Role of Mohalla Clinics in Delivering Health Care Services in Delhi

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LAKSHITA

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CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110067

DECLARATION

Date: 20/07/2018

This is to certify that the dissertation titled **"ROLE OF MOHALLA CLINICS IN DELIVERING HEALTH CARE SERVICES IN DELHI"** submitted by me under the guidance of Dr. Sunita Reddy in partial fulfilment for the award of the degree of **MASTER OF PHILOSOPHY** is my original work and has not been previously submitted for any other degree of this University or any other University.

Place: New Delhi
Date: 20 /07/2018

LAKSHITA

CERTIFICATE

We recommend that this dissertation be placed before the examiners for evaluation.

Dr. Sunita Reddy
(Supervisor)

Prof. Ramila Bisht
Chairperson

CHAIRPERSON
Centre of Social Medicine & Community Health
School of Social Sciences
Jawaharlal Nehru University
New Delhi-110067

Telefax: +91-(11) 2670 4420 (Direct), 26742676, 26741557 (Ext. 4420), E-mail: csmchjnu@gmail.com

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ACRONYMS

AAP	Aam Aadmi Party
AIDS	Acquired Immune Deficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BJP	Bharatiya Janata Party
BPL	Below Poverty Line
B-S-P	Bijli-Sadak-Paani
CAMO	Chief Administrative Medical Officer
CATS	Centralized Ambulance Trauma Services
CCTV	Closed Circuit Television
CDMO	Chief District Medical Officer
CGHS	Central Government Health Scheme
CHC	Community Health Centre
C-H-E-S-S	Cleanliness-Health-Education-Sanitation-Social Sectors
DCB	Delhi Cantonment Board
DDA	Delhi Development Authority
DGEHS	Delhi Government Employees Health Scheme
DFW	Directorate of Family Welfare
DGHS	Directorate General of Health Services
DHS	Directorate of Health Services
DMC	Delhi Medical Council
ESIC	Employees’ State Insurance Scheme
FHS	Family Health Strategy
FW	Family Welfare

GDP	Gross Domestic Product
GNCTD	Government of National Capital Territory of Delhi
HIV	Human Immunodeficiency Virus
IHBAS	Institute of Health Behaviour and Allied Sciences
IMR	Infant Mortality Rate
IPP	Indian Population Project
ISM&H	Indian System of Medicine and Homeopathy
JJ	*Jhuggi-Jhopdi*
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
L-G	Lieutenant Governor
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCD	Municipal Corporation of Delhi
MCH	Maternal and Child Health
MLA	Member of Legislative Assembly
MMU	Mobile Medical Unit
MoHFW	Ministry of Health and Family Welfare
MT	Medical Tourism
MTP	Medical Termination of Pregnancy
MTW	Multitask Worker
NA	Not Available
NCT	National Capital Territory
NDMC	New Delhi Municipal Council
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHP	National Health Policy
NHS	National Health Service
NHSRC	National Health Systems Resource Centre

NRHM	National Rural Health Mission
NSS	National Sample Survey
OBC	Other Backward Castes
OBS	Obstetrics
OOPE	Out-of-Pocket Expenditure
OPD	Out Patient Department
PHC	Primary Health Centre
PHN	Public Health Nurse
PNDT	Pre-Natal Diagnostic Techniques
SC	Scheduled Caste
SDG	Sustainable Development Goal
ST	Scheduled Tribe
SUS	Sistema Único de Saúde
Under- 5	Under-five
UFWC	Urban Family Welfare Centre
UHC	Universal Health Coverage
UK	United Kingdom
USAID	United State Agency for International Development
VO	Voluntary Organisation
WHO	World Health Organisation

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Chapter 1 - Introduction and Conceptualization

1.1 Introduction

India had a beautiful imagination of the three-tier healthcare delivery system when the Bhore Committee was formed in the late 1940s. In the system, the Primary healthcare forms the first point of contact for individuals, families, and communities with the national health system aiming to bring health care as close as possible to people where they live and work (WHO, 1978). In rural areas, primary healthcare is provided through a system of Sub-centres (SCs) and Primary Health Centres (PHCs). One SC covers a population of 5000 in plains and 3000 in hilly and tribal regions, and one PHC covers a population of 30000 in plains and 20000 in tribal and hilly regions. Four PHC are included in one Community Health Centre (CHC) which covers a population of 1, 20,000 in plain areas and 80,000 in tribal and hilly regions (Bhandari and Dutta, 2007, p.277).

Primary healthcare in urban areas is provided through the means of Urban Family Welfare Centres (UFWCs) and Urban Health Posts. These health posts and UFWCs deliver primary health care to a population of 50,000 as per government norm. In smaller cities, state government and in large cities, the large municipal bodies manage the health services (Agarwal, 2009, p. 19)

Secondary Healthcare forms the second level of the health services system, and also serves as a referral unit for patients referred from PHCs requiring specialised care and treatment. While secondary healthcare is provided through CHCs and District hospitals the tertiary care is provided through medical colleges and advanced medical research institutes viz. All India Institute of Medical Sciences is among those (AIIMS). These institutions offer specialised diagnostics, medical, surgical as well as intensive care services.

The three levels of health care in India is envisioned in the form of a pyramid-like structure where the primary healthcare forms the bottom of the pyramid which “streamlines upward” towards more specialised tertiary health care and forms the top of the pyramid.

Contrary to this, the current health care delivery situation in Delhi shows that the pyramid is inverted. The tertiary healthcare forms the base and primary health care acquires the top of the pyramid (Hazarika et. al., 2016. p. 133). The broad base of the pyramid illuminates that Delhi's healthcare system is flooded with high end, technologically sophisticated, super-speciality and multispecialty corporate hospitals. It is mainly to attract foreign patients from neighbouring countries and other parts of the world seeking various kinds of treatments. And the narrow top is the manifestation of neglected primary healthcare services.

Primary healthcare continues to be in a state of complete neglect especially in urban slums of India. The deteriorating living conditions coupled with lack of access to basic services poses numerous health challenges for people residing in slums, *JJ* clusters, and other low socio-economic settlements. A large proportion of vulnerable population in urban slums remains outside the purview of any public health coverage. The evidence also suggests that those at the bottom of the socioeconomic pyramid are most vulnerable due to lack of access to primary/essential health care (Agnihotri and Agarwal, 2007).

There is wide range of factors influencing the access to healthcare services. These include demand side and supply side factors. While the former includes cultural and educational aspects the later refers to non availability of the services. Cultural and educational factors play an important role for people to recognise the ill-health and the prospective benefits of seeking health care. Besides, financial constraints may refrain people from utilising available services, even if they are aware of the benefits of health care. On the supply side, many times appropriate health services may not be available mainly in urban slums and rural areas. Many occasions lack of availability of services is the cause for not accessing health care irrespective of the cost of care (Banerjee, et. al., 2012).

Lack of accessibility and availability of primary health care compels people to go to higher level hospitals even for the minor ailments. This is one of the prime reasons for overcrowded and overburdened secondary and tertiary care hospitals. Due to the under-functioning/non-functioning of PHCs, the referral system has become dysfunctional leading to excessive patient load in secondary and tertiary care hospitals (MoHFW, 2013). Patients come to these specialised institutions even with minor ailments like cold

and fever leading to unmanageable patient load, long waiting hours, poor service delivery, and patient dissatisfaction (Lahariya, 2016). It is clear that because of the poor functioning of primary health care system; the demand for secondary and tertiary care services is emerging rapidly. However, controlling flow of patients among the three levels (primary, secondary and tertiary) of care is one of the most significant challenges faced by Delhi's healthcare delivery system.

Delhi, in particular, also bears a steady influx of healthcare seekers from neighbouring states. Migratory population contributes to a substantial patient load stressing the already overloaded hospitals. It clearly highlights the disparity in the rural-urban distribution of specialized care centres and poor quality of health care services in the rural areas. Approximately two third of the patients in urban hospitals come from rural areas (Yeravdekar et. al., 2013). In most of the cases, migrants come in critical conditions for life-saving interventions or for sick newborn and infant care making it less available for the (poor) residents of Delhi (Mazumdar, and Mazumdar, 2015).

The present infrastructure is insufficient for handling the massive load of patients undermining the quality of care. There is always resource constraint both concerning human resource as well as finance. Shortage of health workforce is one of the cricual factors which make the healthcare delivery system weak (Bajpai, 2014). Less than four health care providers are available for every 10000 population in Delhi. About 40 per cent of the sanctioned posts of medical officers and about 20 per cent of paramedical posts are vacant (Mazumdar and Mazumdar, 2013).

Shortage is not limited to doctors alone but the other health personnel as well. It includes Auxiliary Nurse Midwife (ANM), nursing staff, lab technicians and radiographers. Municipal Corporation of Delhi (MCD) has a critically high shortage of staff in medical (40 per cent) and para-medical (45 per cent) positions. State government hospitals and dispensaries have high deficit in Lecturer/academic positions (68 per cent) and administrative (41 per cent) positions (Praja Foundation, 2017, pp. 18-19). This shows a severe scarcity of health workforce in Delhi's health system.

The density of doctors in urban areas is four times higher compared to rural areas and the nurses are three times higher in urban areas in contrast to the rural. This shortage of health workforce leads to overburdening of the existing workforce which works under tremendous stress. This pressure has a negative impact on their morale (Bajpai, 2014, p.8).

Deficiencies in the public sector and the unwillingness of the policymakers to overcome these deficiencies further leads to deterioration of the quality of services in public sector. Consequently, the inability of the PHCs to provide quality health services had led to the emergence of the private sector as a major stakeholder in providing healthcare services. The public health services are being provided through public-private partnership in the present situation. It is one of the ways of inviting private sector in delivery of health care services. Privatization in public sector is evident not only in providing health services but outsourcing the services in government hospitals like kitchen, laundry and security services. The public-private partnership has also been extended to diagnostic and curative services, making these services less accessible to a large section of people. Besides, imposition of user charges further makes the government hospitals out of the reach of the people (Bajpai, 2014).

Nishtar explains this mix of public-private in health care as 'mixed health systems syndrome' which refers to compromised quality and equity (Nishtar, 2010). This syndrome has serious implications on the healthcare users which includes recurrent and catastrophic OOPE on health. Furthermore, it imposes financial burden on the households which leads to impoverishment (Killingsworth et. al., 1999; van Doorslaer et. al., 2006 cited in Sheikh, Saligram and Hort, 2015).

One of the major health challenges in India is the high OOPE on health. The OOPE accounts for 62.6 per cent of total health expenditure. Also India is among the countries with the highest OOPE which is nearly thrice the global average of 20.5 per cent. As per the World Bank data, India is one among the top 20 countries having highest spending on private healthcare, i.e. at 4.2 per cent of GDP (World Bank, 2001). It also ranks among the countries with lowest spending on public healthcare, i.e. at 1.16 per cent of Gross Domestic Product (GDP) (MoHFW, 2016). Data suggest that India has the history of

under-spending on healthcare which leads to high OOPE. Poor government spending on health is crucial factor for high OOPE on health in India (Lahariya, 2018).

The low public spending and high OOPE on health has a serious implication on the families especially the BPL families. It was estimated that expenditure on health contributes to 2.9 per cent urban and 3.6 per cent rural poverty. It was also estimated that annually, 60 to 80 million people either fall into poverty or destitution because of health-related expenditure (Lahariya, 2018).

1.2 NCT Delhi - The Study Area

Delhi is surrounded by Haryana from the west, north and south and Uttar Pradesh (UP) from the east with the total area of 1483 Sq. Km. According to the 2011 census, Delhi's population is about 1.68 crore. More than 97 per cent of the population lives in urban areas. Delhi is among the fastest growing cities of the country and a prosperous state with second highest per capita income which is approximately three times higher than the national average. Delhi's average per capita income remained more than 2.5 lakh in the three consecutive years, i.e. 2015-16, 2016-17 and 2017-18, (GNCTD, 2017-18).

Delhi has 11 districts (State), and each one is headed by a Chief District Medical Officer (CDMOs). Delhi is also divided into 12 zones (Municipal Corporation of Delhi) which are headed by 12 Chief Administrative Medical Officers (CAMOs). The CDMOs work under the administrative control of Directorate General of Health Services (DGHS). They have the responsibility to monitor the functioning of dispensaries/health centres in their respective districts. In 2011, Delhi's more than 53 per cent of the population lived in three districts viz. South, West and North-west districts (Praja Foundation, 2017).

Table 1.1

DISTRICT-WISE POPULATION OF DELHI-Census 2011

District	Population 2001	% of Total Population of 2001	Population 2011	% of Total Population of 2011	Rank in 2011
North-West	2860869	20.65	3656539	21.78	1
South	2267023	16.37	2731929	16.27	2
West	2128908	15.37	2543243	15.15	3
North-East	1768061	12.77	2241624	13.35	5
South-West	1755041	12.67	2292958	13.66	4
East	1463583	10.57	1709346	10.18	6
North	781525	5.64	887978	5.29	7
Central	646385	4.67	582320	3.47	8
New Delhi	179112	1.29	142004	0.85	9
Total	**13850507**	**100**	**16787941**	**100**	

Source: Planning Department, Government of NCT Delhi

Table 1.2 Health Facilities in Delhi

		Year	
So. No.	**Health Facilities**	**31st March, 2016**	**31st March, 2015**
1	Hospital	83	94
2	Primary Health Centres	7	2
3	Dispensaries	1240	1507
4	Maternity Homes and Sub Centres	193	265
5	Polyclinics	48	42
6	Nursing Homes	1057	1057
7	Special Clinics	14	27

Table 1.2 shows health facilities in Delhi as on 31st March 2016. Delhi Government alone is a significant contributor in case of primary health care having 655 (53 per cent) dispensaries -185 Allopathic Dispensaries, 164 Aam Aadmi Mohalla Clinics (pilot and regular), 60 Seed Primary Urban Health Centres (PUHC), 40 Ayurvedic, 20 Unani and 103 Homeopathic Dispensaries, 24 Mobile Clinics, 59 School Health Clinics. These 655 dispensaries function under Delhi Government and are managed by around 25000

Doctors and allied health workers for delivery of health services (GNCTD, 2017-18, p. 236).

Some of the vital health indicators of Delhi are shown below (Table 1.3 and 1.4). One of the major improvements in the Delhi's health indicators is the reduction in Under-five mortality rate from 55 in 1998 to 22 in 2016. It is evident from the Table 1.5 that Delhi has better health indicators as compare to the India's average health indicators. It has the lowest crude death rate in the country i.e. 4 and second highest life expectancy, i.e. 73.8.

