitals, Municipal Hospitals, etc. The procedure for admission of patients shall be as provided in subsequent clauses.
 15. That the charitable hospitals shall admit indigent patients to the extent of 10% of their operational beds/average occupancy for medical examination and treatment. So also, the Charitable Hospitals shall admit weaker section patients to the extent of 10% of their operational beds/average occupancy for medical examination and treatment coming to their hospitals from the sources referred to in clause 14. The Charitable hospitals shall verify the economic status of the patients from their Medical

Social Worker on the basis of scrutiny of any one of the following documents produced by the concerned patients: (i) Certificate from Tahasildar, (ii) Ration Card/Below Poverty Line Card.

16. The Members of the Monitoring Committee in Greater Mumbai Region shall be as follows:
 - (i) Joint Charity Commissioner, Maharashtra State, Mumbai (Chairman).
 - (ii) Joint Director of Health Services (Medical), Mumbai (Member Secretary).
 - (iii) Secretary/Nominee of Association of Hospitals in Mumbai (Member).
 - (iv) Health Officer, Municipal Corporation of Greater Mumbai, Mumbai (Member).

The Monitoring Committee at the District Level shall be as follows:

- (i) Joint Charity Commissioner (Regional Level) or his nominee (Chairman).
 - (ii) Civil Surgeon (Member Secretary).
 - (iii) Health Officer of Zilla Parishad (Member).
 - (iv) Representative of Charitable Hospitals in Districts (Member).
17. The Monitoring Committee shall hold its meeting once in a month and monitor implementation of the Scheme by each of the Charitable Hospitals. The Monitoring Committee shall also consider grievances of the patients, if any, made and submit its report to the Charity Commissioner.
18. In case of the breach of the Scheme and / or the terms and conditions of section 41AA by any Charitable Hospitals, besides the penal action as is provided under section 66 of the BPT Act, the Charity Commissioner shall make report to the State Government recommending withdrawal of the exemption granted to the concerned hospitals during the next preceding year in payment of contribution towards P.T.A. Fund and the amount of contribution towards P.T.A. Fund be recovered from the said hospital. The Charity Commissioner may also request the Government to withdraw any other concessions / benefits given to the said hospital.
19. The Charitable Hospitals which face individual difficulties in meeting objectives / obligations under this scheme shall be at liberty to apply to the Charity Commissioner with all supporting documents who may consider suitable modifications, if a case for relief is made out.
20. The Charity Commissioner shall notify the list of the Charitable Hospitals in Greater Mumbai Region on the Notice Board of this office and two newspapers widely circulated in Greater Mumbai, one in Marathi and the other in English and the list of Charitable Hospitals in each District on the Notice Board of the office of the Joint Charity Commissioner and the two widely circulated newspapers of the District.
21. Each of the Charitable Hospitals governed by this Scheme shall publish the Scheme on its Notice Board displayed at a conspicuous place of the Hospital.

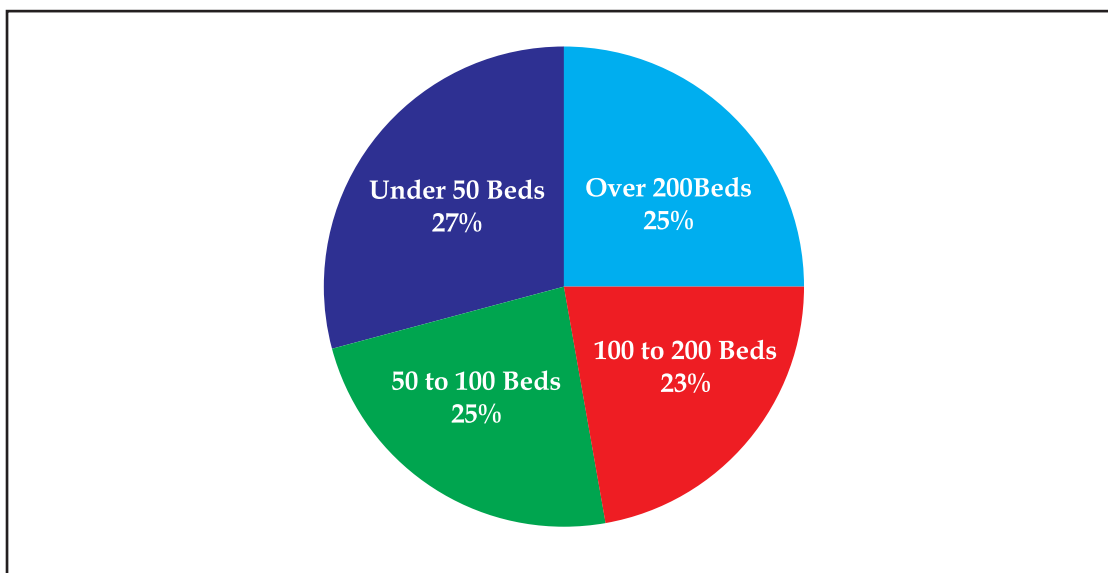
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Annexure 2

Charitable Hospitals in Mumbai: Numbers and Spread

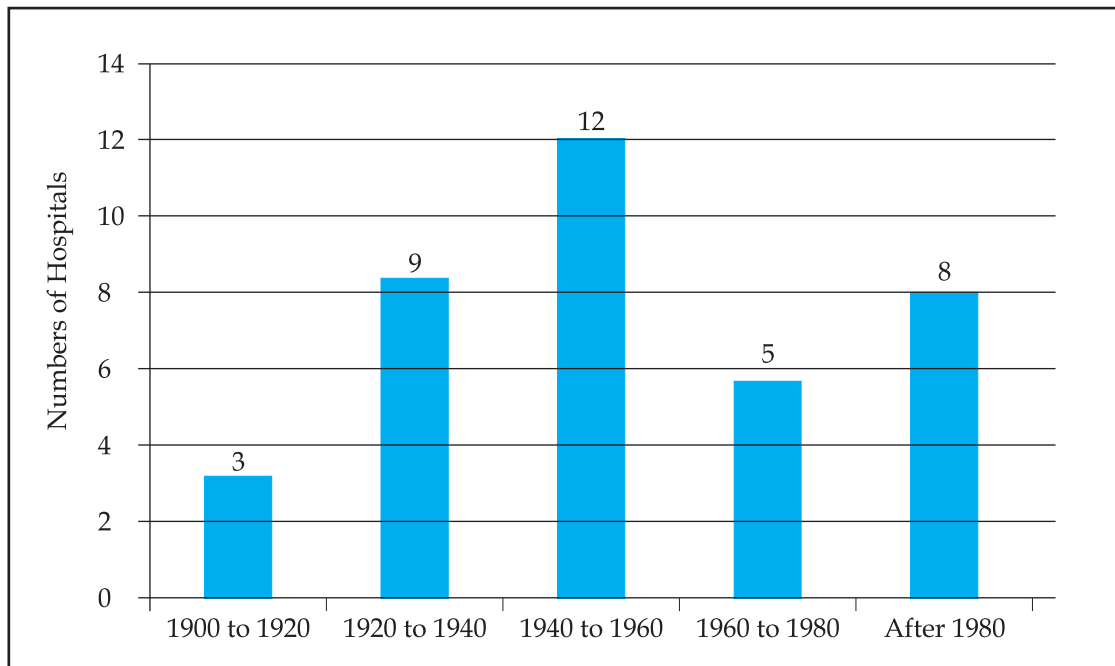
According to available data, there are 81 of state funded private charitable hospitals in Mumbai. The size and distribution of the hospitals are given in the following figure. This is based on bed data submitted by 60 hospitals. The remaining 21 hospitals include clinics with outpatient care and hospitals which have not submitted bed data yet. The reliability of bed data reported to the Charity Commissionerate is under question, as hospitals tend to under-report.