Table: 1.3

SELECTED VITAL RATES OF DELHI

Year	Birth Rate* (CRS)	Death* Rate (CRS)	Average no. of events per day		Infant Mortality Rate				
			Births (CRS)	Deaths (CRS)	Neonatal Mortality Rate (CRS)	Neonatal Mortality Rate (SRS)	Post-natal Mortality Rate (CRS)	Infant Mortality Rate (CRS)	Infant Mortality Rate (SRS)
2010	21.66	7.48	985	341	15	19	7	22	30
2011	20.89	6.63	969	307	15	18	7	22	28
2012	20.90	6.10	988	287	14	16	10	24	25
2013	21.07	5.52	1014	266	15	16	7	22	24
2014	20.88	6.77	1024	332	14	14	8	22	20
2015	20.50	6.82	1025	341	16	14	7	23	18
2016	20.38	7.61	1036	387	13	12	8	21	18

Source – O/o RGI, Govt of India & DES, Delhi

Table: 1.4

Under Five Mortality Rate in Delhi and India (1998-2016)

Year	Delhi	India
1998	55	95
2005	47	74
2009	37	64
2010	34	59
2011	32	55
2012	28	52
2013	26	49
2014	21	45
2015	20	43
2016	22	39

Source – O/o RGI, Govt of India.

Source: GNCTD, 2017-18, pp. 245-246

Table: 1.5 Vital Indicators: Delhi v/s India

Vital Indicators	Delhi	India
Infant Mortality Rate	18	34
Neo-Natal Mortality Rate	12	24
Under-Five Mortality Rate	22	39
Total Fertility Rate	1.6	2.3
Crude Death Rate	4 (lowest in the country)	--
Life Expectancy	73.8 (2nd highest in the country)	--

Source: GNCTD, 2017-18

Looking at the budgetary outlay on health in Delhi, it is at about 10 per cent in 2012-13 according to RBI publication (RBI, 2013) which is the highest in the country (Mazumdar

and Mazumdar, 2013). Per capita government health expenditure in Delhi state was INR 1,420 in 2012-13 while the average for the major states of India in that year was INR 737 per capita. Much of the remaining health expenditure is out of the pockets of people (Lahariya, 2017).

1.3 Challenges in Delhi's Health System

Delhi, being the capital of country, has a vast healthcare delivery system with diverse type of healthcare providers. The health services in Delhi are provided by multiple healthcare providers like the Municipal Corporation of Delhi (MCD), the New Delhi Municipal Council (NDMC), and the Delhi Cantonment Board (DCB). In addition, there are many more institutions functioning under Central Government and state government which also play an undeniable role in providing services not only to Delhi' population but to migratory population as well.

The rapid pace of urbanisation has altered the landscape of Delhi from the majority of rural to urban area. Annually, 78,000 people migrate to Delhi in desire for decent employment and to improve their socioeconomic status (Barara et. al., 2016). In the absence of proper shelter, most of the migrant population is forced to live in slums/ JJ clusters/ resettlement or unauthorised colonies in Delhi. They lack access to healthcare services along with the shortage of basic services. Data suggest that government hospitals in Delhi bear 70 per cent of the patient's load in OPD that come from neighbouring states/outside Delhi (Bhandari et. al., 2017). This makes the health services less accessible to the citizens of Delhi especially living in low socioeconomic conditions in slums/ JJ clusters/ unauthorized/ resettlement colonies. Therefore, one of the significant problems related to health care in Delhi is lack of access to primary healthcare, especially for the urban poor[i]. Another critical issue is the deficiency of adequate preventive health measures in the public health system.

Today, the biggest challenge faced by Delhi's health system is the sub-standard performance of primary health care system which leads to patient overcrowding in the secondary and tertiary hospitals. Unpredictable availability of providers, lack of services, medicines, and diagnostics and poorly functioning referral linkages are the key

challenges in Delhi's health system. A large number of patients, even with common illnesses seek treatment at the secondary and tertiary care health facilities which lead to excessive patient load, long waiting time and poor service delivery which ultimately leads to patient dissatisfaction. Many of these patients thus end up accessing either non-qualified providers or private providers, even at out-of-pocket (OOP) expenditure (Lahariya, 2016).

Delhi had a remarkable growth of private sector in healthcare over the last few decades. The private sector is growing in the form of quacks, qualified medical practitioners, nursing homes and big corporate hospitals which plays a significant role in delivering health services in the capital. The growing privatisation is not only limited to providing health care services, but a massive intrusion of the private sector had also been observed in outsourcing of services, contracting in and contracting out of health personnel, the imposition of the user fee and public-private partnership in delivering diagnostic as well as curative services. These services are only utilised by those who can afford it, making healthcare a commodity that can be purchased and a privilege for those who can afford it. In addition, the emergence of the private sector (only for curative care) completely overlooks the preventive care which has always been assumed as a responsibility of the government till date.

Also, the health systems in cities face huge challenges as they bear the double burden of diseases, i.e. infectious diseases as well as the spread of non-communicable diseases (WHO, 2016). Looking at the disease burden specifically in Delhi, the hospital-based disease surveillance system endorses that it bears 'double-burden' of diseases. Non-communicable diseases account for nearly a third of all ailments in Delhi, and half the deaths. Most of the non-communicable diseases like diabetes and blood pressure related diseases are on the rise which is majorly caused by the sedentary lifestyle. There is also a steady rise in communicable diseases mainly the respiratory diseases including T.B., asthma etc. (Mazumdar and Mazumdar, 2013). The existing health system found to be unable to deal with this double burden of diseases and meeting the increasing health needs of the population of Delhi.

Despite having multiple healthcare providers in Delhi, people still lack access to quality healthcare services. The health system needs complete revamping to overcome these challenges. In this backdrop, Delhi government opened Mohalla clinics at different locations to provide primary healthcare to the citizens of Delhi. At present, 158 Mohalla clinics[1] are operational in the National Capital, and the government has promised to set up 1,000 clinics to unburden the overloaded health infrastructure and facilities thus to improve the efficiency and performance of the overall health care delivery system in Delhi.

With this background of challenges mentioned above, the study seeks to understand the role of Mohalla clinic in delivering health care services in Delhi.

1.4 Methodology and Methods

1.4.1 Research Questions

- What is the conceptual basis for entry of Mohalla Clinic in the existing health care delivery system?
- What is the role of Mohalla Clinics in delivering health care services in Delhi?
- What are the perceptions of health care providers about Mohalla Clinics?
- What are the experiences of patients seeking care at Mohalla clinics?

1.4.2 Research Objectives

With the overall objective to understand the role of Mohalla clinics in providing and improving access to health care services the study attempts to achieve some of the specific objectives listed below.

- To study the health seeking behaviour of patients in relation to Mohalla Clinics.
- To understand different perception and experience of patients regarding accessibility, utilisation and quality of health services provided by Mohalla clinic.
- To understand the perception and experience of doctors and other paramedic staff working in Mohalla clinics.

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[1]http://www.delhi.gov.in/wps/wcm/connect/doit_health/Health/Home/Directorate+General+of+Health+Services/Aam+Aadmi+*Mohalla*+Clinics (last accessed on July 17, 2018)

1.4.3 Research Design

The current study is cross-sectional in nature. The interviews with patients and providers were conducted during a particular period and with selected number of respondent both patients and provides across different clinics in Delhi. Collection of data was done using the mixed method approach to have a broader and deeper understanding of research problems. The quantitative approach was used to get closed-ended information. Qualitative approaches attempted to understand the subjective perceptions and experiences of the respondents where they were not limited to give pre-determined responses and were allowed to frame their narratives in their own words.

The quantitative method was used to study the socioeconomic profile of the patients attending the Mohalla clinics. The data on quality of health services provided by these clinics have also been collected using the quantitative method. The qualitative approach was used to understand the conceptual basis of Mohalla clinics for its entry into the existing healthcare delivery system. Qualitative data was also collected on the role of Mohalla clinics/Polyclinics in delivering health services for urban poor in Delhi. The data was also collected on the type and quality of services provided by these clinics. Qualitative data was also collected from the doctors/paramedic staffs and key informants to understand their perception about these clinics.

1.4.4 Research Methods

Mohalla clinics were the focal point for conducting the fieldwork. Patients coming to the clinics were interviewed. Exit interviews were taken. Quantitative data was obtained using a semi-structured interview schedule to understand the socioeconomic profile of the patients attending Mohalla clinics. The data on family members' details, income, type of house and basic amenities viz. the source of drinking water and toilet facility were collected. Information on common ailments (such as diarrhoea, fever, cough and cold, dengue, malaria, chikungunea, typhoid, diabetes and illnesses related to blood pressure) for which they come to the clinic regularly had also been collected.

Qualitative data had been collected by conducting in-depth interviews of the patients/doctors/key informants. Open-ended questions were asked to get detailed information from the respondents. Thus, the respondents were not 'conditioned' to

answer from the limited choices. Respondents exiting Mohalla clinics were included for collection of data through face-to-face in-depth interviews to find out the answer to the research questions.

In-depth interviews of the patients were conducted to understand the presence and kind of health facilities in the area they are residing. The data had been collected on what is the first point of contact for them to seek treatment in case of any illness. The respondents were also interviewed about where they used to go for the treatment of minor/major ailments before coming up of Mohalla clinics and what is their priority for the treatment now (after coming up of these clinics). Questions related to the quality of services provided by these clinics were also asked. Respondents were also interviewed about the previous history of major illness and their expenditure on health in the last one year. Perceptions about Mohalla clinics and experiences of patients at these clinics were also recorded during the interviews.

In-depth interviews of health personnel (including medical and paramedical) working in the clinics were also conducted to understand the concept of Mohalla clinic and its place in the existing healthcare delivery system. The doctors of the Mohalla Clinics were also interviewed using an interview schedule to understand their experiences at these clinics and how it is different from their working experience at other hospitals/clinics. The research also intends to identify the challenges faced by them in delivering health care services and seek suggestions for improvement. A key informant interview was also conducted to understand the administrative challenges in running the clinics and seek suggestions for improvement.

The researcher also visited the nearby private practitioners/quacks/*Bengali*[2] doctors to understand their views about these clinics. An attempt has been made to seek information on impact of Mohalla clinics on their private practice and number of patients coming to them everyday before and after the launch of Mohalla clinics.

Observation has also been used as a direct method for data collection. Observation is not just seeing things but looking at them carefully and trying to understand them deeply, to

[2] Bengali doctor are the unqualified quacks providing health services at local community level

get detailed information about them. This method was pursued as a systematic process using a check-list to do it efficiently. Observation gave an opportunity to the researcher to gather information from the naturally occurring events in the Mohalla clinics.

1.4.5 Secondary Data

Secondary data from different sources like Scholarly articles, records of Mohalla clinic, Aam Aadmi Party manifesto, daily archives, Delhi Government reports, policy documents, and government websites, newspaper articles, media reports and blogs were also collected to understand the research problem intensely.

1.4.6 Geographical Area

Mohalla clinics were launched as an innovative initiative by Delhi government, so Delhi was chosen as the study area to conduct the fieldwork for collection of primary data. A total of 16 Mohalla clinics were visited by the researcher to understand the overall picture and functioning of Mohalla clinics in Delhi. These clinics include both types of clinics; rented as well as porta-cabin.

Four clinics were chosen (out of those 16 clinics) to conduct the interviews. The rationale for selecting those clinics was based on their level of functionality, i.e. fully functional, partially functional and poorly functional clinic. Functionality was determined by the number of patients, type of services and human resources (HR) available in the clinics. Two clinics were fully functional in terms of patients' inflow, HR and services available. One of the clinics had good patient inflow and sufficient human resources; another clinic had good patient inflow, sufficient human resources along with an automatic medicine dispensing machine. The third clinic which didn't have blood test facility was taken as a partially functional clinic. The fourth one was poorly functional as the number of patients was less as compared to the other clinics and the clinic lacked required staff members.

The interviews of the patients were conducted either in the waiting room of the clinics or outside the clinics or any other place comfortable for the patients.

In the other 12 Mohalla clinics the doctors and other paramedic staffs were interviewed to get an idea about the services delivered, the human resource available, and job satisfaction, major challenges faced by them in providing health services and suggestions

for improvement, patient inflow and kind of ailments they come with. During these visits, the researcher also had informal discussions with the patients and paramedic staffs to get their frank opinions about these clinics.

1.4.7 Sample Size

The respondents were selected across the age groups, caste, class and gender. The sample included women, men, children and elderly population from different sections of society. In case of children below 14 years, the parents/guardians of the children were interviewed. Exit interviews of 105 patients from four clinics were conducted. Out of these 105 respondents 20 were selected for case study.

Among the key informants, 16 doctors from 16 clinics were formally interviewed using an interview schedule. Paramedic and other assisting staffs of all the 16 clinics (one from each clinic) were also interviewed which include pharmacists, lab technicians, ANMs and helpers to understand the issues related to the Mohalla clinics and challenges faced by them while working in these clinics. Informal discussions with the staff members were also included in the study to gauge their opinion about these clinics. An official from Delhi government was also interviewed as a key informant to understand his perspective about Mohalla clinics and the administrative challenges in running these clinics.

1.4.8 Inclusion and Exclusion Criteria

Patients exiting the Mohalla clinics were included in the study. A doctor and one paramedical staff from each of the 16 Mohalla clinic visited were interviewed as a key informant. Severely ill patients and children below one year of age were excluded from the study.

1.4.9 Ethical Issues

The research study had been conducted solely for the academic purpose, and the objectives of the study were communicated to all the respondents. Informed consent was taken from the clinic incharge as well as from the respondents. The participation of respondents in the study was entirely voluntary, and the respondents were free to exit from the study at any point in time. Verbal consent was taken from the patients attending Mohalla clinics after explaining the purpose of the study. Every information sheet

(questionnaire) was assigned a unique number, and the information given by them was kept confidential. No insensitive question was asked during the interview, and if the respondent found uncomfortable in sharing any details, medical history and experience, the interview was discontinued. In case of children under 14 years of age, the parents/care providers/guardians were interviewed.

The names of the key informant, doctors and paramedical staff working in Mohalla clinics were kept anonymous, or pseudo-names were given. Information given by them was kept confidential, and no unauthorised person can have access to the collected data. Empathetic behaviour and professional attitude was maintained with the respondents throughout the research process.