Figure 13: Distribution of State funded Hospitals according to number of Beds



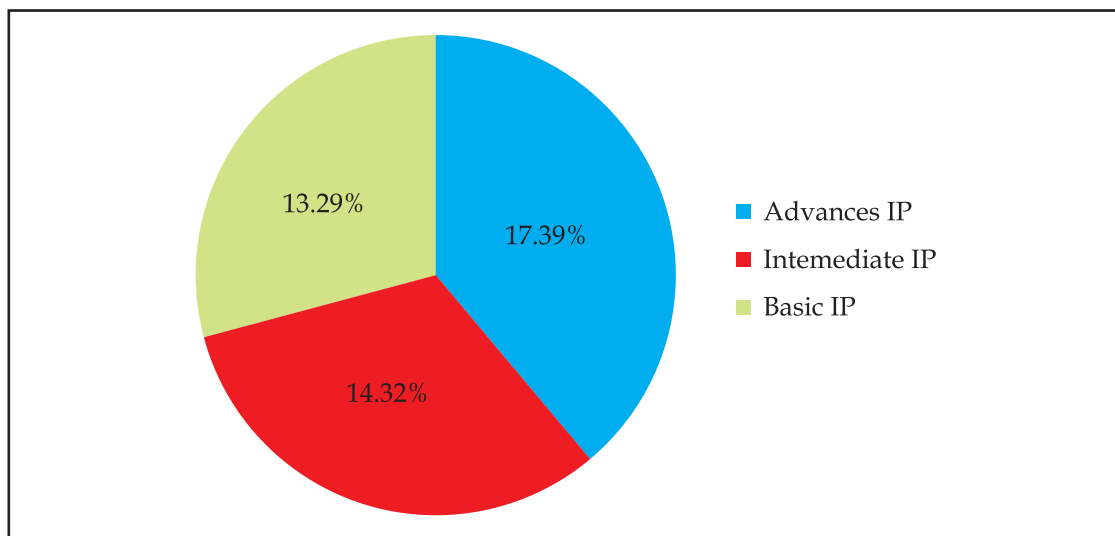
The next figure gives the distribution of hospitals according to the year of establishment. Most of the 37 hospitals for which dates of establishment are available were built after independence.

Figure 14: Hospitals by year of Establishment



In terms of the type of care that is offered; the hospitals can be categorised as follows:

Figure 15: Type of Hospitals



The geographical distribution of these hospitals and beds give some interesting results. Most of the hospitals and bed capacity are seen to be concentrated in certain pockets of the city, as the following maps show:

Figure 16 : Number of Beds across Wards

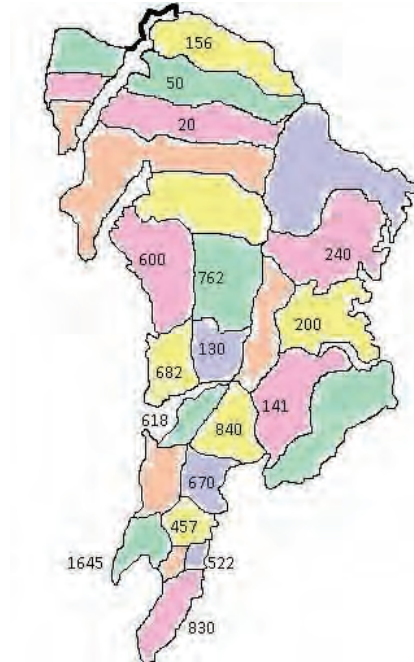
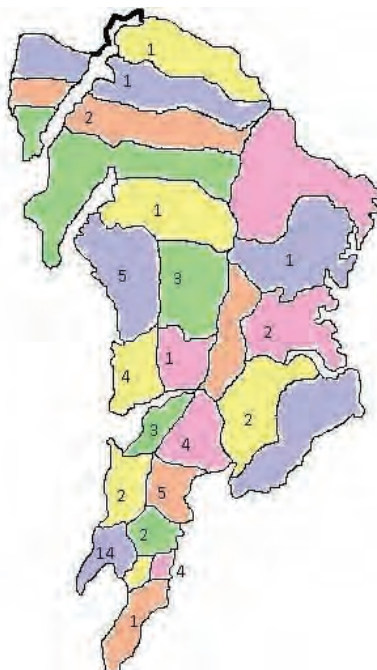


Figure 17 : Number of Hospitals across Wards



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Annexure 3

Disaggregated Tables

Table 3: Percentage of IP Cases in overall Patients across different Hospitals

Size of the charitable hospital	Dec-11		Nov-11		Oct-11	
	Percentage of IP in total Indigent	Percentage of IP in total weaker sections	Percentage of IP in total Indigent	Percentage of IP in total weaker sections	Percentage of IP in total Indigent	Percentage of IP in total weaker sections
Around 200 (One of the four hospitals that asked for Exemption)	7.93%	10.96%	7.88%	5.79%	11.66%	16.07%
Around 250 (One of the four hospitals that asked for Exemption)	29.17%	100.00%	48.28%	NA	66.67%	NA
Around 130	29.41%	35.00%	31.43%	40.91%	29.41%	47.37%
Around 300 (One of the four hospitals that asked for Exemption)	59.09%	100.00%	62.50%	100.00%	70.59%	100.00%
Around 370 (One of the four hospitals that asked for Exemption)	80.39%	95.24%	73.47%	100.00%	70.37%	16.67%
Around 100	15.79%	17.39%	NA	NA	10.53%	19.23%
Around 100	96.00%	15.94%	100.00%	15.63%	48.31%	18.10%
Around 350	51.75%	NA	NA	NA	NA	NA
Overall Percentage of IP	26.08%	22.46%	22.32%	16.59%	25.67%	19.79%

Table 4: Average Bed days per Patient: Disaggregated for Indigent Patients

	Size of the charitable hospital	Hospital Reported Indigent number	IP - Indigent Bed Days	Actual Indigent OP Visits	Total Indigent bed days with OP as 1	average indigent bed days per patient
A (One of the four hospitals that asked for Exemption)	around 200	479	472	783	1255	2.62
B	around 700	56	59		59	1.05
C (One of the four hospitals that asked for Exemption)	around 250	24	58	17	75	3.13
D	around 120	34	94	24	118	3.47
E	around 130	9		9	9	1
F	around 100	60	63		63	1.05
G	around 320	6	160		160	26.67
H (One of the four hospitals that asked for Exemption)	around 300	44	344	20	364	8.27
I(One of the four hospitals that asked for Exemption)	around 350	51	492	2	494	9.69
J	around 100	38	21	31	52	1.37
K	around 100	25	76	1	77	3.08
L	around 350	114	878		878	7.7
M	around 400	33	322		322	9.76
N	around 250	16	131		131	8.19
O	around 190	34	155		155	4.56
		985	3325	887	4143	4.21

Most hospitals club IP and OP together and report; hence the OP column carries less numbers .This is also the reason why we had to merge OP and IP in the overall analysis, although it led to overestimation in some cases. Analysis based on data for December 2011.

Table 5: Average Bed-days per Patient: Disaggregated for Patients from Weaker Sections

Average Bed days per patient from weaker sections						
Hospital	Size of the charitable hospital	Hospital Reported Weaker number	IP-Weaker Bed Days	Actual weaker OP visits	Total weaker bed days with OP as 1	Average weaker bed days per patient
A	Around 200 (One of the four hospitals that asked for Exemption)	146	93	219	312	2.14
B	Around 250(One of the four hospitals that asked for Exemption)	5	47		47	9.4
C	Around 120	20	50	13	63	3.15
D	Around 100	6	3		3	0.5
E	Around 320	5	84		84	16.8
F	Around 300(One of the four hospitals that asked for Exemption)	1	20		20	20
G	Around 350 (One of the four hospitals that asked for Exemption)	21	165	1	166	7.9
H	Around 100	23	63	19	82	3.57
I	Around 100	69	56	58	114	1.65
J	Around 400	80	378		378	4.73
K	Around 250	19	134		134	7.05
L	Around 190	92	440		440	4.78
		490	1533	310	1843	3.76
<p>Most hospitals club IP and OP together and report; hence the OP column carries less numbers .This is also the reason why we had to merge OP and IP in the overall analysis, although it led to overestimation in some cases. Analysis based on data for December 2011.</p>						

Table 6: Distribution of Hospitals according to Percentage Beds given to Indigent Patients
 For 42 largest charitable hospitals in Mumbai, Percentage Indigent bed days spent out of total bed days (OP treated on par to IP)*

Percentage	Number	Percentage of Hospitals
(0% - 0.25% bed days given to indigent patients)	8	19.05%
(0.25% - 0.50% bed days given to indigent patients)	5	11.90%
(0.5% - 1.00% bed days given to indigent patients)	7	16.67%
(1.00% - 2.00% bed days given to indigent patients)	10	23.81%
(2.00% - 5.00% bed days given to indigent patients)	9	21.43%
(over 5.00% bed days given to indigent patients)	3	7.14%
Total Hospitals	42	100.00%
*Based on data between July-December 2011		