All the pictures were taken with due permission of the doctors and patients for the purpose of this study.

1.4.10 Challenges of the Study

Difficulty in finding locations of the Mohalla clinics: Some of the clinics are located at the outskirts of the city, many of the clinics are situated in the middle of a community/village/slum; the researcher found it difficult to search the clinic. People call these clinics with different names like *kejriwal wale clinics (Kejriwal's clinics), clinic jahan marizon ko muft dawai milti hai (clinics where the patients get free medicines) nayi dispensary (new dispensary)* etc.

Two of the clinics and a Delhi government dispensary clearly denied permission not only to conduct the interviews but also denied access to the clinics/ dispensary and observing the proceedings in the health facilities (even after showing the permission letter for field work from the University). The doctors and other staff members said that many of the media persons come and take the information from them and print it in different context or for profit making purpose (inclination towards one political party favors the clinics than the other). They clearly said that they are not allowed to share any information about these clinics. To conduct survey/interviews, the researcher needs to get written permission from their respective Chief District Medical Officers (CDMOs).

The honest view of the healthcare providers is the key to a good and strong research but seeking their honest views was a very tricky job. Interviewing doctors was a very challenging task as many of them were reluctant to share information like number of patients seen by them per day/month, number of tests done per day/month and any delay in getting medicines and reasons for delay etc. They have a fear that this would affect their engagement and relationships with the higher authorities (if they get to know). But many of the doctors share their problems and genuine concerns regarding these clinics that would help the policy makers to deliberate upon these issues in future.

Accessing old records of patients and medicines stock book of the clinics was another tough task. The researcher found it hard to get these records. The possible reasons for not sharing the information could be because of the privacy concerns or the record book was not maintained properly or a discrepancy in the data.

All the 16 doctors gave the permission to interview themselves as well as the patients but nobody gave the permission for taking photographs except two clinics. All the other doctors denied photography in and outside the clinics.

There was always a perplexity among the patients about the identity of the researcher even after telling about the researcher and the research objectives. The researcher had to repeat the purpose of the study again and again to get the responses to the research questions.

Chapter 2 - Present Health Care Delivery System in Delhi

2.1 Health Care Delivery System in Delhi

Health care delivery system in Delhi is not as simple as in other states of India because of the existence of multiple healthcare providers. Delhi has a highly developed health infrastructure as compare to other states. Government of Delhi and the Municipal Corporation of Delhi (MCD) is the foundation of the public health service delivery system in the Delhi which provides most of the health services in public sector. Multiple private health providers and Voluntary Organizations (VOs) also play an essential role in providing healthcare services in Delhi.

Along with the major health service providers, such as Department of Health and Family Welfare, Government of National Capital Territory of Delhi (GNCTD) (Directorate of Health Services and Directorate of Family Welfare) and three local government bodies, viz. the Municipal Corporation of Delhi (MCD), the New Delhi Municipal Council (NDMC) and the Delhi Cantonment Board (DCB), there are some other health facilities and institutions which are operated by Central Government and different government departments and agencies.

Department of Health and Family Welfare, Government of Delhi, is responsible for provision of health care facilities to the residents of Delhi. Among the other responsibilities, it is also accountable for drafting health policy and macro-plan for health, implementing the National and State health policy and state and national programmes. The health service delivery system is controlled by the Department of Health and Family Welfare consists of the following agencies:

Directorate of Health Services (DHS) is the technical department under Health and Family Welfare Department which is responsible for providing primary health care services through its dispensaries/health centres and outreach health services through the means of its special schemes like mobile health scheme and school health scheme. It implements the National and State level health programs dealing with controlling both communicable and non-communicable diseases.

Directorate of Family Welfare (DFW) is responsible for Maternal and Child Health (MCH) and Family Welfare (FW) programmes and the services for which it uses the health infrastructure under DHS and Local Bodies viz. dispensaries, MCW Centers, Health centers created under the Indian Population Project (IPP) VIII Project of MCD, NGOs and private sector. DFW implements Reproductive and Child Health, Immunization, Pulse Polio programs, Pre-Natal Diagnostic Techniques (PNDT) and Medical Termination of Pregnancy (MTP) Act etc. Health and Family Welfare Training Centre is the state level training centre organizes training for all categories of health personnel of the Government of Delhi.

Directorate of Indian System of Medicine and Homeopathy (ISM&H): It is headed by the Director ISM&H (who is an IAS officer) assisted by Deputy Director ISM and Deputy Director of Homeopathy. Health care services are provided through dispensaries and hospitals. It has a Drug Control Cell for Ayurveda and Unani systems of medicine.

Municipal Corporation of Delhi (MCD): Health Department under MCD is responsible for provisioning of health care services through its dispensaries, maternity homes, MCW centres, polyclinics, Primary Health Centres/Sub-Centres, school health clinics and mobile dispensaries. The IPP – VIII was implemented to provide MCH and Family Welfare services to slum dwellers through a network of maternity homes, health centres and health posts.

New Delhi Municipal Council (NDMC) provides preventive, promotive and curative services in the NDMC areas. The primary health services are delivered through NDMC dispensaries. School Health Clinics offer comprehensive services to children in NDMC schools. The secondary level services were provided by the Charak Palika Hospital and Palika Maternity hospital. National Programmes were implemented in coordination with Government of India and Government of Delhi. The registration of births and deaths is also done by NDMC in the NDMC area.

Delhi Cantonment Board (DCB) provides services through health centre and hospital in Delhi Cantonment area. School health clinics provided services to children in DCB schools. National Health Programmes implemented with the support of Government of

Delhi. The births and deaths registration is done by Delhi Cantonment Board in their jurisdiction.

Central Government Health Scheme (CGHS) in Delhi provides services to the Central Government employees and families, Members of Parliament, Governor, and Commissioners of Central Government. CGHS delivers services through dispensaries under the different systems of medicine and hospitals.

Directorate General Health Services (DGHS) (Railways) provides health services to their employees and their families through hospitals, dispensaries/health centres. In Delhi, Northern Railway Zone provides medical services through dispensaries and a hospital.

Employees State Insurance Scheme (ESIC) financed by contributions made by employers and employees covered under the scheme who also contribute fixed proportion of wages. Services are provided through ESI hospital and dispensaries. In case of specified contingencies resulting in loss of wages or earning capacity, the employees are entitled to cash benefits. Women employees are entitled to maternity benefits. If the death of an insured employee occurs due to employment injury, the dependants are entitled to family pension.

Statutory Autonomous Bodies/ Institutions provide health care services to the people of Delhi through dispensaries and hospitals. Voluntary Organizations and Private Nursing Homes/Hospitals also deliver health care services in Delhi. Private hospitals and Nursing Homes are registered by the Directorate of Health Services, Government of Delhi under the provisions of "Delhi Nursing Homes Registration Act 1953" and rules framed there-under. Health services are provided through dispensaries, health centres, polyclinics, maternity centres, district hospitals and teaching/tertiary care hospitals. Special health schemes like the school health scheme and mobile health scheme provide outreach services. Besides DHS, it implements several state and national health programmes through its special programme officers.

The Principal Secretary heads the Department of Health and Family Welfare. He also controls the Directorate of Health Services which is the technical wing of the Health and Family Welfare Department. This wing is expected to play a significant role in planning,

provisioning and regulating health services in Delhi and all the government hospitals under Government of NCT of Delhi, Autonomous Bodies like Delhi AIDS Society, Drug Controller and other National Programmes, IHBAS, Directorate of Food Adulteration and CATS. The Department of Health and Family Welfare liaison with other local bodies; MCD, NDMC, DCB and other government and non-government health care organizations to provide health services to the people of Delhi.

In addition, the Principal Secretary coordinates the activities for the Government of NCT of Delhi with the MoHFW, Government of India. The Principal Secretary also manages the Directorate of Health Services in the issues like the construction of new hospitals and dispensaries, execution of several National and State programmes related to medical and public health and for prevention, control and eradication of major diseases.

Within the above mentioned administrative system, the health facilities in Delhi are organised hierarchically and follow a referral system where the Primary Health Care is a vital component and forms the basis of the health system. Referrals are made from the Primary Health Centres (PHCs) to the Secondary and Tertiary level hospitals for specialised care. Despite the presence of a well-defined organisational structure, Delhi's health system is facing major challenges.

2.2 State of Delhi's Health Care System

Being capital of the country, Delhi has a better healthcare delivery system than the other states. In Delhi, public health aspect is managed by multiple agencies viz. the state government, the Delhi Development Authority and the three Urban Local Bodies (MCD, NDMC and DCB). Because of the presence of multiple providers, there is always an ambiguity in their roles and responsibilities which leaves loophole in program implementation.

One of the major challenges is Delhi has to cater to the need of the floating and migratory population. There is a steady influx of healthcare seekers from the neighbouring states also. A major chunk of patients come from the national capital region (NCR) and nearby states overburdening the health facilities and making it less available to the permanent

citizens of Delhi. Moreover, this migratory population from the states like Uttar Pradesh, and Haryana increases the burden of communicable diseases in Delhi.

Data show that Delhi has a mixed bag of achievements and shortcomings. Although, having the lowest death rates and one of the best life expectancy levels in the country, Infant Mortality Rate (IMR) continues to be high at 24 deaths per 1000 live births as of 2013, according to the latest available estimates from the Sample Registration System. Delhi is found to have the highest IMR i.e. 29/1000 live births, across all four metro-cities of India (Mazumdar and Mazumdar, 2015, p. 28). Healthcare seekers from neighbouring states add to the poor health indicators like deaths of 'out-born' infants who come in critical conditions to seek life-saving intervention. In case of death of the newborn, the deaths get registered on Delhi's account and inflate the mortality indicators.

As health is a state matter, the state government has the responsibility to plan and implement the service delivery system. So it is the responsibility of the government of Delhi to cater to the health needs of the less privileged. The health should be made available to them either free of cost or at an affordable cost. But the data show that private facilities are utilised more by the lower income households; in contrast to the high and middle-income households who utilise the government facilities more.

A study shows that only 17 per cent of low-income households used government hospitals as against 26 per cent of high-income and 22 per cent of middle-income households. Also, it is the lower-income households who mainly use private clinics, i.e. 80 per cent and remaining 20 per cent are utilised by middle and high-income households. These outcomes are contradicting the government's visualization that the subsidised and government hospital services are being utilised more by patients who can afford to pay in contrast to the private sector which is largely being used by those who either less able or not able to afford the private services. This shows that the utilization is lowest among the poor who need it the most. It has also been noticed that the lower income households have least insurance coverage and they mainly seek institutional as well as allopathic care rather than indigenous practitioner. Market mechanisms play an important role in expenditure on health which put an unnecessary burden on the section

of people with lesser ability to pay. The determinants of health-seeking behaviour which control sickness point outs that the lower income households with less education are more prone to seek care in Delhi. This confirms the fact that Delhi has an inequitable system in terms of health seeking patterns (Gupta and Dasgupta, 2013).

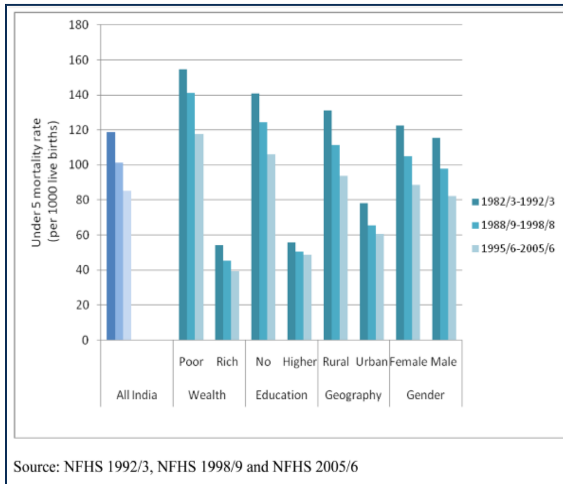
This inequitable distribution of health care among the different sections of the society is the biggest challenge to make the health care services inclusive and accessible to all. Meaning, those who have greatest health care needs are least likely to have their health needs met and face challenges the most in accessing health services (Banerjee et. al., 2012).

Health inequalities results from a set of social, economic and political factors that influence the distribution and level of health within a society. It is important to address these structural factors as they also constitute social determinants of health. Also, some health inequalities may result from unjust distribution of primary social goods, power and resources represent health inequities.

Social determinants of health play a critical role in determining the health status of the people. Socioeconomic status is among the important determinants which affects the access and utilisation of healthcare services, therefore the health status. Poor living conditions and lack or no access to basic amenities among the people residing in slums, *JJ* clusters, unauthorised colonies and other low-income resettlement colonies are the key risk factors responsible for their poor health.

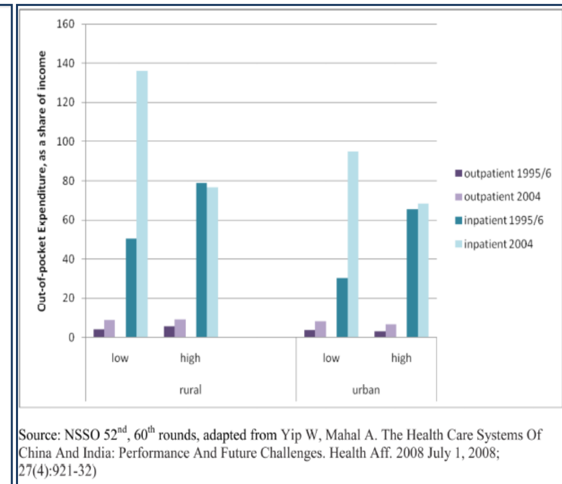
The figures given below clearly highlight the inequalities in Under-5 mortality and OOPE in the low and high income-groups.

Figure: 2.1 Inequalities in Under-5 Mortality



Source: NFHS 1992/3, NFHS 1998/9 and NFHS 2005/6

Figure: 2.2 Trends in OOPE on Health in Household, per Episode, as a Share of Income by Income Group and Residence



Source: NSSO 52nd, 60th rounds, adapted from Yip W, Mahal A. The Health Care Systems Of China And India: Performance And Future Challenges. Health Aff. 2008 July 1, 2008; 27(4):921-32)

From figure 2.1, it is apparent that the difference in the Under-5 mortality between rich and poor is very high. Figure 2.2 also shows that the low-income group bears a disproportionately higher burden of treatment cost than the high income group. One of the reasons could be that people belonging to the high-income group are less likely to fall sick than people belonging to the low-income group. The other reason could be that the people from middle and high-income group utilise the government health facilities whenever they fall sick.

A study by Gupta also shows that low-income households spent 2.3 percent of total health expenditure in contrast to middle and higher income households which spent slightly less than 0.5 percent. It is not difficult to determine the reasons for the increased expenditure. The lower-income households have a higher rate of morbidity and most of them are not covered under any insurance scheme (Gupta, 2000 cited in Gupta and Dasgupta, 2013).

Notwithstanding, the progress been made to improve access to health care for poor population inequalities continue to persist based on socioeconomic status, geography and gender. Some of the major hurdles to ensure equity in service delivery, financing and financial risk protection in India are discussed below (Balarajan et. al., 2011).

- Imbalanced resource allocation

- Limited physical access to quality health services
- Inadequate human resources for health
- High out-of-pocket health expenditures
- Health spending inflation
- Behavioral factors that affect the demand for appropriate health care.

2.3 Challenges in Delhi's Health System

2.3.1 Double Burden of Diseases- Delhi faces double-burden of diseases; not only communicable but there are high burden of non-communicable diseases which is evident from the hospital-based disease surveillance system. As some infectious diseases are declining, there is a steady rise in lifestyle diseases like diabetes and heart diseases. Non-communicable diseases account for nearly a third of all ailments in Delhi, and half the deaths (Mazumdar and Mazumdar, 2015, p.28). The rising non-communicable diseases along with communicable are putting additional stress on Delhi's health system.

2.3.2 Shortage of Human Resource- Delhi has a serious crunch of health personnel as also recognised by Aam Aadmi Party (AAP) Minister Rajendra Pal Gautam[3]. It has been found that less than four health care providers are available for a 10,000 population in the state. About 40 per cent of the approved positions of medical officers and about 20 per cent of paramedical posts remain vacant (Mazumdar and Mazumdar, 2015, p.28). Other than overcrowding and fight between the doctors and patients and among the patients, the quality of services is another important issue arises due to lack of sufficient staff. The public facilities have been rated as 'highly unsatisfactory' that includes the interpersonal dimensions of 'behaviour of the provider' and 'proper examination' (Mazumdar and Mazumdar, 2015, p. 28). This lack of adequate health workforce makes the existing services overloaded and staff overburdened.

2.3.3 Lesser Focus on Primary Healthcare- Delhi has a well-developed and mature secondary and tertiary care which attracts medical tourists from across the world. On the other hand, it lacks primary healthcare leading to excessive patient load in the higher

[3] https://www.thequint.com/hotwire-text/all-departments-in-the-delhi-government-have-staff-shortage-says-minister (last accessed on May 23, 2018)

level hospitals even for minor ailments. In the current scenario, there is a complete neglect of public health aspects of housing, water, sanitation and nutrition. The focus is only on the big super specialty hospitals which have become monuments of diseases providing world class services (Bajpai 2014, p.16). The highly medicalised approach of the current vertical programs may help in reducing the burden of disease, but they lack public health approach.

2.3.4 Heterogeneity in Health Needs across Vertices- Because of highly diverse, floating and migratory population, the healthcare needs of the population of Delhi are quite diverse. Different sections of the society have different health needs. For example, people with lower socioeconomic background mostly living in a slum or *JJ* cluster require preventive health services from communicable diseases like Tuberculosis and malaria etc. But people who belong to higher socioeconomic strata have different health needs; they need health services for the treatment of lifestyle diseases like diabetes or hypertension etc. The formula of one size fits all will not all. Distinguishing between health needs of the population is one of the biggest challenges for the policy-makers.

2.3.5 Quality of Doctors- There is always a disproportionate distribution of medical colleges and the existence of temporary medical colleges lacking basic infrastructure which results in poorly trained medical professionals. Secondly, Delhi Medical Council and Medical Council of India have a conflict of interest in aptly addressing complaints against doctors, mostly because these boards comprise of doctors themselves (Phadke, 2016). Kumar (2006) pointed out on the increasing quackery issue and estimated that there are around 30,000 unqualified practitioners in Delhi. The quality of doctors is also impacted by regulation of private clinics and hospitals (GNCTD, 2016, p. 135).

2.3.6 Frequent Change in Healthcare Policy- Constant change in the healthcare system with the change of government is another major challenge to run the health system efficiently. Sustenance of any particular idea or scheme is essential for its long-term success and must be independent of any political will (Hazarika et. al., 2016, p. 135).

2.3.7 Transparency in Healthcare- One of the major areas which lack transparency is in the procurement and delivery of medical equipment. Lack of rational and timely planning is the major hurdle to reach out to the economically weaker sections of the society.

2.3.8 High Out of Pocket Expenditure - India is one of the top 20 countries of the world with highest private spending. It also ranks among the countries with lowest public spending on healthcare (MoHFW, 2016). In the absence of any health insurance and alternative source of payment, people have to pay from their pockets for the utilisation of the healthcare services (Hazarika et. al., 2016).

Health Services both preventive and curative services are important determinants of health outcome of an individual. The Delhi government has added another layer in addition to the existing three-tier health system to provide primary health services at the community level and to improve access to quality healthcare. By opening these clinics in the neighbourhood of the people, Delhi government is making the health services available at the doorstep of the patients. These clinics have the potential to take care of 80-90 per cent of the health needs of the people at community level itself thereby facilitating in decongesting the secondary and tertiary hospitals.

As on 31st March 2016, there were 83 Hospitals, 7 Primary Health Centers, 1240 Dispensaries, 193 Maternity Homes and Sub Centers, 48 Polyclinics, 1057 Nursing Homes and 14 Special Clinics exist in Delhi. Delhi Government alone is a significant contributor in case of primary health care having 655 (53 per cent) dispensaries as on date -185 Allopathic Dispensaries, 164 Aam Aadmi Mohalla Clinics (pilot and regular), 60 Seed Primary Urban health Centres (PUHC), 40 Ayurvedic, 20 Unani and 103 Homeopathic Dispensaries, 24 Mobile Clinics, 59 School Health Clinics. These 655 dispensaries under Delhi Government are managed by around 25000 Doctors and allied health workers for delivery of health services (GNCTD, 2017-18). Although Delhi seems to have sufficient health care facilities but these services do not extend to the most of the urban poor who have restricted access to primary health care services (Agarwal et. al., 2007, p. xi).

A variety of agencies deliver health care services in Delhi which leads to uneven distribution of health services. This often causes overlap and duplication of services. This has an implication especially for the poor who often don't have access to any of those. On the other hand, some sections have access to all kind of services for example people belonging to middle class working in government sector can access almost all type of services. In this situation, coordination at the state level becomes difficult which poses serious challenges for policy making and program designing (Sood, 2017).

The lack of coordination among the different agencies leads to huge development of private sector in Delhi. The profit-driven private practice becomes dominant in the last few decades. Private practice varies from one doctor clinic, quacks to *Bengali* doctor, and nursing homes to small hospitals and goes up to big corporate hospitals. At the one end, private hospitals deliver world class facilities at competitive price to the patients coming from abroad which are out of the capacity of most Indians. On the other end of the spectrum, there is unregulated private sector which offers affordable but varying quality of services; most often by unqualified providers (Yeravdekar et. al., 2013).

No doubt, a large fragment of the population is still under poverty which cannot pay for the services provided by the private sector. Urban India spends a lot of "Money for Nothing" in the private sector. People spend a lot on unnecessary drugs (Das and Jeffrey, 2006). The repercussions of growth of private sector in Delhi have been reflected in the falling standards of health care in government-run hospitals which is the only place where the poor can seek health care at no or minimum cost[4]. Also, there is hardly a "referral system" that operates in the public health system in India leading to excessive patient load in government hospitals. The poor functioning or absence of the peripheral health services in major parts of the country leaves no choice for the people but to overload the already overstretched facilities of bigger hospitals in towns and cities, bringing about a marked deterioration in their functioning or to shift towards the unqualified providers/quacks.

[4] http://ijme.in/articles/public-hospital-and-private-practice/?galley=html (last accessed on September 25, 2017)

Other than the health institutions mentioned above, Delhi is flooded with a large number of quacks. Overcrowded and under-resourced public hospitals and expensive private hospitals that charge excessive fee, force the poverty-stricken families to turn to quacks[5] who generally suppress the symptoms rather than treating the actual cause by prescribing steroids.

The DMC which is a statutory body that governs the practice of modern medicine in the state has a rough figure of 50,000 quacks in Delhi. There are over 700 quacks in one assembly constituency which comes out to be one quack for every 400 Delhi residents. As per the president of the DMC, Dr. Arun Gupta, the data is grossly overestimated and impossible[6].

Even after the existence of multiple healthcare providers, poor in Delhi lack access to health care. There are different types of barriers which prevent the people to access health care. Millman defined three major types of barriers to access health care viz. structural, financial and personal and cultural barriers. Structural barriers are the obstacles to access medical care which is directly associated with the location, number, type, concentration or organisational arrangement of health care providers. Financial barriers may limit access to health care either by restraining patients' ability to pay for required medical services or by discouraging doctors and other healthcare providers to treat patients with limited resources. Another important barrier is the personal and cultural barriers which hinder people from seeking medical attention or continuing the treatment after receiving care or from following the recommended post-treatment guidelines. But it is important to mention here that the mere absence or presence of a barrier does not ensure whether services can be obtained or not (Millman, 1993).

Delhi government (Aam Aadmi Party) by launching Mohalla clinics aims to remove some of these barriers by making the primary health care available free of cost at the community level with a potential to modify the health seeking behaviour of the people.

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[5] https://www.livemint.com/Science/BFelCnQ2fp120Kf5dhBQZP/Why-do-quacks-function-freely-in-India.html (last accessed on February 9, 2018)

[6] https://www.hindustantimes.com/delhi-news/delhi-medical-council-to-conduct-survey-in-delhi-to-estimate-the-number-of-quacks/story-vJMVj4MdxEMFjzErzjmcTM.html (last accessed on February 19, 2018

2.4 Origin and Inception of Mohalla Clinics

2.4.1 Origin of Mohalla Clinics

The Mohalla clinic scheme was launched by government of Delhi in the year 2014 under the Chief Minister Mr. Arvind Kejriwal with an aim of reaching out to the most vulnerable, underserved and excluded segments living in slums, *JJ* clusters, and low socio-economic and resettlement colonies to ensure access to health services in Delhi.

The concept of Mohalla clinics has its origin from Mobile Medical Units (MMUs) or Mobile Vans. These Mobile Vans provide health services in the most underserved colonies, slums and *JJ* clusters. These units aim to make the health services available at the community level, i.e. bringing the doctor and medicines as close to the community as possible. The response of these Mobile Vans was overwhelming which raised a high demand for such services in these communities. The present government realised the need for expansion of the Mobile Vans. But it was also recognised that delivery of health services by MMUs is not only unpredictable and affected by external factors such as availability of vehicles, drivers, doctors, and road conditions but may not be sustainable in future, as well. Also, the administrative and procedural complexities in purchasing a large number of vehicles and recruitment of contractual staff including doctors were considered limiting factors.

The Health Minister of Delhi realised that instead of having an ad hoc solution of MMUs, a sustainable solution is required. The discussion of the Health Minister with other officials and experts gave rise to a new concept (with few modifications in the earlier one) where there is a component of assurance of availability of providers, medicines and service package, with sufficient community linkage and engagement. After a few deliberations, the concept shaped as Mohalla clinics which got immediate support from top political leadership in the state (Lahariya, 2017).

The first clinic was inaugurated on July 19th, 2015. This clinic has been set up at a low cost of around Rs.15-20 lakh[7] i.e. the clinic was built at 1/25th the cost required to

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[7]http://www.business-standard.com/article/current-affairs/can-community-clinics-boost-health-care-116042300708_1.html (last accessed on September 11, 2017)

establish a dispensary as per Delhi's Health Minister. These clinics provide primary level medical consultation where a doctor screens patients and prescribes medicines and refers to polyclinics for further consultation and screening.

2.4.2. Components of a Mohalla Clinic

Mohalla Clinics are established either in porta cabins or rented premises. These clinics generally have two or three rooms depending upon the location of the clinic. Each has four staff members - a doctor and a lab technician who collects blood samples for tests and a pharmacist to give medicines. A helper, who acts as a compounder making the list of patients, distributes the token and manages the patient load at the clinic. Some of the clinics also have Auxiliary Nurse Midwife (ANM) looks after Antenatal Care (ANC) which is an indispensable component of primary health care. The clinics offer 109 free essential drugs, 212 basic tests and counselling. The blood samples collected at the clinics are sent to a private laboratory which usually delivers the reports next day. The clinic runs for four hours from 9 Am. to 1 Pm. six days a week.

The doctors appointed for these clinics are empanelled private doctors who work as consultants, and they are paid on the basis of number of patients seen by them in a day. They are reimbursed at the rate of Rs. 30 per patient.

Mohalla clinics are equipped with smart-tablets a special software to collate patients' information like personal details, symptoms, diagnosis, no. of visits, medicines prescribed, tests done, and treatment is given. A photograph of the patient is also taken in the first visit (In the next visit, the doctor asks for any of these details for reference and gets the profile of the patient). The smart tab is connected through a *Wi-Fi* system to a handheld printing machine. There is an automatic prescription generation system after the diagnosis is made by the doctor. The helper takes out the printout of the prescription and gives the medicines (sometimes the prescription slip also) to the patients.

The registration process has become entirely digital using the smart-tab which has also made the consultation process paperless and environment-friendly. The creation of digital records has reduced the need for additional human resources for record keeping. The technology has made the record maintenance hassle-free which earlier was a very tedious

task. This technology has also helped in maintaining transparency and accountability. Also, the tab also keeps record of medicines and update automatically based on the utilisation of medicines. The self-depletion of medicine stalk saves lot of time of the pharmacist which can be utilised for some other purposes[8].

Some of the clinics have also introduced automatic medicine dispenser on a pilot basis to reduce the need of a pharmacist. The machine has been funded and installed in collaboration with US Agency for International Development (USAID). The machine runs on sensor technology making the clinics to work more efficiently and ensure transparency. It can hold up to 60-70 types of medicines, including syrups. The patient is getting medicines prescribed by the doctor through the machine which means it's coming from the correct source. The medicines are stocked in this machine according to the weather conditions and looking at the type of medication that is frequently used. Other medicines are also available that are given manually from the pharmacy depending on the quantity required.