Table 7: Distribution of Hospitals according to Percentage Beds given to Patients from Weaker Sections

For 42 largest charitable hospitals in Mumbai, Percentage weaker section patient bed days spent out of total bed days (OP treated on par to IP)

	Number	Percentage of Hospitals
(0% - 0.25% bed days given to weaker section patients)	15	35.71%
(0.25% - 0.50% bed days given to weaker section patients)	5	11.90%
(0.5% - 1.00% bed days given to weaker section patients)	8	19.05%
(1.00% - 2.00% bed days given to weaker section patients)	6	14.29%
(2.00% - 5.00% bed days given to weaker section patients)	2	4.76%
(over 5.00% bed days given to weaker section patients)	6	14.29%
Total Hospitals	42	100.00%
*Based on data between July-December 2011		

Annexure 4

Proposed Ward-wise Referral Network between Public and Private Charitable Hospitals

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
A	Colaba Dispensary	Colaba Dispensary, Colaba Municipal School, 1st floor, Lara Nigam Road, Colaba, Mumbai - 400 001.	The Bombay Hospital Trust, 12 Marine Lines, Mumbai 400 020
A	Paltan Rd. Dispensary	308, Shahid Bhagatsingh Marg, Fort, Mumbai - 400 001	
		Head Office Building, 2nd floor, Annex Building, Mumbai-400 001	
		Ayurvedic Dispensary, Head Office Building, 2nd floor, Annex Building, Mumbai - 400 001	
		Municipal Dispensary, Maruti Lane, Mumbai	
		Municipal Dispensary, Sabu Siddiq Road, Mumbai (upgraded)	
B	Janabai Rokade	Municipal Dispensary, 259, Sardar Vallabbhai Patel Marg, (upgraded)	Habib Esmail Hospital & Medical Trust, 159, Jail Road (East), Near Imam Husein Chowk, Dongri, Mumbai - 400 009
B	Jail Rd. Dispensary	Municipal Dispensary, 44 Jail Road, North (upgraded)	Noor Hospital Trust, 50, Mohammed Ali Road, Noor Hospital Bldg, Mumbai - 400 003
		Municipal Dispensary, Valpakhadi Chawl, Noor Baug	M.S. Saboo Siddiqui Maternity Aid General Hospital (Muslim Ambulance Society), Imamwada Road, Opp Mughal Masjid, Mumbai - 400 009
		Unani Dispensary & Dental Clinic, 20, Kolsa Street, Kolsa Mohalla, Pydhonie	The Bomanjee Dinshaw Petit Parsee Hospital, B. D. Petit Parsee General Hospital, Bohmanji Petit Road, Cumballa Hill, Mumbai - 400 039
		Municipal Dispensary, Jail Road, Dongri, Mumbai-400 091	
C	Chandanwadi	Municipal Dispensary, Haji Hasan Ahmed Bazar Marg, Gogri Moholla	
C	Panjarpole Dispensary	Municipal Dispensary, 198, Panjarpole Lane, Bhuleshwar (upgraded)	

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
C	Zaobawadi MH	Municipal Dispensary, Babasaheb Jaykar Road, Thakurdwar Junction, Mumbai -400 002	
		Chandanwadi Municipal Dispensary, Sonapur Street, Mumbai -400 002 (upgraded)	
		Duncan Road Municipal Dispensary, 2nd Cross Gully	
D	Banganga	Municipal Dispensary, R.S.Nimkar Marg, Foras Road,	Motiben B Dalvi Hospital, Gaondevi, Mumbai - 400 007
D	R S Nimkar Marg	Bane Compound Municipal Dispensary, Tulshiwadi, Arthur Road, Tardeo(upgraded)	Brahman Sabha Mumbai Mahaskar Sutika Grih General Nursing Home, Raja Ram Mohan Roy Road, Girgaum, Mumbai - 400 004
D	Khetwadi	Municipal Dispensary, 303, Raja Rammohan Roy Marg, Girgaon	Shree Ram Ek Dharmada Trust Rukshmani Lying - In Hospital Obstetric & Gynac Outdoor Department, 9, Babulnath Road, Mumbai - 400 007
D	Bane Comp. Disp	Nana Chowk Municipal Dispensary, Fire Brigade Compound, Byculla	Cumballa Hill Hospital & Heart Institution, 85, August Kranti Marg, Mumbai - 400 038
D	Nana Chowk Disp	Tardeo Dispensary	D S Kothari Hosptial, Kamala Kutir, Opp. Kasturba Chowk, C.P. Tank, Mumbai - 400 004
			St. Elizabeth Hospital, J. Mehta Road, Malbar Hill, Mumbai - 400 006
			Shri Ayurved Prachar Sanstha (Smt Kamaladevi Gauridutt Mittal Ayurvedic Hospital), Income Tax Bldg, Charni Road, Mumbai -400 004
			Conwest Jain Clinic Group Of Hospitals, B-10, Nikadwari Lane, Khadilkar Rd, Girgaon, Mumbai - 400 004
			Breach Candy Hospital, 60-A, Bhulabhai Desai Rd, Mumbai - 400 026
			The Bhatia General Hospital, Tardeo Road, Mumbai - 400 007
			Sir Hurkishondas Narrottamdas Hospital & Research Centre, Padmashri Gordhan Bapa Chowk, Raja Rammohan Roy Road, Mumbai - 400 004
			The Saifee Hospital Trust, 15/17, Maharshi Karve Marg,

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
			Opp Charni Road Railway Station, Mumbai - 400 004
			Jaslok Hospital, 15, Dr. G. Deshmukh Marg, Mumbai 26
			Children Orthopedic Hospital, Haji Ali Park, K Khade Marg, Mahalaxmi, Mumbai - 400 034
E	Tadwadi	Dhaku Prabhuwadi Dispensary Ghodapdeo, Mumbai -400 033	Prince Aly Khan Hospital, Aga Hall, Nesbit Road, Mumbai - 400 010.
E	Nawab Tank	Bai Gaurabai Dispensary Kamathipura Stable (upgraded)	Masina Hospital Trust, Swant. Savarkar Marg, Byculla, Mumbai - 400 027
E	Kasturba Hosp.	Municipal Dispensary, Patanwala Marg, Byculla (upgraded)	
E	Reay Rd. MH	48, Hujaria Street Dispensary	
E	Botliboy	Tadawadi Dispensary, BIT Chawl Compound, Mazgaon (upgraded)	
E	Sauter Street	Souter Steet Dispensary (upgraded) Municipal Dispensary Rasul Jeera Compound, Keshavrao Khade Marg, Mumbai - 400 011	
		Seth Motishah Lane Dispensary, Mazgaon - 400 010	
		Nawab Tank Bridge, Dockyard Road - 400 010	
		Lal Vitachi Chawl Municipal Dispensary, N. M. Joshi Marg, Mumbai - 400 011	
		Siddharth Nagar Dispensary Bhapty Road, Kamathipura	
		Tank Square Garden Dispensary Sewri	
FS	Abhyuday Nagar	Mulraj Bhavan Dispensary Sewri	The Mahatma Gandhi Memorial Hospital, S. S. Rao Road, Opp M. D. College Parel, Mumbai - 400 012
FS	Kidwai Nagar	Ambewadi Dispensary Mumbai - 400 033	K.B. Haji Bachooali Charitable Ophthalmic & E.N.T. Hospital, 58/80 Jehangir Merwanji Street, Parel, Mumbai - 400 012
FS	2nd Oct. Colony	Dadasaheb Falke Road Dispensary, Dadar	Bai Jerbai Wadia Hospital For Children , Acharya Donde Marg, Parel, Mumbai - 400 012
FS	V. Shantaram	F/South Ward Dispensary, Parel	The Nowrosjee Wadia Maternity Hospital Acharya Donde Marg, Parel, Mumbai - 400 012