Certainly, this machine has reduced some of the burden on the existing staff members working in the clinics but the thought that it will replace a qualified pharmacist is not possible. One of the reasons is that the machine has a limitation as it can carry only 60-70 types of medicine but the list is huge. The machine is also unable to meet the requirements of different patients for example if a patient needs only five tablets, the medicine has to be given manually as the machine holds only a set of 10 medicines. This means that a helper is always required to deal with all these problems.

2.4.3 Aim of Mohalla Clinics

The Mohalla Clinics in Delhi aims to provide good quality affordable healthcare at the doorstep of the patients. As per Delhi's Health Minister, Mr. Satyendar Jain, about 95 per cent of the cases can be handled at the Mohalla clinics itself. These clinics can improve access to primary health care and make it freely available at the doorstep of the patients and reduce. This in turn will help in reducing the burden on secondary and tertiary care hospitals.

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[8] http://aamaadmiparty.org/aap-government-healthcare-facilities-guide/ (last accessed on July 17, 2018)

These clinics have been opened with an aim to provide easy geographical accessibility to essential health services. The clinics provide free consultation, free medicines and free diagnostics at one place. Making these services freely available and easily accessible encourages people to seek treatment at an early stage of illness. This would ultimately result in reducing cost of the treatment on serious diseases.

The opening of these clinics had reduced the waiting time for each patient in seeking care. Because of less patient load in the clinics as compare to the secondary and tertiary hospitals, the waiting time is also less. These clinics are more beneficial for the daily wage labourers as they don't have to lose their wages for missing hours due to long waiting and transportation time. As these clinics have brought health services at the doorstep, women are highly benefited because of their presence in their vicinity. Earlier, they used to avoid going to hospitals (which are generally far away from their home) until their illness becomes serious but now they come to the clinic even with minor symptoms.

In India, 80-90 per cent of illnesses can be treated at the primary level, but due to defunct PHCs, patients rush to the higher hospitals. It has been noted in the interviews that patients avoid going to nearby dispensary for seeking care. The reasons given by them were either the dispensary is too far from their home or there is a huge patient load in the dispensary. In case of minor ailments like cough and fever, they either go to the medical stores without consulting a doctor or get unscientific advice from quacks or go to the higher level hospitals. The first two has a repercussion for the health of the patients and the third one has serious implications for the health system. The unscientific advice leads to incomplete treatment which ultimately causes progression of disease. Visiting government hospitals for trivial issues like cold and flu overload the hospitals and make their services less available for those in need. It becomes more troublesome for the patients who come with serious illnesses. Mohalla clinics are expected to spare doctors at higher level hospitals to focus on complex diseases and surgeries by treating minor ailments outside the big hospitals. One of the objectives of these clinics is to decongest these secondary and tertiary level hospitals and save the scarce specialised services and human resources available at the higher level government hospitals.

2.4.4 Situating Mohalla Clinics in the Present Healthcare Delivery System

To ensure geographical access to quality healthcare services, the government has created a whole new health care delivery model where the Mohalla clinics are at the community level. The Mohalla clinics by adding another layer to the Delhi's healthcare delivery system become the first contact point for the patients for primary health problems. Above Mohalla clinic, there are polyclinics for specialised services with departments for general medicine, paediatrics, dermatology, surgery, orthopaedics, ENT, ophthalmology, OBS and Gynecology, pharmacy. Currently, there are 24 polyclinics and number of patients in these clinics varies from 200-1000 per day. The government has planned to open 1000 Mohalla clinics and 150 such polyclinics. Above polyclinics, there are multi-specialty hospital (also called as secondary level hospitals) and super-specialty hospitals (tertiary level hospitals).

Delhi's health system has hundreds of Primary Health Centers (PHCs/dispensaries) run by multiple agencies like Central government health scheme (CGHS), Employees' State Insurance Corporation (ESIC), MCD, charitable trusts and NDMC. Mohalla clinics are further added to improve access to primary health care services mainly for the urban poor. Now, these clinics serve as the first contact point for the people, offer timely consultation, and lessen patients' load at secondary and tertiary health facilities. It is important to mention here that these clinics neither fit under the category of Sub-centres nor Primary Health Centres.

Healthcare in India wipes out savings and push families into debt even for one episode of illness, particularly low-income groups. In the absence of a national health insurance system for citizens, most of them are thrown at the mercy of private healthcare provider. Mohalla clinics offer a package of primary health services which include free medicines, diagnostics, and consultation at the community level. India is one of the countries with highest OOPE on health and low health insurance coverage, so the provision of free and assured package of health services offered by these clinics is a positive step. This would reduce the financial burden on households by minimising care seeking and opportunity cost (travel costs and lost wages). By providing decentralised access to primary health

care, these clinics have the potential to expand coverage, especially to the urban poor who earlier were not covered under any of the schemes.

In a recent survey a young policy researcher Anurag Kundu from Aam Aadmi Party said that they had recorded and tabulated statistics which show that 31 lakh patients have already availed the services at one or the other 158 Mohalla clinics across the national capital[9]. Mohalla clinics have been opened in addition to the existing health facilities. These community clinics run by the Delhi government could be termed populist, but they are capable of meeting the health needs of the people, making basic healthcare accessible and decongesting higher level health facilities (Lahariya, 2016, p. 15). As the project is still in its embryonic stage, its impact and success is yet to be discovered.

[9] https://yourstory.com/2017/06/delhi-Mohalla-clinics/ (last accessed on September 28, 2017)

Chapter 3 - Review of Literature

India is rapidly urbanising, and urbanisation has been the defining characteristic of Indian demography from the last few years. After China, India has the largest urban population in the world (Gupta et. al., 2009). The rapid pace of urbanisation offers new livelihood opportunities which increase the income of the urban population. The new livelihood opportunities attract people from rural to urban areas. Therefore, the rise of urban population is mainly due to the migration of rural population to the urban areas. This migrant population is the most deprived and marginalised rural population come to urban areas in search of a livelihood (Basta, 1977; Bradley et al., 1992, cited in Kumar and Mohanty, 2011).

Rapid urbanisation and formation of cities also pose serious challenges for the urban population because these cities are badly-equipped to deal with the rapid changes brought by it. The very first observable impact of urbanisation is the formation of slums and shanty towns resulting from cities not being able to accommodate migratory population in the inhabitable areas adequately served by basic amenities (WHO and UN-HABITAT, 2010).

Looking at the data, India's average growth rate is two per cent whereas urban India grew at three per cent, and megacities grew at four per cent and slum populations increased by five percents. The phenomenon which describes this character of Indian demography is called "2-3-4-5 syndrome". It is clear that the slum population is growing at a remarkably high rate (Agnihotri, et. al., 2007).

There are some other reasons which contributed to rapid growth of slum population other than migration; one, the natural rise in urban poor population having a higher fertility rate than middle and upper class in urban areas. Second, expansion of boundaries of city to include peripheral rural areas, some of which get transformed into slums as former rural land is colonised for housing purposes. (Agarwal and Sangar, 2005)

Some of the other negative consequences of such rapid and unplanned urbanisation are high population density, pollution, health problems, unemployment etc. Due to the unavailability or non-affordability of proper housing, a majority of the migrated population, not only poor but also non-poor, is forced to live in congested and slum areas, in most inhuman condition where they are denied right to live a dignified life.

The rise in slum population poses huge challenges for the government. This increase in population leads to poverty and greater inequalities in income in the urban areas and exerts tremendous pressure on the public delivery of services and public infrastructure systems like water supply, sewage and drainage system, solid waste management, affordable housing, health and education etc. It has been observed that urban populations demonstrate more differences compared to rural communities in terms of poverty, nutritional status, morbidity and mortality (Basta, 1977; Bradley et al., 1992, cited in Kumar and Mohanty, 2011).

Ministry of Urban Development, after recognising the basic and infrastructural need, launched the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) in 2005 with an emphasis on sewerage, solid waste management, drainage, water supply and urban transport. The Housing and Urban Poverty Alleviation Ministry also launched the basic services and the integrated housing and slum development programme for the urban poor which emphasised majorly on housing. However, there remained an unstated need for closing the gaps by bringing in health outcomes and services in this discourse (Gupta and Mondal, 2015 pp. 192-193).

3.1 Current Scenario in Delhi

Talking specifically about the city of Delhi which is highly urban; 75 per cent of its total area falls under the urban jurisdiction i.e. approximately 1483 sq km. The density of population in the urban area is as high as 14698 persons per sq km as per 2011 Census. 98 per cent of population of Delhi (total population of Delhi is 16.79 million), i.e. 16.37 million people live in the urban area (GNCTD, 2016-17). On the one hand where the city is growing at a fast rate, slums are also rising rapidly.

People living in slums and unauthorised colonies are the most vulnerable population, and this population is increasing day by day. This increase in population in slums has a serious repercussion on the health of the urban poor. Ramana and Lule highlighted that the urban poor face more health risks than the average urban inhabitants in urban areas (Ramana and Lule, NA). It is clear that the urban poor face more health problems than the other urban residents who belong to the better-off sections of the society. Social and economic inequality in the urban areas makes good health a privilege for some sections of the society rather than all sections.

It is also found that in the urban areas the average health indicators are always found to be better than in the rural areas. But these indicators represent the averages which mask the inequities. The study of the dichotomies in urban and rural areas has mainly resulted in ignoring the needs of the urban poor. The better-off urban averages have masked the ailing situation of the urban poor (Agnihotri et. al., 2007, viii). Health indicators of the average urban population show good health status, but these indicators did not and will not articulate the health status for the urban poor. "Given the huge size, diverse, and stratified nature of Indian society, the health outcomes can be described as mirroring the multiple axes of socio-economic inequalities, such as rural-urban; inter and intra state; caste; income; and gender" (Baru and Bisht, 2010, p.2).

Socio-economic inequalities arise due to social stratification (based on caste, class and gender) in the society which makes access to health services challenging for some people more than the others. In cities, urban poor are more vulnerable to illness because of their low socioeconomic status, unhygienic living conditions and lack of awareness about the preventive care. A government report also highlighted that urban poor are vulnerable to health hazards as a result of degraded living conditions, lack of access to health care, temporary or irregular employment, extensive illiteracy and lack of bargaining power to demand better services. The report also mentions that although the health services in Delhi is better than other Indian states, *JJ* clusters, unauthorised colonies, pavement dwellers and resettlement colonies have abysmal access to health services (Agarwal et. al., 2007). It has also been observed that Primary healthcare facilities are still largely absent in urban slums. It is apparent that most of the health problems in slums arise from

the lack of access to basic civic amenities and public services which have a direct as well as indirect effect on the health of the urban poor. The poor health of the urban poor is an outcome of health inequities because of unjust economic arrangement and political structure of the society.

Another reason which makes the urban poor more vulnerable is that most of the slum dwellers are highly dependent on the daily wages. The irregular and untimely payment of the wages leaves them with no savings for expenditure/catastrophic expenditure on health and pushes them in debt like situation. A survey report also highlighted that low-income households living in slums and/or resettlement colonies are also susceptible to the economic shocks associated with serious disease. Given their high dependence on labour income, and low levels of savings, there is a real risk of indebtedness in times of ill-health (Sundar and Sharma, 2002, p. 4731). This indebtedness aggravates the economic inequalities and creates problems of exclusion for the slum dwellers. This social exclusion for urban poor increases their vulnerability to ill-health and lack of access to health care makes the already poor health of the urban poor even more miserable.

Although the health needs of the urban poor are high, they either don't have or lack access to health care. The two important reasons responsible for this poor access are "poor outreach services and weak referral system of the urban public health system", says Indrajit Hazarika who is a senior lecturer at the Indian Institute of Public Health. Because of their low socio-economic background, they cannot afford the services at private hospitals. "Social exclusion along with lack of information and assistance restrict the use of private facilities by poor people. More importantly, lack of economic resources inhibits the use of private facilities. These factors make the urban poor more vulnerable and worse off than their rural counterparts." (Shetty, p. 627)

Sangar (2005) pointed out that the access to health services of the urban poor is comparable to the restricted access of rural populations. Facts show that in rural areas, the shortages are more apparent making the health care policies and subsidies to focus more on the rural areas neglecting of urban public health care systems (Butsch et. al., 2012). It was also found that sometimes the health conditions of urban poor are poorer than the rural poor (Ramana and Lule, NA).

As India has always been seen mainly as a rural society, the focus of government to provide primary health care was almost entirely rural oriented. The government is highly biased towards offering services in the rural areas only. Most of the programmes have been rural-based only, and one of the most significant was National Rural Health Mission (NRHM) in 2005 which was launched to improve the infrastructural shortcomings in the rural areas of the country. This programme had diverted the scarce resources of the public sector to rural areas at the cost of deteriorating services in the cities. This predisposition which also focused on providing primary healthcare to the rural poor was also not corrected by the voluntary community health movement (Madhiwalla, N., 2007).

Based on the available literature, it is apparent that the urban health has never been the prime centre of public health policies in most developing countries. The focus of most of the health policies and programs is on the rural health as the majority of the population lives in rural areas. It was often considered that the vast number of health facilities and health personnel in urban areas, particularly in the private sector, would automatically cater to the rising population in urban areas and its health needs.

Government health facilities are the major healthcare providers to the vast sections of society especially the underserved population in a country like India. Talking specifically about Delhi, it has a large number of government health facilities but these facilities face huge challenges in delivering health services to all. Delhi has more than 40 government-run hospitals and more than 1200 dispensaries but there is a huge infrastructural and staff deficiency in these health facilities.

Data on human resources in Delhi's dispensaries/hospitals show that there is a serious staff crunch in government health facilities which adds to the suffering of patients who rely on public healthcare systems.

It is evident from the figure 3.1 that MCD face extremely high shortage of medical staff, i.e. 40 per cent and paramedical staff, i.e. 45 per cent. Figure 3.2 shows that the State government dispensaries/hospitals have serious deficiency in lecturer/academic positions, i.e. 68 per cent and administrative positions, i.e. 41 per cent (Praja Foundation, 2017).

Due to this shortage of staff the existing staff feels overloaded which leads to lack of patient care in government dispensaries/hospitals.

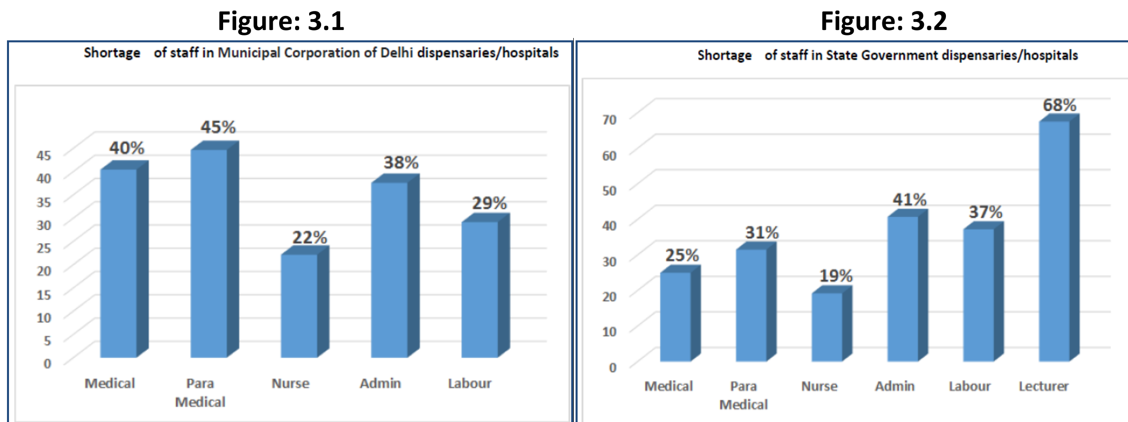

Figure: 3.1

Source: Praja Foundation, 2017, p.18

Figure: 3.2

Source: Praja Foundation, 2017, p.19

Taking benefit of the insufficiency in the government health system, private sector is penetrating more and more in the urban areas of Delhi. Due to the ignorance and lack of political willpower of the policymakers, the public sector in health becomes fragile which give more and more space to the private practitioners in the health system.

Opening doors for the private sector further degrades the quality of services provided by public dispensaries/hospitals. Also, the poor quality of the public health services had led to exit of middle class from the public sector which further downgraded the quality of health services. This pushes poor people to opt for the private sector. These private institutions only provide curative services which are unaffordable to masses of the country keeping aloof from the larger socioeconomic, cultural and political context of the people. It has been observed that the development of private sector in health is escalating the problem even more and making the health system more inequitable as these private health facilities are out-of-reach of the urban poor due to financial limitations. Sometimes, due to financial constraints, urban poor could not seek medical care from qualified private providers, and finally land up seeking care from unqualified quacks. Urban poor opt for unqualified health providers/quacks because they are affordable and are located in their neighbourhood. This gives rise to another problem of quackery.

Many studies of the private providers in Delhi revealed that the quality of care is low in the poorer neighbourhoods. “The care differed with the difference in incentives (income and reputation) and competencies amongst the providers. It was also found that the services of the more competent doctors are availed by rich and the poor had access to lower quality of doctors (Chavali, N.A). There is a clear demarcation that the expensive private care caters to the elite population and poor quality public-funded care for the poor. This shows that there is a stark disparity in access to quality health care for the urban poor and average urban population in India.

In India, where Medical Tourism (MT) is growing on the one hand, urban poor don’t have or have limited access to primary health care. MT caters to the illnesses of the wealthy thereby serving the interest of handful of people. Hence, the services promoted by these institutions, offering services to the medical tourists, are not essentially aligned with the epidemiological priority in the country. Only the upper crust gains through this skewed priority in service structure. As a result, MT may not have any significant impact on the pattern or the prevalence of major diseases in the country, where under-nutrition, high infant and maternal mortality and communicable diseases still prevail (Reddy and Qadeer, 2010, p.74). There are some serious repercussions of MT like shift of subsidies from public to the private sector and exceptionally low share in public healthcare sector (Choudhury and Dutta, 2004 cited in Reddy and Qadeer, 2010, p.74).

As the resources have been transferred and subsidies have been given to the private sector, the public sector remains at the receiving end and gets less priority (mostly utilised by the disadvantaged section of the society) in comparison to the private sector (utilised only by the people on the upper crust of the society). It was assumed that MT would add to the economic growth of the country but this growth is limited for some sections of society. In a study conducted by Qadeer and Reddy, it was also clearly highlighted by one of the doctors said that “by getting patients from abroad, dollars will get priority and the less privileged Indian patients will take a backseat” which is right in the current scenario (Qadeer and Reddy, 2013). Medical tourism which caters to a fraction of the population is developing but at the cost of depriving poor from accessing basic health care.

In this process, the burden falls on the poor and marginalised population as these services are unaffordable. The above discussion clearly indicates that urban poor lack access to health care. Not only financial factors but there are several other factors which determine access to health.

Figure: 3.3

Barriers to accessing health services with specification of supply and/or demand influence

Dimension of barriers (Peters *et al.* 2008)	Barriers (Ensor and Cooper 2004)
Geographic accessibility	
• Service location (S)	• Indirect costs to household (transport cost) (D)
• Household location (D)	
Availability	
• Health workers, drugs, equipment (S)	• Waiting time (S)
• Demand for services (D)	• Wages and quality of staff (S)
	• Price and quality of drugs and other consumables (S)
	• Information on health care choice/providers (D)
	• Education (D)
Affordability	
• Costs and prices of services (S)	• Direct price of service, including informal fees (S)
• Household resources and willingness to pay (D)	• Opportunity costs (D)
Acceptability	
• Characteristics of the health services (S)	• Management/staff efficiency (S)
• User's attitudes and expectations (D)	• Technology (S)
	• Household expectations (D)
	• Community and cultural preferences, attitudes and norms (D)

Source: Adapted from Peters *et al.* (2008) and Ensor and Cooper (2004).
Notes: D = demand side; S = supply-side.

Source: Jacobs et. al., 2011

World Health Organisation highlighted that there are different dimensions of barriers to evaluate access to health care such as geographical access, availability, affordability and acceptability (Jacobs et. al., 2011). A summary of the identified barriers based on the four dimensions of access and demand-supply side perspective shown in figure 3.3.

Access and utilisation of health services is a multifaceted phenomenon affected by various factors which include the availability of services, distance of the health facility from the household, cost of the services and quality of care provided. The utilisation is directly affected by the personal behaviour and attitude, cultural beliefs and socio-economic status of the individual/family (Singhal, 2015). Some of the important barriers to the utilization of healthcare in the slums are restricted access to health services and insufficient knowledge of slum population about healthcare facilities.

Agarwal and Sangar (2005) refined the factors responsible for why do primary health services for the urban poor are not reachable? These factors can be classified into four broad categories as discussed below (Agarwal and Sangar, 2005):

- Systemic factors which include lack of services and organized public sector infrastructure in urban areas, the higher share for bigger cities, poor access and utilisation despite the proximity, lack of sensitisation among the service providers, poor living conditions that complicates the lack of health services.

- Urban poor related factors including illegality of slums and social exclusion, invisible large proportions of slums, weak social fabric, collective negotiation capacity, temporary migration and floating populations.

- Limited capacity of and weak coordination among different Stakeholders- Weak/no coordination among private and public urban health stakeholders and weak municipal capacity in most States.

- Inadequate political and civil society consciousness- Rural poverty receives most attention while the urban poor have been neglected.

Given the rapid rise in India's urban population, these urban health care problems will considerably increase in the future. "The prevention and treatment of diseases will remain a privilege of better-off households unless there is a change in policy; an increase in public health investments and new plans to make existing (private) health care accessible to all. As of now, access to health care services is mainly dependent on socioeconomic status. Social polarisation is thus reflected in the wide gap between the ability of the rich and the poor to cope with ill health." (Butsch, et. al., 2012, p. 24)

It was found that the health status of urban population seems better than their rural population but, urban average residents mask this growing inequalities and disparities between the rich and poor even if the proportion of population living in poverty seems to be reducing. The urban poor, within urban areas, face more health hazards than the average urban populace (Ramana and Lule, NA p. 2). Overall, socioeconomic and health

conditions are better in urban areas as compare to rural areas but the urban average figures mask the real health status and health service coverage for the urban poor.

Tibaijuka (2003) argues that "there are two cities within one city - one part of the urban population enjoys all the benefits of urban living, whereas the other part (slum dwellers) lives in worse conditions than their rural relatives" (United Nations Human Settlements Program, 2003). One of the biggest challenges is improving health outcomes for urban populations, particularly for the slum population. Along with poverty, lack of permanent employment and tenure, frequent migration, threat of eviction, lack of access to basic amenities like water and sanitation, overcrowding, and social discrimination contributes to poor health of population living in urban slums and makes the delivery of health services more difficult in those areas (Gupta et. al., 2009, p. 12).

Because of the heterogeneous population in the urban areas, there are different expectations from the urban health systems. Most of the time, the problems of urban poor get overlooked as the health system cannot meet their needs which leads to their increased vulnerability and exclusion. It is evident that despite increased income and existence of medical facilities in the proximity, the urban poor has greater difficulty in staying healthy than their rural counterparts. "The urban poor are at the junction of underdevelopment and industrialisation, and the patterns of their disease reflect the problems of both. Firstly, they bear a heavy burden of infectious diseases and malnutrition and secondly, they suffer the typical spectrum of chronic and social diseases." (Rifkin, 1987, p. 58)

The health infrastructure in urban areas is deficient to fulfil the basic needs of rising urban population especially the population of urban poor. Although urban areas have more health facilities (including government and private) and better transport facilities than rural areas but the geographical location, operating time and other characteristics of government health facilities prevent the urban slum populations (which accounts for 35-40 per cent of urban populations of India) to make use of these facilities. Moreover, the rapid growth of population has put the urban infrastructure such as land, health services, education and administration under tremendous pressure (Agarwal et. al., 2007).

Therefore, rapidly increasing slum population makes the already limited health facilities and services, further inadequate and making it even more inaccessible for the urban poor.

Most of the urban dwellers do not get benefitted from the better healthcare services. The reason is as a large population lives in the shanty towns and slums so the benefits are taken only by few who are relatively better off (Rifkin, 1987). Only the middle and the upper class have access to treatment in private hospitals if they can afford it. It was found that 80 per cent of healthcare expenditure in India is private. The underserved population and poor are often left to the mercy of government hospitals/institutions[10].

The major issues that have been identified as challenges to urban health care in the country are the inadequacy of urban health infrastructure, congestion in hospitals, lack of outreach, and functional referral system, norms and standards for the urban health care delivery system. Some of the other issues include social exclusion, lack or ignorance of information to access advanced health care services and lack of purchasing power (John et. al., 2008 cited in Bajpai, 2014, p.8). Non-functioning or poorly-functioning sub-centres, PHCs and CHCs complicate the problem, making people highly dependent on big hospitals for their treatment thereby burdening the infrastructure at these health facilities.

There is an increasing tendency to focus on selective care for targeted populations and reduce public investment in the health sector (World Bank, 1993) which makes the public sector even more deficient. One of the major reasons mentioned "against public investment on health care is that instead of poor, it is the rich who take benefit from public spending. World Bank's benefit incidence analysis strengthened the argument that it is the rich who benefit from hospital services." (Mahal et. al., 2001 cited in Dilip and Duggal, 2004, p. 4)

Evidences show the presence of sharp disparities in urban areas which exist in health conditions and access to health care between the better-off and the urban poor. These disparities are increasing day by day with the expansion of private sector in health. Also,

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[10] http://www.firstpost.com/india/transforming-healthcare-why-america-should-learn-from-aaps-mohalla-clinics-in-delhi-2906980.html (last accessed on August 24, 2017)

the primary health services are out of reach for the urban poor in India as the primary health care facilities have not developed at the same rate as the urban population explodes, especially the population of poor. (Gupta et. al., 2009, pp. 9-10)

The city administrations often do not count the people who live in informal settlements or slums. Many of them live in terrible conditions which exclude them from the urban development around them. Within a city, they represent the hidden or hard-to-reach populations who need to be reached most urgently (WHO, 2016). For promoting the general health of the community, it is essential to make the health care services accessible for all. If the public health services are strengthened and access for the poor to these services improves utilisation rates for the poor will also go up, and the class differentials we now see will also diminish if not disappear (WHO, 2016).

The role of the government sector is very crucial in strengthening the public health services, especially the primary health care and improving access to health services for this underserved population. Because of their vulnerable conditions, they are in great need of the preventive care rather than just providing medical care once the disease occurs. Primary Health Care is not only providing primary level care as there is a huge difference between the two terms.

Alma-Ata declaration in 1978, laid the foundation for comprehensive primary health care and its central attributes were: first contact (accessibility), longitudinality (person focused preventive and curative care overtime), patient-oriented comprehensiveness and coordination (including navigation towards secondary and tertiary care)" (Maeseneer et. al., 2007, p.2). Primary Health Care caters to the needs of the individuals as well as the communities and addresses the social determinants of health (Maeseneer et. al., 2007, p.17). Therefore, the key to Primary Health Care is community participation. The idea of primary health care is based on the principle of equity (Rifkin, 1987). But the current situation shows that the citizens are nowhere in the policy-making.

The primary health care approach was defined as "essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation

and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (Zodpey, 2010, p. 55).

Primary health care is a comprehensive concept which offers a balanced mix of preventive, promotive, curative, diagnostic and rehabilitative services. Further, it can be said that the public health emphasizes on preventing the occurrence of diseases while clinical services aim to treat patients once they have acquired an illness (Lahariya, 2017).

In India, the status of primary healthcare has been distressing. There has been enhanced emphasis on construction of new hospitals which is presumed to improve the access to health care. But creation of physical infrastructure is not sufficient to ensure universal access to primary health care. The health services must be conveniently found and financially accessible which increase the physical availability that ultimately translates into increased utilisation of the services and thus improved health status of the population (Zodpey, 2010, p. 55).

If we take an example of Delhi, Primary health Centres (PHCs) suffer from a lack of funds, human resources and infrastructure. The condition of PHCs is even worst in underserved colonies including slums and *JJ* clusters. In the urban areas of Delhi, at many places, the primary healthcare facilities may not be in the vicinity of urban slum population. The proximity of health facilities to the slums affects the health-seeking behaviour of the people living in and around these areas. The households which are close to the health facilities have greater access to these services. At some places even after the presence of health facilities in the neighborhood, the services remain underutilised because of their poor/non-functioning. This makes the people to seek care from secondary and tertiary care hospitals, consequently overload them.

Also, there is a discrepancy in the care provision as the focus is more on the curative care and complete disregard for the preventive and promotive care. There is an over-emphasis on private sector for constructing more super-speciality institutions in urban areas which provide high-tech services to a particular section of the society and are entirely out of reach of the urban poor.