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
FS	Naigaon MH	Naigaon Mat. Home Dispensary, Mumbai - 400 014	Maru Hospital & Research Centre, (BIDADA TRUST) 286-B, Dr. Babasaheb Ambedkar Road, Opp Indian Tobacco Company, Mumbai - 400 012
FS	Ram-Laxman Tekdi	Kala Chowky Dispensary & Part time Dental Clinic Abhyudaya Nagar	
FS	F/S Ward office	Sewri Cross Rd. Dispensary, Mumbai - 400 015	
		Kidwai Nagar Dispensary	
		Trivedi Sadan Dispensary, Curry Road	
FN	Korba Mithagar	Wadala Road Rly. Stn. Municipal Dispensary	Lion Tarachand Bapa Hospital And Centre, Behind Jain Soc, Sion West Mum-22
FN	Don Bosco	Antop Hill Dispensary	Smt Sushilaben R Mehta And Sir Kikabai Premchand Cardiac Institution, Plot No. 90, Road No 31, Near Gandhi Market, Sion East, Mumbai 400 022
FN	Antop Hill	Rawli Camp Dispensary, Sion Koliwada	Ayurvediya Prasarak Mandal Sanchalit Sheth R V Ayurvedic Nursing Home, Near Rly. Station, Sion
FN	Pratiksha Nagar	Lal Bahadur Shastri Marg Dispensary, Matunga	K.J. Somaiya Medical Trust, Somaiya Ayurvihar, Near Everard Nagar, Eastern Express Highway, Sion, Mumbai - 400 022
FN	L.B.S. HP	Transit Camp Sion Koliwada Dispensary	Shree Vardhaman Stha. Jain Shrivak Sangh, Matunga, Conducts, Shree P.B. Hemani Sarvajanic Jain Clinic, Sarvajanic Jain Dispensary, 390 A, Ramniwas, Ground Floor, 3rd Telang Cross Road, King Circle, Matunga (Central Railway), Mumbai - 400 019
FN	Wadala Dispensary	Korba Mithagar Dispensary Wadala	
FN	Raoli Camp MH		
GS	Curry Rd.	Curry Road Dispensary	Mumbai Mata Balsangopan Sanstha, N M Joshi Marg, Mumbai - 400 013
GS	Sasmira	Fergusson Road Dispensary, N. M. Joshi Marg	The People's Mobile Hospital, Dr. Annie Besant Rd, Worli Mumbai 18
GS	Prabhadevi MH	Prabhadevi Dispensary	Gopikrishna Piramal Memorial Hospital, C/O Ganpatrao Kadam Marg, Peninsula Building, Lower Parel, Mumbai - 400 013

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
GS	Jijamata Ngr. Disp	B.D.D. Chawl Dispensary, Worli	
GS	MH Comp. Disp	Beggars Home Dispensary, Mahalaxmi	
GS	Worli Koliwada Disp	Municipal Dispensary, Maharashtra High School compound , N. M. Joshi Marg	
		Municipal Dispensary, Welfare Centre, Senapati Bapat Marg,	
		Worli Labour Camp Dispensary, Sasmira Marg	
		Senapati Bapat Marg Dispensary Holly Cross	
		Jijamata Nagar Dispensary, E. Mozes Road	
		Worli Koliwada Municipal Dispensary	
		Zandu Ayurvedic Munl. Dispensary, S.B.Marg	
		Ayurvedic Dispensary, at Prabhadevi (Ayurvedic)	
GN	Gokhale Road	Matunga Labour Camp., Opp Chawl Supdt's Office, Mumbai - 400 019	S. L. Raheja Hospital, Raheja Hospital Rd, Mahim, Mumbai 16 (At present not functioning)
GN	Shastri Nagar	Bai Gulbai Dispensary	The National Health And Educational So. (P D Hinduja Hospital), 202, Veer Savarkar Road, Mahim, Mumbai - 400 016
GN	Kumbharwada	Dharavi Main Raod Dispensary	Shree Vardhaman Sthanakavasi Jain Shrivak Sangh, Sanchalit Navneet Hospital 12, Gyan Mandir Road, Dadar (West), Mumbai - 400 028
GN	Welkarwadi	Jasmin Mill compound, Shahu Nagar, Dharavi - 400 022	(Opd), Sanchalit Smt. Shantaben & Maniklal Savani Diaganostic Centre, Plot No 255/257, Sion Road, Sion (West), Mumbai - 400 022
GN	Pila Bungalow	Welkarwadi Dispensary, S. V. Marg, Mahim	
GN	Bai Gulbai Disp	Kumbharwada Dispensary, Dharavi	
GN	Mahim MH	Pilla Bungalow Dispensary, Dharavi	
GN	Urban FW Centre	Transit Camp Dispensary, Dharavi	
		Welfare Camp Dispensary, Near Shri Cinema	
HE HE	S V Nagar Golibar	Kherwadi Municipal Dispensary, Bandra Kalina Dispensary, Santacruz (E)	M M babasaheb gawade hospital Guru Nanak Quinentency Memorial Hospital, C/O. Shri S. Such Singh, Gurumukh Singh, Plot No. 341

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
HE	Kalina	Jawahar Nagar, Khar (E)	Near Kalanagar Bandra (East), Mumbai - 400 051
HE	Vakola	Prabhat Colony, Santacruz (E)	
HE	Govt. Colony	Bharat Nagar Dispensary, Bandra Kurla Complex	
HE	Kherwadi MH	S. V. Nagar Dispensary, Santacruz (E)	
HE	V N Desai Hosp.		
HW	Shastri Nagar	Khar Danda Dispensary, Bandra (W)	Jeevan Jyoti Charitable Trust, Pustikhar Society Jogeshwari (West), Mumbai - 400 102, Dispensary Santacruz (West)
HW	Khotwadi	Guru Nanak Dispensary, Bandra (W)	Mahavir Medical Research Centre, Ahinsa Marg, Khar (West), Mumbai - 400 052
HW	Sherly Rajan	Dr. Ambedkar Road Dispensary & Diagnosis Centre, Khar (W)	Smt BCJ General Hospital, (The Santacruz Resident's Association) Corner Of S.V. Road & Tilak Road, Santacruz West, Mumbai - 400 054 (At present Asha Pareikh Research Centre)
HW	S. V. Road	Old khar Dispensary, S. V. Road, Khar (W)	The Bandra Holy Family Hospital, St. Andrew's Rd, Bandra, Mumbai - 400 050
HW	K B Bhabha Hosp.	Shastri Nagar Linking Road Dispensary, Santacruz (W)	Lilavati Hospital, A-791, Bandra Reclamation, Bandra West, Mumbai - 50
HW	Guru Nanak Dispensary		Mahatma Gandhi Seva Mandir Aroyga Kendra, S V Road, Ground Floor, Bandra (West), Mumbai
KE	Natwar Nagar	Kol Dongri Dip., Andheri (E)	Jeevan Vikas Kendra (Sadanad Danait Hospital), Sahar Road, Andheri (East), Mumbai
KE	Tarun Bharat	Caves Road Dispensary, Jogeshwari (E)	Holy Spirit Hospital, Mahakali Caves Rd, Andheri East, Mumbai - 400 093
KE	Sambhaji Nagar	Marol Dispensary, Andheri (E)	Dr. Balabhai Nanavati Hospital, S.V. Rd, Vileparle W, Mumbai - 400 056
KE	Ajgaonkar Plot	Gundawali Dispensary, Andheri (E)	Vasani Diagnostic Centre, Andheri Lions Club, Andheri (East), Mumbai
KE	Nehru Road	Sambhaji Nagar Dispensary, Vile Parle (E)	
KE	M I D C HP	Paranjape Scheme Dispensary, Vile Parle (E)	
KE	Sahar Air Port	Hari Nagar Dispensary, Jogeshwari	
KE	V N Shirodkar MH	Natwar Nagar Dispensary, Jogeshwari (E)	
KE	Sarvoday Nagar	Sunder Nagar Dispensary, Andheri (E)	