A report based on NFHS-3 found that the main source of health care for most of the households in the slum and non-slum areas in every city is the private sector. Because of their better quality, easy accessibility and less waiting time, people prefer using private health facilities. It was also found that government health facilities are utilised more likely by the poor households than slum or other households. The households that usually do not utilise health care services provided by government health facility reported three most common reasons for not using government facilities such as absence of a nearby facility, poor quality of care and long waiting times at government facilities. Along with these three reasons, many of the households mentioned that the OPD timings are not convenient to them which prevent them from using those facilities (Gupta et. al., 2009).

Talking specifically about Kolkata and Delhi, the long waiting time is the main reason highlighted by the respondents for not utilising the government health services. It has been found that the poor people are more likely to complain about the lack of a nearby facility but they are generally less troubled with the long waiting times (Gupta et. al., 2009, pp. 60-61).

The major challenges in India's health services are lack of assured services, unpredictable availability of health providers, lack/poor diagnostics facilities, medicines and poorly functioning referral linkage. Even today these health services are as scarce and underdeveloped as they were when the Bhore Committee was formulated. No doubt that a large number of people seek medical treatment from secondary and tertiary care government health facilities even for the minor ailments like cough, cold and fever leading to overcrowding, long OPD queues, poor quality of services, leaving the people unsatisfied with the existing public health facilities. In this situation, rather than spending on traveling, multiple visits with no service guarantee, long waiting time to be seen by a physician and then paying for medicines and diagnostics, people from poorest quintile either neglect their illnesses or prefer going to a private provider or a non-qualified quack even if they have to spend money from their pocket (Lahariya, 2017).

One of the important obstacles in accessing good quality healthcare for poor households is economic constraints. The Commission on Macroeconomics and Health highlighted some of the other important factors which prevent poor from accessing medical care from

qualified doctors. The report states that "access to medical care continues to be problematic due to locational reasons, bad roads, unreliable functioning of health facilities, transport costs and indirect expenses due to wage loss etc., making it easier to seek treatment from local quacks" (Gupta and Guin, 2015, p. 251).

It is clear from the above discussion that there is a huge gap and disparity in access to health services between the marginalised communities and better-off social groups. Social stratification in the Indian society is the major cause why urban poor face this disparity and inequity and lack access to health care. Looking at the challenges mentioned above, there is an urgency to strengthen primary health care and reduce inequity and inequality in access to health services.

Universal Health Coverage (UHC) could be a "major step towards reducing inequity in access to health care. UHC aims to ensure that all people and communities obtain the quality health services they need without facing any financial hardship" (WHO, 2016, p.51). This goal requires a robust, efficient, properly-run health system. There is also a great need to have a system for financing health services; access to essential medicines and technologies; and sufficient capacity of well-trained, motivated health workers.

UHC is an indispensable component of the Sustainable Development Goals (SDG 3). It aims to achieve UHC which include financial risk protection, access to quality basic health care services, access to safe, effective, quality, and affordable essential medicines, and vaccines for all (WHO, 2017). The services should also meet the specific needs of the communities, and nobody should undergo financial hardship or be pushed into debt as a result of accessing health care (WHO, 2017).

To achieve the UHC, Brazil had developed a concept in the 1980s i.e. Family Health Strategy under the National Health System, the Sistema Único de Saúde (SUS). Brazil is progressing towards achieving the universal health coverage population through its national health system which emerged in 1985. The system had made a significant investment in expanding access to health care for all of its citizens. The municipalities are accountable for providing most primary care services as the healthcare management is decentralised. Most of the common medications and publicly financed health services are

freely available and universally accessible to all at the point of service, and 26 per cent of the population is also enrolled in private health plans.

A unique initiative in the system has been the rapid expansion and development of community-based approach to deliver primary health care. After the origin of MCH program which rely on community health agents, the Family Health Strategy (FHS) evolved. The FHS Program has evolved as a strong system for provision of primary care for defined populations. The interdisciplinary healthcare teams are at the center of the Program. The FHS team comprises of a medical doctor, a nurse, a nursing assistant who are assisted by four to six full-time community health agents. Each team covers a population of up to 1000 households. These teams are organised in such a manner that it leaves no gap and overlap between catchment areas. FHS teams facilitate access and first-contact care by organising themselves geographically near people's homes. The interdisciplinary teams provide comprehensive care. The proactive community health agents inquire about problems of the patients before they reach the health post. Expansion of the program has played a vital role in improving health equity particularly in access to and utilisation of care (Macinko and Harris 2015).

The concept of FHS is to deliver community-based primary care at the doorstep of the patients. Likewise, the National Health Service (NHS) which was launched in the United Kingdom (UK) has been a pioneer in primary health care. Each household is registered with a "general practice" as it is called which has about five general practitioners, two to three nurses and six support staff. A typical practice team caters to about 6,000 patients. Similarly, Thailand had also tried to improve health outcomes through its primary health centres under the leadership of a district hospital. Each of its primary health centers has coverage of about 3,000 to 4,000 people and consists of a team of about five nurses or paramedical workers. In the same way, Sri Lanka, Cuba, Costa Rica, and Iran have similar strategies and results with cashless or highly subsidised services[11].

[11] https://scroll.in/pulse/870405/in-new-health-and-wellness-centres-india-has-a-good-plan-for-primary-care-backed-by-little-action (last accessed on June 20, 2018)

If we look at India, it is among the few countries with less than 1 per cent of GDP spending on public health which results in three-quarters of the expense being met from out-of-pocket paying by individual households (Reddy and Mary, 2013) which makes it among the countries with largest out-of-pocket expenditure on health. No doubt, India had also taken many initiatives and made remarkable progress to achieve the aim of UHC and reduce financial hardship but reaching the most vulnerable, underserved, marginalised population living in slums/ unauthorised and resettlement colonies/*JJ* clusters remains a constant challenge.

As health is a state subject in India, the state government is responsible to take care of the health needs of its residents. Delhi, being a capital of the country had also taken many initiatives to improve access to primary healthcare for the underserved population. The motto of the Citizen Charter of Directorate General of Health Services, GNCTD is to provide quality healthcare at the doorstep. Realizing the need to ensure "Health for All" without suffering any financial hardship and to achieve UHC, Delhi government had initiated an innovative project to provide primary health care through "Mohalla clinics" (neighbourhood clinics). These clinics have the potential to meet the essential healthcare needs of Delhi's population thus help the government to move towards achieving universal health coverage.

The idea of Mohalla clinics was based on the Mobile Medical Units (MMUs) or Mobile Vans. The aim of these MMUs or Mobile Vans is to reach the unreached/underserved, vulnerable pockets. These vans provide basic health care to the population residing on the fringe of society at their door-step based on their felt needs making it more accessible to the marginalised population. One of the key strategies of these vans is to strengthen healthcare facilities and taking the healthcare to the doorstep of the people.

As also mentioned by Lahariya, the origin of the idea of Mohalla clinic came after the success of Mobile Medical Units (MMU) or mobile vans. Keeping in mind the shortcomings of these Mobile vans like unpredictable services, visits to only some specific areas, their limited number and unpredictable availability of vehicle the recent Delhi government designed the concept of Mohalla clinics. It was then supplemented by the desire and electoral commitment of the top political leadership to strengthen the

health systems instead of providing temporary solutions (Lahariya, 2017). The recent Delhi government launched these clinics to take the healthcare as close as to the people where they live just like Mobile Vans rather than people travel long distances to reach health facilities to receive healthcare.

The Aam Aadmi Mohalla Clinic has also been conceptualised as a mechanism to provide access to quality primary health care services at the doorstep of the patients where they live or work. The concept of Mohalla clinics was developed keeping in mind that the clinics must be in the neighbourhood of the people or within walking distance (around 2-3 km radius or 10-15 min walking) to improve the geographical access to primary health care services for the residents of Delhi. The clinics should open for at least 4-6 hours of every working day which would assure the availability of identified essential health services, medicines and diagnostic tests. This initiative aims to expand the range and reach of health services in underserved and unserved areas such as slums. In a unique model, all services-consultation, medicines, and diagnostic tests are provided in one spot and are available free of cost for people from all income groups (Sharma, 2016).

Mohalla clinics bring health care as close as possible to the people and form the first point of contact for individuals, families and communities. A clinic would cover a population of 10,000 so that the doctors can give sufficient time to each patient. It was estimated that 80-90 per cent of health problems are likely to be treated at this level reducing the numbers of patients in need for referral thereby reducing patients' load in secondary and tertiary care hospitals and decongest them.

Mohalla clinics were started keeping in mind some principles. First and foremost is the principle of accessibility. Mohalla clinics have improved access to quality health services to all. By following the principle of equity, these clinics focus on the poor, disadvantaged, marginalised and excluded sections of the society while delivering health services. Mohalla clinics provide assured package of essential health services rather than providing a limited package of services to expand coverage with services for additional diseases and illnesses. These clinics also ensure that the services meet the expectations of the people and are delivered as per standard guidelines to maintain the quality of services. These clinics provide financial protection to the urban poor by reducing the financial

burden on the urban poor. Mohalla clinics make the health services affordable and accessible with no direct or indirect payment for utilisation of these health services. Community participation is another important principle which was kept in mind while planning Mohalla clinics in any area. The active engagement of community members in selection and identification of sites for these clinics brings out the necessary ownership (Lahariya, 2017).

Being launched by a particular party (AAP) in its tenure, these clinics have a political origin and grabbed attention of many. Lahariya envisioned that “these clinics had set the background to bring Cleanliness-Health-Education-Sanitation-Social Sectors (C-H-E-S-S or CHESS) as an alternative to Bijli-Sadak-Paani (B-S-P) as electoral agenda and political discourse in India. He added that Mohalla Clinics could stimulate health reforms and to expedite progress towards UHC in India” (Lahariya, 2017, p.1).

Mohalla clinics seem to operationalise the concept of UHC which was established by the High-Level Expert Group; the central government which had recommended a substantial rise in public health financing to give universal access to free primary care services which include essential medicines and diagnostic tests in 2011. There is evidence from around the world which shows that the best way to accelerate health coverage is by increasing access to publicly financed primary care (Sharma, 2016, p. 2855). By launching these clinics, the Delhi government has taken a step ahead to hasten the process of achieving UHC.

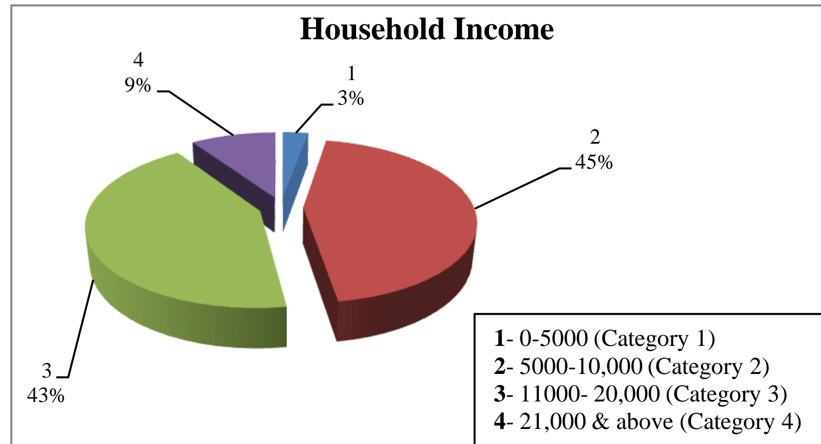
Chapter 4 - Socioeconomic Profile of Patients attending Mohalla Clinics

Mohalla clinics have been started to make health services easily accessible and available to all with a specific focus on vulnerable and underserved communities. With this being the prime objective, most of the Mohalla clinics have been opened especially in the poor neighbourhoods with low socio-economic status like resettlement and unauthorised colonies, *JJ* clusters and slums of Delhi, where most of the urban poor live. Some of the clinics have also been opened even in the middle or in upper-class colonies. As the socio-demographic and economic characteristics play significant role in determining the health status and access to health care services, this chapter aims to understand these factors.

Based on the data given by 61st Round of National Sample Survey (NSS, June 2004 - July 2005), a state-specific poverty line for urban and rural was published by Planning Commission. For Delhi, the poverty line was differently estimated for the urban and rural area; i.e.at 612.91 for urban and 410.38 for rural areas as compared to the national average of 538.60 for urban and 356.30 for rural India. It was estimated that approximately 9.91 per cent of Delhi's total population, i.e. 16.96 lakh persons live below poverty line (GNCTD, 2017-18). This population is most vulnerable to fall sick but the irony is that this section of the society lack access to health care services in Delhi.

Based on the findings from the field, it is clear that patients from varying socio-economic and demographic characteristics use Mohalla clinics. It is evident from the figure given below that 45 per cent of the households who belong to the Category 2 where the overall household income is between Rs. 5000-10,000 utilise the services provided by these clinics. Almost equal number of households, i.e. 43 per cent of the households falls under the Category 3 where the overall household income falls between Rs. 11,000-20,000. Very few i.e. 9 per cent of the households fall under Category 4 who come to Mohalla clinics for any of the health related problems.

Figure: 4.1



It is strange that only 3 per cent of the households use Mohalla clinics which belong to the income group ranges from Rs. 0-5000 (Category 1). It was found during the field work that very few of the patients attending these clinics belong to poor families. As mentioned earlier most of them belong to either Category 2 or 3. It has also been observed that poor patients (Category 1) come for treatment of their ill health when they fall sick whereas patients from Category 2 and 3 come mainly for routine medical check-ups and preventive measures like blood sugar test, thyroid test and blood pressure measurement etc.

As mentioned earlier that these clinics were opened keeping in mind the lack of access to health services for urban poor, but the result reflects that access has improved for a small fraction of poor population. But these clinics have the potential to alter the health-seeking behaviour and meet the health needs of the poor population with time.

4.1 Gender-wise Distribution of Patients Attending Mohalla Clinics

It has been found during the fieldwork that 68 per cent of the female patients attend Mohalla clinics for treatment of their illnesses in contrast to only 32 per cent of the male patients. There are several reasons for more female and less male patients attending these clinics. Availing treatment at Mohalla clinics becomes difficult for those who work during the day and leave early in the morning. As men have to leave early in the morning for their work, they are less benefitted from these clinics. The working hours of the

clinics (8 Am. to 2 pm.) can be stated as one of the reasons for less utilisation of these clinics by men. Women, because of their domestic nature of work can come to these clinics even after finishing their household chores or as per their convenience.