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
KE	Sq. Colony MH	Sambhaji Nagar Ayurvedic Dispensary	
KE	Marol MH		
KW	Tata Compound	N. J. Wadia Dispensary, Opp. Andheri Rly. Stn., Andheri (W)	Prakrutik Chiktsha Vidnan Trust, Saint Dnaneshwar Rd., Near Chandan Cinema , Juhu, Mumbai - 400 049.
KW	Versova	Versova Dispensary, Andheri (W)	Society Of Helper's Of Mary Sanchalit Shraddha Vihar Hospital, Veera Desai Road, Andheri (West), Mumbai - 400 058
KW	N J Wadia	Lion's Juhu Jalan Dispensary, Vile Parle (W)	Homeopathes Education Society (Shree Mumbadevi Homeopathic Hospital), R G Gadkari Marg, Opp Cooper Hospital, Vile Parle (West) MUMBAI
KW	Anand Nagar	Municipal Market Dispensary, Vallabhkhair Road, Vile Parle (W)	Bharatiya Arogya Nidhi, N.S. Road No. 13, Juhu Scheme, Vile Parle West, Mumbai 400 057
KW	Lokhandwala	Oshiwara Maternity Home Dispensary	Lotus Eye Hospital, (Lotus Hospital Trust), 13th Road, J.V.P.D Scheme, Vile Parle (West), Mumbai
KW	Nehru Nagar		BSES MG Hospital, S.V Rd, Andheri West, Mumbai 58
KW	Juhu Dispensary		Kokilaben Dhirubhai Ambani Hospital (Malti Vasant)
KW	Bhardawadi		
KW	Oshiwara MH		
PS	Chincholi	Topiwala Dispensary, Goregaon (W)	Nil
PS	Pandurangwadi	Chincholi Dispensary & Dental Clinic, Sq. Colony, Goregaon (E)	
PS	Mitha Nagar		
PS	Motilal Nagar		
PS	Pahadi School		
PS	Goregaon MH		
PN	Somwar Bazar	Choksy Dispensary, Choksy MH, Malad (W)	Nil
PN	Kurar Village	Manori Dispensary, Malad (W)	
PN	Pathanwadi	Malawani II nd Dispensary, Malad (W)	
PN	Tank Lane	Pathanwadi Dispensary, Malad (E)	
PN	Appa Pada	Kurar Village Dispensary, Malad (E)	
PN	Malawani 2	Somwar Bazar Nemani Road Dispensary, Malad (W)	
PN	Dindoshi Vasahat	Goshala Road Dispensary, Malad (E)	
PN	M W Desai Hosp.	Valnai Dispensary, Malad (W)	
PN	Valnai	School Road Dispensary, Malad	

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
PN	Malawani 1	Riddhi Gardern Dispensary, Malad	
RS	Charkop 1	Akurli Road Mat Home Dispensary, Kandivali (E)	Shree Kandivali Hitwardhak Mandal KHM" Medical Centre Shri Mangubhai Dattani Bhavan
RS	Dahanukar wadi	Hanuman Nagar Dispensary, Kandivali (E)	Pravatibai Chavan Charitable Trust, Datta Mandir, L.G.C, Dahanukar Wadi, Kandivali (West), Mumbai - 400 067
RS	Damu Pada	Dahanukarwadi Dispensary, Kandivali (W)	Jankalyan Arogya Charitable Medical Society Trust, Sanchalit Shalinitai Hospital, 32/D, 6, Akurli Omkar, Shakari Society Ltd, Mhada R 2, Lokhandwala Complex, Kandivali (East), Mumbai - 400 101
RS	Hanuman Nagar	Charkop Sector 1 Dispensary, Kandivali (W)	Lion's Clinic (Lions Club Of Malad - Borivali), Podar Bhavan, Parekh Lane, Off S V Road, Kandivali, Mumbai - 400 067
RS	Babrekar Nagar	Babrekar Nagar Dispensary, Kandivali (W)	Vaishnav Seva Trust Hospital, Mathuradas Road, Kandivali (West), Mumbai - 400 067
RS	Centenary		Jeevan Jyoti Charitable Trust, Sanchalit Jeevan Jyoti Hospital, Plot No 40, Mhada, Lokhandwala Complex, Kandivali (East), Mumbai - 400 101
RS	Akurli Rd. MH		Dr. Ram Manohar Lohiya Shikshak Sanstha Charitable Arogya Kendra (OPD), Bridgekesal Datta, Mandir, Dhanukar Wadi, Kandivali (West), Mumbai - 400 067
RC	Tata Power House	Charkop Sector No.5 Dispensary	Shree Samasta Parajiya Suvarna General Hospital, Kastur Park, Shimpoli Road, Borivali (West) Mumbai - 400 092
RC	Eksar	Gorai Road (Mhada)Dispensary, Borivali (W)	
RC	Borsapada	Eksar Village Dispensary, Borivali (W)	
RC	Babhai Naka	Gorai Village Dispensary, Gorai, M.H.B Dispensary, Gorai, Borivali (W) K.K.Dispensary	
RC	Charkop 5	Gorai Village Dispensary, Gorai, M.H.B Dispensary, Gorai, Borivali (W) K.K.Dispensary	
RC	Gorai	Gorai Village Dispensary, Gorai, M.H.B Dispensary, Gorai, Borivali (W) K.K.Dispensary	

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
RC	Rajda School		
RC	Rajendra Nagar		
RN	Y R Tawade Marg	Y. R. Tawade Marg Dispensary, Dahisar (E)	Karuna Medical Society, Jeevan Beema Nagar, Borivali (West), Mumbai - 400 103
RN	Bhagali Pada	Dahisar Dispensary, L.T. Road, Dahisar (W)	Shri. K.V. O Jain Manav Kalyan Kendra (Prince Helath Centre) O.P.D, S.V. Road, Dahisar (East), Mumbai - 400 068
RN	Navagaon		
RN	Dahisar Disp		
L	Bail Bazar	Bail Bazar Dispensary, Kurla	Kurla Medical Welfare Center's Ram Agarwal Eye Hospital, 518, New Mill Road, Mahavir Co Op Hsg Society, Near New Post Office, Kurla (West), Mumbai - 400 070
L	Asalfa Village	Chunabhatti Dispensary, Kurla	Kurla Lion's Medical Centre, Near Kurla Garden, Lbs Road, Kurla, Mumbai - 400 070
L	Kaju Pada	Christian Village Dispensary, Kurla	
L	Kamgar Nagar	Qureshi Nagar Kasai Wada Dispensary, Kurla	
L	Nehru Nagar	Mohilly Village Dispensary, Kurla	
L	Buddha Colony	Asalfa Village Dispensary, Kurla	
L	Match Factory	Safed Pool Dispensary, Kurla	
L	Mohily Village	Nehru Nagar Dispensary, Kurla	
L	Amar Nagar	Kajupada Dispensary, Kurla	
L	Tunga Village	Buddha Colony Dispensary, Kurla	
L	Kurla Bhabha Hosp.	Chandivali Dispensary, Sangharsh Nagar	
L	Chunabhatti MH	New Tilak Nagar Dispensary	
ME	Nimoni Baug	Deonar Colony Dispensary, Deonar	Nil
ME	Ayodhya Nagar	Tromby Dispensary, Trombay	
ME	Shivaji Nagar	Ayodhya Nagar Dispensary,	
ME	Bainganwadi	Gavanpada Dispensary,	
ME	Lotus Colony	Cheeta Camp Dispensary,	
ME	Mankhurd	Suraksha Society Dispensary, Vashinaka	
ME	Deonar MH		
ME	Centenary Govandi		
ME	Cheeta Camp		
MW	Chembur Colony	Chembur Naka Dispensary, Chembur	Sushrut Hospital & Research Centre, 365, Swastik Park, Chembur East, Mumbai - 400 071

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
MW	Lal Dongar	Mahul Village Dispensary,	Inlakhs General Hospital, Inlakhs Hospital Road, Chembur Colony, Mumbai 71
MW	Pestum Sagar	Labour Camp Dispensary, Chembur	
MW	Subhash Nagar	Chembur Colony Dispensary, Chembur	
MW	Ghatla Village	Lal Dongar Dispensary, Chembur	
MW	Chembur MH		
MW	Tilak Nagar		
N	Pant Nagar	Vikhroli Parksite Dispensary,	Maganlal Popatlal & Sarvodaya Hospital, Rifle Range, Lbs Marg, Ghatkopar (W), Mumbai - 400 086
N	Ramabai Colony	Sarvoday Nagar Dispensary, Ghatkopar	Harilal Jechand Doshi Ghatkopar Hindu Sabha Hospital, Medical Aid Fund, C/O Ghatkopar Hindu Sabha Office, Sharadhanand Rd, Ghatkopar Mumbai - 400 086
N	Laxmi Nagar	Parisiwadi Municipal Dispensary, Ghatkopar	Ghatkopar Seva Sangh Bhanumati Jagubhai Tana Medical Complex (OPD), L B S Marg, Ghatkopar (West), Mumbai - 400 086
N	Kirol Village	Kirol Village Dispensary, Vidya Vihar	
N	Varsha Nagar	Ramabai Colony Dispensary, Ghatkopar	
N	Sainath Nagar	Pant Nagar Dispensary, Ghatkopar	
N	Sarvoday Nagar	Sainath Nagar Dispensary	
N	Barve Nagar		
N	Rajawadi School		
N	Parksite		
S	Kanjur Village	Tagor Nagar Dispensary, Vikhroli (E)	L.H. Hiranandani Hospital, Olympia, Central Avenue Hiranandani Business Park Powai Mumbai - 400 076 .
S	Shivaji Talao Disp	Tirandaz village Dispensary	
S	Subhash Nagar	Kanjur Village Dispensary, Kanjur Marg	
S	Tembhi Pada	M.V.R.Shinde Dispensary Ishwar Nagar	
S	Tulset Pada	Tembhi Pada Dispensary, Bhandup	
S	Kannamwar Nagar	Shivaji Talao Dispensary, Tank Road, Bhandup	
S	Hiranandani	Tulset Pada Dispensary, Bhandup	
S	Paspoli Village		
S	Tagore Nagar MH		
S	Bhandup MH		
T	Nanepada	P.J.K. Dispensary M G Road	Pragati Foundation Hiramongi Hospital, Mulund, Mumbai

Ward Name	Health Post	Dispensary	Name of Linked Charitable Hospital
T	DDU Marg	Mulund Colony Dispensary, Mulund	
T	Mulund Colony	Dumping Road Dispensary, Mulund (W)	
T	Mulund MH		
T	M T Agarwal Hosp		
T	Veer Savarkar Hosp		

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Annexure 5

	Public Hospitals in Mumbai
	Government Hospitals in Mumbai
1	Jagjivan Ram Hospital (Railway) Agripada
2	E. S. I. S. Hospital Andheri
3	MIDC Hospital Center Andheri (E)
4	Kasturba Hospital Arthur Road
5	K. B. Bhabha Hospital Bandra
6	Harilal Bhagwati Municipal General Hospital Borivali (W)
7	Central Railway Hospital Byculla
8	J. J. Hospital Byculla
9	Municipal Eye Hospital Byculla
10	St. George Hospital C.S.T. (V.T.)
11	B.A.R.C. Hospital Chembur
12	Mangal Anand Hospital Chembur
13	RCF Hospital Chembur
14	Smt. Diwaliben Mehta Municipal Hospital Chembur
15	Bhabha Hospital Chembur
16	Family Planning Hospital Colaba
17	G. T. Hospital Crawford Market
19	Cama Albless Hospital Dhobi Talao
20	E.S.I.S. Hospital Dhobi Talao
21	Godfrey Clinic Fort
22	Seth A.J.B. Municipal ENT Hospital Fort
23	Rajawadi Hospital Ghatkopar
24	Sant Muktabai Municipal General Hospital Ghatkopar
25	Siddharth Hospital Goregaon
26	Centenary General Hospital Govandi
27	Haji Ali Children's Orthopedic Hospital Haji Ali
28	Cooper Hospital Juhu
29	E.S.I.S. Hospital Kandivali
30	Centenary General Hospital Kandivali (W)
31	Khar T. B. Hospital Khar
32	Bhabha Hospital Kurla
33	Agarwal Trust Eye Hospital Kurla (W)
34	K. B. Bhabha Hospital Kurla (W)
35	M. W. Desai Municipal General Hospital Malad
36	S. K. Patil Municipal General Hospital Malad (E)

37	E.S.I.S. Hospital Marol
38	E.S.I.S. Hospital Mulund
39	Municipal Hospital Mulund (E)
40	Swatantra Veer Sawarkar Municipal General Hospital Mulund (E)
41	Manasdevi T. Agarwal Municipal General Hospital Mulund (W)
42	B.Y.L. Nair Charitable Hospital Mumbai Central
43	Police Hospital Nagpada
44	Police Hospital Naigaon
45	INHS Asvini Navy Nagar
46	Health Unit (Railway) Hospital Parel
47	K.E.M. Hospital Parel
48	M.G. Memorial Hospital Parel
49	Tata Hospital Parel
50	Tata Memorial Hospital Parel
51	Wadia (Female) Hospital Parel
52	Wadia (Children) Hospital Parel
53	I.I.T. Hospital Powai
54	Naval Dockyard Hospital Powai
55	Mumbai General Hospital Santacruz (E)
56	V. N. Desai Municipal General Hospital Santacruz (E)
57	Sewree T. B. Hospital Sewree
58	Lokmanya Tilak Municipal General Hospital Sion
59	Sion Hospital Sion
60	E.S.I.S. Hospital Thane
61	Mental Hospital Thane
62	Turbhe Hospital Turbhe
63	K. M. J. Phule Municipal General Hospital Vikhroli (E)
64	Acworth Municipal General Hospital for Leprosy Wadala
65	B.P.T. Hospital Wadala
66	E.S.I.S. Hospital Worli
67	Mata Bal Sangopan Hospital Worli
68	Poddar Hospital Worli
69	Police Hospital Worli

Source: Compiled from the records of Mumbai Mahanagarपालिका, Suhasini Arya (2013), "A Comparative Study of Public and Private Health Services in Mumbai Region - Availability and Utilisation Pattern" SNDT University, Mumbai.

Annexure 6





Some indicative "Charitable" Hospital Advertisements and Rates - All information from their respective websites.


- a. Kokilaben Dhirubhai Ambani Hospital ()
<http://www.medsave.in/hospitals/C001B005C0536.pdf>

		Kokilaben Dhirubhai Ambani Hospital & Medical Research Institute Every Life Matters							TARIFF W.E.F. 01.04.2013	
		(General)							(Currency ₹)	
	General	Twin Sharing	Single Economy	Single Regular	Single Classic	Deluxe Single	Suite	Deluxe Suite		
Bed Charges										
Regular	1,400	2,750	3,600	3,900	7,500	9,000	12,000	18,000		
ICCU	4,000	6,000	6,700	7,350	8,000	11,000	15,000	20,000		
MICU	4,000	6,000	6,700	7,350	8,000	11,000	15,000	20,000		
SICU	4,000	6,000	6,700	7,350	8,000	11,000	15,000	20,000		
NICU	3,000	5,000	6,000	7,000	8,000	11,000	15,000	20,000		
PICU	3,000	5,000	6,000	7,000	8,000	11,000	15,000	20,000		
Step down ICU	3,500	5,000	6,000	7,000	7,250	8,500	12,500	17,500		
Note: Bed charges are calculated from 12:00 noon to 12:00 noon irrespective of the time of admission.										
Visit Charges (additional premium fees are applicable for certain consultants. Please inquire at the reception/admission desk)										
Inpatient Routine Visit	800	1,200	1,500	1,750	2,000	2,500	3,000	4,000		
Surgeon Fees (additional premium fees are applicable for certain consultants. Please inquire at the reception/admission desk)										
Minor	2,000	3,500	5,000	7,000	9,000	11,500	14,000	18,000		
Intermediate	3,000	6,000	8,000	10,000	12,000	17,000	22,000	27,500		
Major	7,000	14,000	21,000	28,000	35,000	45,000	55,000	65,000		
Major Plus	11,000	23,000	37,000	51,000	65,000	77,500	90,000	110,000		
Supramajor	25,000	40,000	55,000	75,000	95,000	122,500	150,000	175,000		
Supramajor Plus (A)	40,000	72,000	98,000	124,000	150,000	205,000	260,000	325,000		
Supramajor Plus (B)	40,000	72,000	98,000	124,000	150,000	205,000	260,000	325,000		
Anaesthesia Charges										
Minor	700	1,225	1,750	2,450	3,150	4,600	5,600	7,200		
Intermediate	1,050	2,100	2,800	3,500	4,200	6,800	8,800	11,000		
Major	2,450	4,900	7,350	9,800	12,250	18,000	22,000	26,000		
Major Plus	3,850	8,050	12,950	17,850	22,750	31,000	36,000	44,000		
Supramajor	8,750	14,000	19,250	25,250	33,250	49,000	60,000	70,000		
Supramajor Plus (A)	14,000	25,200	34,300	43,400	52,500	82,000	104,000	130,000		
Supramajor Plus (B)	14,000	25,200	34,300	43,400	52,500	82,000	104,000	130,000		
Theatre Charges (Per Hour)										
Minor	2,000	2,700	4,125	5,575	7,000	8,000	9,000	9,700		
Intermediate	2,200	3,000	4,500	6,000	7,500	8,500	9,500	10,500		
Major	3,500	4,700	5,975	7,250	8,500	9,250	10,000	12,500		
Major Plus	3,700	5,000	6,325	7,675	9,000	10,000	11,000	14,000		
Supramajor	4,500	5,800	7,025	8,275	9,500	11,000	12,500	16,000		
Supramajor Plus (A)	5,000	6,500	8,000	9,500	11,000	12,250	13,500	17,000		
Supramajor Plus (B)	5,000	6,500	8,000	9,500	11,000	12,250	13,500	17,000		
Deposit										
Minor	21,000	35,000	43,000	53,000	64,000	76,800	116,000	146,000		
Intermediate	27,000	41,000	49,000	60,000	69,000	82,800	137,000	173,000		
Major	47,000	62,000	75,000	92,000	109,000	130,800	211,000	265,000		
Major Plus	66,000	99,000	121,000	149,000	176,000	211,200	322,000	416,000		
Supramajor	89,000	124,000	157,000	199,000	242,000	290,400	466,000	587,000		
Supramajor Plus (A)	239,000	336,000	376,000	432,000	496,000	595,200	809,000	1,041,000		
Supramajor Plus (B)	157,000	217,000	245,000	281,000	325,000	390,000	526,000	671,000		
Maternity	NA	90,000	NA	NA	110,000	NA	220,000	330,000		
ICU Admission	NA	94,000	97,000	101,000	105,000	120,000	140,000	160,000		
Medical Admission	23,000	52,000	66,000	78,000	92,000	110,000	125,000	135,000		
Note: 10% advance to be paid at the time of booking the bed/OT and balance at the time of admission.										

* All the above tariff and schedule of deposit is subject to change without prior notice.
 Emergency Charge will apply beyond normal hours, Sundays and public holidays.

http://www.kokilabenhospital.com/patients/patientsguide/patient_rooms.html

CLASS	FACILITIES
Deluxe Suite	<p>The tastefully designed luxurious deluxe suite affords all amenities, designed to cater to the comforts of patients and the accompanying relatives. The terrace views over the Western Suburbs are very relaxing. Besides 24/7 room service, all entertainment and communication needs like TV with multiple channels, fridge, Wi-Fi facility, direct dialling and two-way nurse call system are available.</p> 
Suite	<p>The patient and relative can stay in the suite with amenities like separate rooms for both, access to terrace, separate bathrooms, separate TVs with multiple channels, fridge, Wi-Fi facility, direct dialling, two-way nurse call system, personal safe and many more facilities for total comfort.</p> 
Single	<p>Single rooms are self-contained with bathroom, sofa-cum-bed for a relative, TV with multiple channels, fridge, direct dialling, two-way nurse call system and personal safe.</p> 
Twin	<p>Room shared by two patients. Each patient's relative has a separate couch and every patient has a separate TV with multiple channels, direct dialling, two-way nurse call system and personal safe.</p> 

CLASS	FACILITIES
General	<p>Our general ward rooms are three, four or five bedded units (unlike dormitory rooms). Each unit has a TV with multiple channels, direct dialling, two-way nurse call system for each patient and personal safe for each patient, also including a resting recliner for every patient's relative.</p> 
Isolation Rooms	<p>Isolation Rooms, with 40 isolation beds in our hospital, are basically single rooms where patients are admitted to prevent cross infections. There are two types - Positive Pressure Room & Negative Pressure Room. Positive Pressure Rooms are used to accommodate patients who are at risk of contracting infections very easily, whereas Negative Pressure Rooms are used to accommodate patients who may be infected and may spread infections to others.</p>

Outpatient departments

- The OPD is functional between 8.00 a.m. to 8.00 p.m. from Monday to Friday and between 8.00 a.m. to 6.00 p.m. on Saturday.
- First Consult fees are INR 1000/- for most consultants and INR 2000/- for Premium Consultants
- Follow up visit charges are INR 700/- for most consultants and INR 1500/- for Premium Consultants
- When you need three follow up visits within a period of 30 days from the first consultation, with the same consultant you will be charged INR 700/-
- Tariffs are subject to revision without prior intimation.
- International tariffs are applicable to foreign nationals only.

Amenities



Convenient amenities

Apart from comprehensive healthcare services, the hospital offers patients and visitors world-class amenities amid unparalleled comfort.

Convention Centre

With its best-in-class acoustics and in-house banqueting facilities, the Convention Centre is geared to host medical conferences and clinical workshops. Equipped with latest technology, the Centre has the ability to link the hospital with other national and international institutions with real-time video conferencing. The Centre has a capacity to host up to 750 participants. For further information, please e-mail us at conventioncentre.kh@relianceada.com

Food Court

At Kokilaben Hospital, we have a Food Court along with a Chaat & Juice Centre and a Subway Outlet that serves a mix of regional and international dishes.

Fine Dining Restaurant

The Fine Dining Restaurant located on the ground floor serves gourmet meals catering to every palate.

Java Green

We also have Cafeteria outlets within the hospital at various floors that offer 24/7 quick-bite options to the patients, guests and visitors.

Business Centre

Managed by Reliance World, the digitally equipped Business Centre offers a range of services that can be availed by anybody on a pay-per-use basis. Some of the services offered here include High-Speed Internet, Video Conferencing, Ready-to-Use Offices and Digital Services (like B/W & Colour Printing, Scanning & Data Transfer, CD Burning, Medical Records Digitisation & Photocopying). Our Business Centre also has three meeting rooms equipped with communication technology to fulfill business requirements. The centre also has a dry pantry.

Pharmacy

At Kokilaben Hospital, the pharmacy services are available for 24 hours. Our pharmacy ensures that all medicines are authentic and stored as per the required standards.

ATM

The ATM facility is available at two places on the ground floor of the hospital - one outside the food court and the other next to salon in the Convention Centre wing.

WiFi

Our hospital is WiFi enabled. The pre paid vouchers are available 24 hours at the pharmacy.

House Phones

The house phones, which would connect you to in-patient rooms, are available outside the Food Court on the ground floor.

Prayer Room

An 'all faith' prayer room is situated on the ground floor.

The Gift Shop

The gift shop on the ground floor showcases a wide range of collection ranging from cards, soft toys and showpieces to books, paintings and many other accessories for you to choose from for a friend or family member who is recuperating in the hospital that will brighten their spirits and help ease their recovery.

Salon

The salon is located on the ground floor in the Convention Centre wing that offers a wide range of services from haircuts, tailor made wigs for cancer patients to different types of massages providing a relaxing experience which improves the overall well being of the body.

b. Lilavati Hospital (<http://www.lilavatihospital.com/tariff.aspx>)

	Common	Economy	Twin	Special	Deluxe	Super Deluxe	Ex. Suit
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RADIOLOGY							
X-Ray							
X-Ray Chest - PA View	480	620	700	740	790	910	1,010
Mammography							
Bilateral	3,600	4,680	5,220	5,580	5,940	6,840	7,560
Unilateral	2,400	3,120	3,480	3,720	3,960	4,560	5,040
Ultrasound							
Abdomen	1,560	2,030	2,260	2,420	2,570	2,960	3,280
Abdomen & Pelvis	2,400	3,120	3,480	3,720	3,960	4,560	5,040
Small Parts	1,800	2,340	2,610	2,790	2,970	3,420	3,780
CT Scan							
Abdomen & Pelvis	7,800	9,750	10,530	11,700	13,650	15,600	17,550
Brain	3,600	4,500	4,860	5,400	6,300	7,200	8,100

WARD PROCEDURES							
ECG	130	170	190	200	210	250	270
ABG	420	550	610	650	690	800	880
Intubation	1,660	2,160	2,400	2,580	2,740	3,160	3,480
Arterial Line	1,320	1,720	1,920	2,040	2,180	2,500	2,780

VII) MISCELLANEOUS CHARGES

Fine for misplaced passes							
Per Pass	500	500	500	500	500	500	500
Ambulance charge per hour							
Regular	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cardiac	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Telephone charges							
Local (per 60 sec)	NA	NA	10	15	15	20	25
STD/ ISD call	Actuals + 10% Service Charge						

Ambulance charges will be billed to & fro even if the patient utilises it one way . If Cardiac Ambulance is availed charges for the accompanying Resident Doctor will be billed extra @ Rs.400/- (Per Hour)

II) ACCOMMODATION CHARGES

Ward	950	2,000	3,500	6,500	7,500	15,000	22,000
ICU / ICCU / SICU	3,000	3,500	5,500	9,000	12,000	17,000	25,000
Acute Stroke Unit	3,000	3,500	5,500	9,000	12,000	17,000	25,000
Paediatric / Neonatal ICU	3,000	3,500	5,500	9,000	12,000	17,000	25,000

- Accommodation will be billed at the end of each calendar day. Check-in time is flexible, hence room charge for the date of admission will be billed only once irrespective of the time of admission. Accommodation charge will be applicable for minimum one day even if the patient occupies the bed for a short duration.
- The cut-off time for transfers is 11 am. For each calendar day the highest room charge applicable between 11 am to 12 midnight will be billed after considering transfers, if any.
- Check-out time is considered as 8 am. If the patient's discharge orders are received for final billing before 8 am, room charge for discharge day is exempted.
- Accommodation charge includes the patient's prescribed diet. Additional food / beverages / mineral water for the patient or for visitors will be charged extra.
- Charges for all hospital services (except medicines and surgical materials) vary based upon the allowed class of accommodation. Medicines and materials should be procured through the hospital only and not from outside.
- Day Care functions between 8 am to 8 pm. Patients requiring stay beyond 8pm will need to be admitted and shall be charged as per the class selected. i.e Twin & above
- Bed charges for Hematology / Oncology Unit (8B) / Day Care Unit is Rs 1500/- per day.

III) VENTILATOR / ROOM RETENTION / ISOLATION ROOM CHARGE

Ventilator Charge	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Room Retention	NA	NA	NA	13,000	15,000	30,000	44,000
Isolation Room	-	-	6,000	-	-	-	-

- Charges for ventilator usage will be billed on a per day basis for the duration that the patient requires bed -side ventilator support.
- Patients admitted in Special / Deluxe / Super Deluxe / Ex. Suit class rooms may be allowed to retain their allotted room while they are transferred to the Intensive Care Unit.
- Please note that room retention is allowed subject to availability and only for the duration that the patient is admitted in the ICU. Patient's relative should be prepared to vacate the room immediately if the hospital requires the bed to admit another patient. The stipulated room retention charge includes bed tea only; any other food item that is ordered will be charged extra.
- Isolation room will be allotted in cases where infection control precautions need to be taken.

IV) DOCTOR'S VISIT FEES

	Common	Economy	Twin	Special	Deluxe	Super Deluxe	Ex. Suit
Visit	800	1,000	1,200	1,400	1,600	2,000	2,500
Emergency Visit	1,600	2,000	2,400	2,800	3,200	4,000	5,000
ICU / STORKE UNIT / PICU visit	800	1,000	1,200	1,400	1,600	2,000	2,500
Intensivist Charge	1,200	1,200	1,200	1,200	1,200	1,200	1,200

- Doctor's Visit Fees stipulated above are fixed for all classes and can be charged through the hospital bill only.
- Emergency visit charges will be applicable between 11pm - 6 am when a Doctor is specially called to see the patient.
- Intensivist Visit will be charged on a per day basis during the period of stay ICU / ICCU / SICU / PICU / NICU.

c. Bombay Hospital (<http://www.bombayhospital.com/inpati.htm>)

ROOM FACILITIES

NATURE OF ACCOMMODATION

Class	No. of Beds	Particulars	Room Charges / Day
Deluxe	10	Two Rooms with pantry and two bathrooms, centrally air conditioned, well furnished with 2 TVs, Refrigerator and telephone.	10000/-
First - MRC	12	Single accommodation with attached bathroom, sofa-cum-bed for attendant, piped oxygen, suction facility, centrally air conditioned, well furnished, with T.V., Telephone and Refrigerator.	6000/-
First - NW	30	Single accommodation with attached bathroom, sofa-cum-bed for attendant, centrally air conditioned, well furnished, with LCD T.V., and Telephone.	6000/-
NW SP-II (9th & 10th Floor)	27	Single accommodation with attached bathroom and sofa-cum-bed for attendant, Central A/C & TV.	4500/-
MRC SP-II (11th & 9th Floor)	24	Single accommodation with attached bathroom and Piped oxygen & suction facility with TV.	4500/-
A/C-II (14th Floor NW)	11	Single accommodation, sofa-cum-bed for attendant, centrally air conditioned, well furnished, with T.V.	3000/-
NW-II (9th & 10th Floor NW)	54	Two patients in a room, attached bathroom and sofa-cum-bed for attendant of each patient Central A/C	3300/-
MRC-II (12th & 8th Floor)	40	Single accommodation with sofa-cum-bed for attendant, common bathroom, but with Wash Basin facility and piped oxygen & suction facility	2900/-
SP L II (14th Floor NW)	16	Two/Four Patient in a room, Central A.C., oxygen & suction facility, Wash Basin facility, Chair for attendant.	2000/-
Lower-II	105	Two to Four patients in a room with common bathroom & Chair to attendant.	1700/-
General Ward	262	Dormitory beds with common bathroom.	Rs. 0
I.C.U./I.C.C.U.	81	Central/Bed side monitors with ventilators.	As
Recovery Room	42	Central/Bed side monitors with ventilators.	Per Class
Neo-Natal	10	Bed side monitors with ventilators & incubators	
P.O.I.C.U.	8	Central/Bed side monitors with ventilators	

a. Jaslok Hospital:

(<http://www.jaslokhospital.net/SpecialtiesDetails.aspx?CatId=4&SCatId=75&SPNm=Tariffs>)

THE FOLLOWING ARE THE DAILY CHARGES FOR ROOMS.

	Regular & Plasty Room	Surgical ICU/ICCU Neuro ICU	PICU	HDU unit K.T.R	Isolation Room Rates	Premature Baby Wards	Guest Special Room 20th Flr	Admission Deposit Non-ICU	ICU
S/Del	15,000	15,400	15,400	13,860	10,530	7,990	3,300	75,000	1,00,000
A-Del	6,000	9,900	9,900	9,130	6,660	5,090	3,300	40,000	60,000
A	5,000	8,000	8,000	7,570	5,830	3,440	3,300	30,000	60,000
C	3,500	5,750	5,750	5,320	6,660	2,290	3,300	20,000	45,000
E	1,600	3,750	3,750	3,750	3,270	1,400	3,300	10,000	25,000
Ecr	1,540	3,575	3,750	3,750	3,270	1,270	3,300		
EMS/ICU	Per Day	2,060							
EMS/ICU	Per Hour	550							
Casulty	Per Hour	385							
Iccu Iso.	Per Day	7,330							
Foreigner Deposit New								110,000	

The tariffs include meals, linen and nursing. They do not include the Consultant doctor's visits, laboratory charges, procedures, tests, drugs and telephone bills.

Emergency Charges : will be levied at 1 ½ times the regular charges for operation, procedures and investigations when done outside the normal hospital working hours. Charges for procedures / investigations / operations will be billed according to the class of accommodation.

ADMISSION DEPOSIT

Class	Non-ICU Deposit (Rs.)	ICU DEPOSIT
Suite Deluxe	75,000	100,000.00
A – Deluxe	40,000	60,000.00
A	30,000	60,000.00
C	20,000	45,000.00
Economy	10,000	25,000.00
For Foreign Patients	110,000	

In surgical cases, the deposit will be based on the grade of Operation.

OPD Consultations for Speciality Clinics & Other Clinics.

	Rates
First OPD Consultation	1000
Within 7 days from first consultation	No fees
After 7 days from first consultation	500
Second Follow-up within one month	650
IP Follow-up within one month from date of discharge	650
General OPD Consultation(concessional)	500
Physiotherapy First Consultation	800
Speech Therapy First Consultation	550
Maternity Registration	550
Maternity Registration - follow-ups	275



Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.