One of the other reasons why a large number of women come to these clinics is the presence of these clinics in their neighbourhood. Now, they can easily access these clinics as they don't have to depend on their male family member to accompany them to the health facility (which was the case earlier). They can utilise the services provided by these clinics without spending money on transport and medicines and hampering their household work. After interviewing the women coming to the clinics, it was found that the women finish their work early in the morning and come to these clinics around 12-12:30. Earlier, it was very difficult for women to get up early in the morning, reach a government hospital by traveling long distances and spend hours waiting for doctor's consultation. With the establishment of Mohalla clinics, there is a huge reduction in the amount of travel time and expenditure on health.

One of the doctors gave another explanation for more women coming to these clinics. He said that whenever a mother comes to get medicine for her child, she also takes medicine for herself by telling symptoms like headache, body ache or knee pain. Earlier, they used to avoid these symptoms because of lack of time and money to spend on these minor ailments. So it can be said that these clinics have given access to women who earlier found difficulty in accessing the health services. Also, it can be said that Mohalla clinics have immensely altered the health-seeking behaviour of the population especially the women. Meaning, now the women have started recognising these symptoms as illnesses and seeking treatment because of the presence of these clinics in the neighbourhood.

This can also be viewed as excessive utilisation of these clinics for treating the trivial health problems with random symptoms. Just because the clinic is in their neighbourhood, women come and take medicine even for headache. Here, the skills and competence of the doctors play an important role in determining that the illness is worth treating or not otherwise this will add to the burden on health system in the long run.

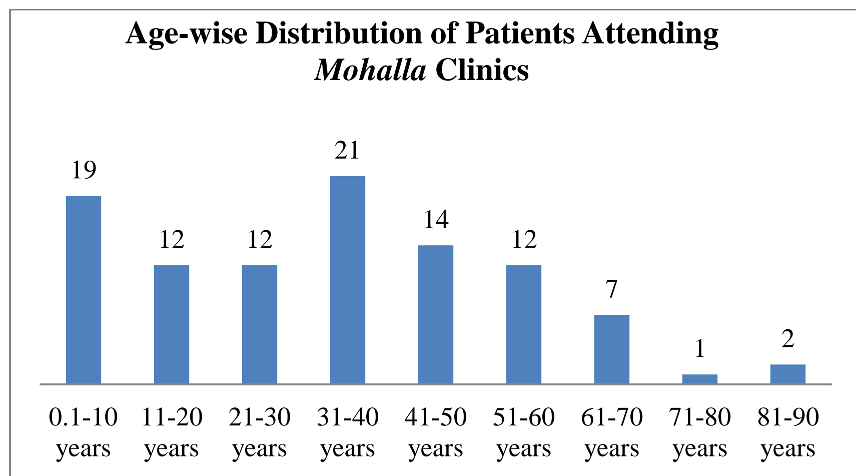
4.2 Age-wise Distribution of Patients Attending Mohalla Clinics

Based on the field work, it has been found that most of the patients, i.e. around 22 per cent are elderly[12] patients, i.e. in the age-group of 51-90 years. It became possible because these clinics are within reach of this population. Earlier, they had to wait for someone to take them to the hospital/dispensary, but now they can visit these clinics on their own without depending on others. One of the elderly patients (interviewed on October 28th, 2017) said that now he comes on his own to take his medicines for diabetes.

Table: 4.1 Number of Respondents (age-wise)

Age Interval	Number of patients
0.1-10 years	19
11-20 years	13
21-30 years	13
31-40 years	22
41-50 years	15
51-60 years	13
61-70 years	7
71-80 years	1
81-90 years	2

Figure: 4.2



Out the patients interviewed during the field work, it was also found that 21 per cent of the patients fall under the age group of 31-40 years. As already mentioned earlier 68 per cent of the patients who attend Mohalla clinics are women, here also it is worth mentioning that out of 21 per cent of patients (who fall under the age group of 31-40 years), 19 per cent were women. Meaning, more women are attending these clinics in the age-group of 31-40 years as compared to the men.

One of the reasons for a higher number of patients in this age group is that it is the most active age-group. Talking particularly about women, all of them are housewives and mothers who fall under this age-group. They are the major contributors to the number of patients attending these clinics.

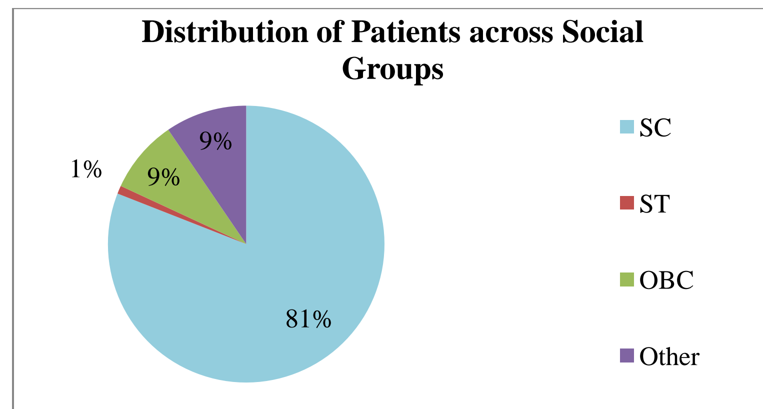
[12] The researcher had defined elderly population who are above the age 50. As the patients came to the *Mohalla* clinics in the age-group from 50-90, this group has been categorised as elderly population

It is clear that these clinics have improved access for vulnerable populations which include women, children and elderly.

4.3 Distribution of Patients across Social Groups

Looking at the different social groups the patients belong to, it gives a clear picture that Mohalla clinics have improved access to health services for Scheduled caste (SC) population as evident from the figure 4.3. 81 per cent of the patients utilising the services provided by the Mohalla clinics belong to the scheduled caste. 9 per cent of the patients from Other Backward Caste (OBC) and 9 per cent of patients from other caste groups (upper caste) use these clinics. It is to highlight here that Muslims, Jaats and Yadavs come under the category of OBC group. Scheduled Tribes (ST) contribute only one per cent to the patients utilising services provided by the Mohalla clinics.

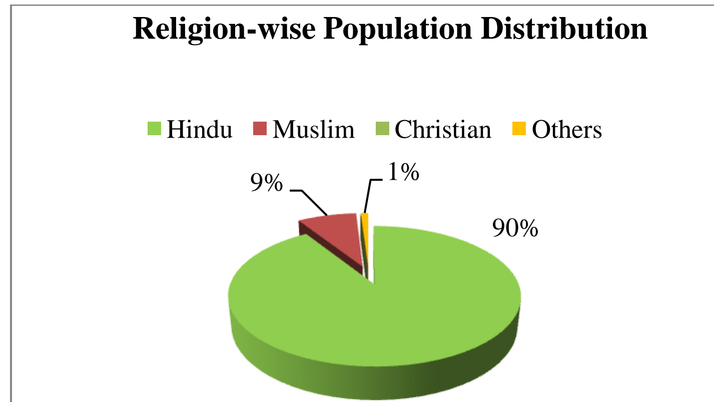
Figure: 4.3



4.4 Religion-wise Patient Distribution using Services at Mohalla Clinics

Looking at religion-wise distribution of the patients who come to Mohalla clinics, most of the patients, i.e. 90 per cent are Hindu. Muslims contribute nine per cent to the patient inflow in these clinics. Other religions contribute only one per cent to the patient load in the Mohalla clinics. It is strange that none of the patients is Christian.

Figure: 4.4

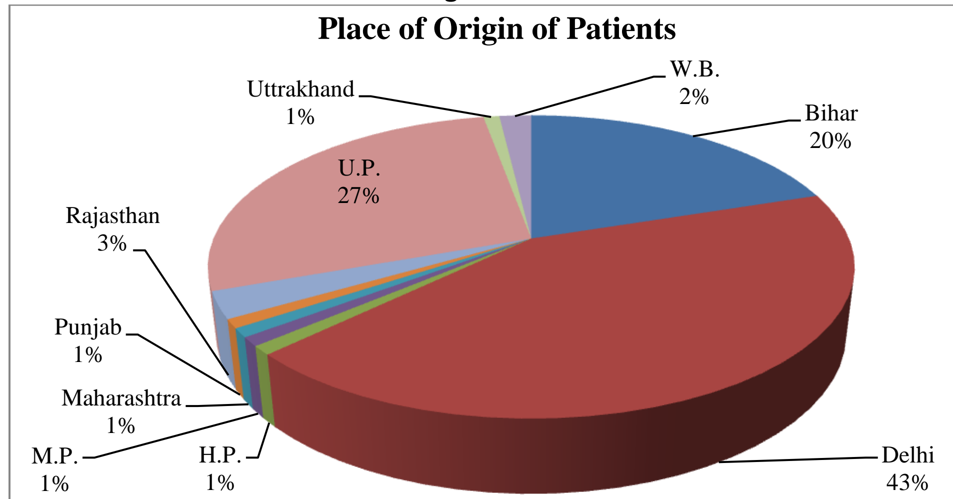


One of the reasons for more number of Hindu patients could be that the communities residing near the clinics visited during the fieldwork were Hindu dominated. Muslims and other religious groups were in the minority in the nearby communities.

4.5 Place of Origin of the Patients

Migration is a fundamental part of population dynamics. Migratory population constitutes a huge proportion of the population in urban slums of Delhi. Migratory population, being a non-native population in Delhi, is more vulnerable and exposed to various kinds of health problems. Mohalla clinics cater to the needs of not only citizens of Delhi but also migratory, and floating population come from neighbourhood states constitute significant patient load. The study shows that only 43 per cent of the patients belong to Delhi and the remaining population is the migratory population from different states. It was found that 27 per cent of the patients are migrated from Uttar Pradesh (UP), and 20 per cent of the patients came from Bihar. Three per cent of the patients are migrated from Rajasthan; two per cent of them belong to West Bengal (WB) and one-one per cent each from Uttrakhand, Punjab, Maharashtra, Madhya Pradesh (MP) and Himachal Pradesh (HP).

Figure: 4.5



Less than half (43 per cent) of the permanent residents of Delhi are utilizing services of Mohalla clinics and remaining 57 per cent are the migrants who use the services. One of the plausible reasons are the affordability of these services as consultation, medicines and diagnostics are available free of cost. It is imperative to mention here is that the large migratory population belongs to the state of Uttar Pradesh and Bihar. One of the reasons for large population from these states could be their proximity to Delhi.

4.6 Living Conditions of the Patients

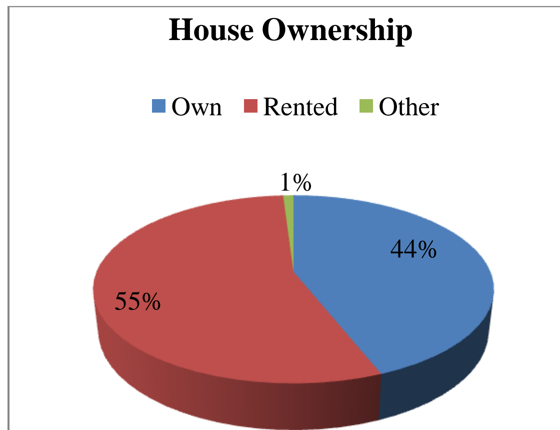
The living conditions have been defined in terms of the following:

- House ownership
- Drinking water facility
- Toilet facility
- Bathroom facility

4.6.1 House Ownership

Almost half (44 per) of the patients live in their own house and 55 per cent of them live in a rented accommodation. Only one patient lives on the pavement who came to the clinic for his treatment. The patient lives on the footpath near a doctor's (who is working in Mohalla clinic) house. He came for his treatment of back pain as the doctor insisted him to come for treatment.

Figure: 4.6



As discussed before more than half of the population is migratory population; they are the ones who live in rented accommodation and those who are citizens of Delhi own house. It is visible from the data mentioned above that the services provided by Mohalla clinics are utilised equally by permanent citizens of Delhi as well as the migratory population.

The Mohalla clinics aim to tackle the health needs of the population of Delhi especially the urban poor living in the slums, unauthorised colonies and *JJ* clusters. The people living in rented accommodation earn a meager amount of income and Mohalla clinics are highly beneficial for them. These clinics have reduced their financial burden on health by saving travel time and costs and lost wages because of the proximity to their homes.

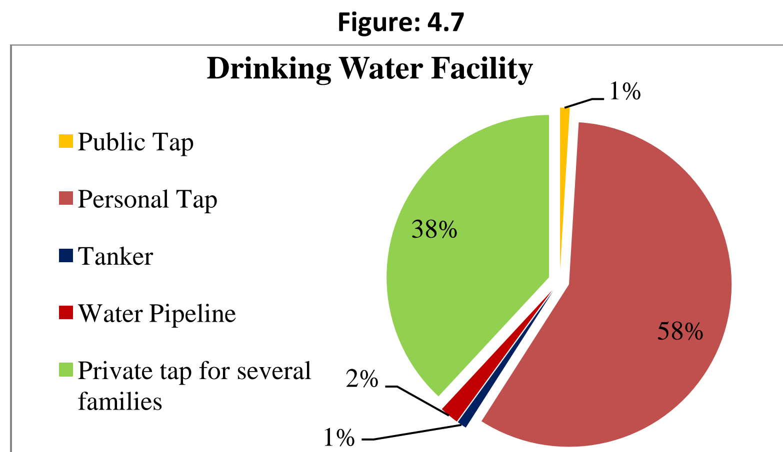
It has also been observed that many middle and even upper-class families who own big houses and bungalow are also benefitted from these clinics. Because of their presence in the community, the patients from middle and upper class also come for regular medical check-ups and diagnostic purposes. As these clinics have better infrastructural facilities and less patient load as compare to the government hospital/dispensary, patient prefer to come here. And most importantly, the services at these clinics can be utilised at ‘no cost’.

It is evident that people choose health facilities mainly based on their convenience/location and perceived quality. It is worth highlighting here that now the middle-class and the rich families have started reclining their faith in the public healthcare system again with this initiative which earlier wasn’t there.

4.6.2 Drinking Water Facility

Water comes under the necessities of life just like food, housing and sanitation. Also, clean and safe water supply is essential for overall improvement of the health of the people. The study found out that 58 per cent of the patients have their own personal tap for drinking water. Another 38 per cent of the families take water from private taps meant for several families. These are the families who live in rented houses where the house owners gave the whole house on rent to more than one family and put a tap for all the families.

Figure: 4.7

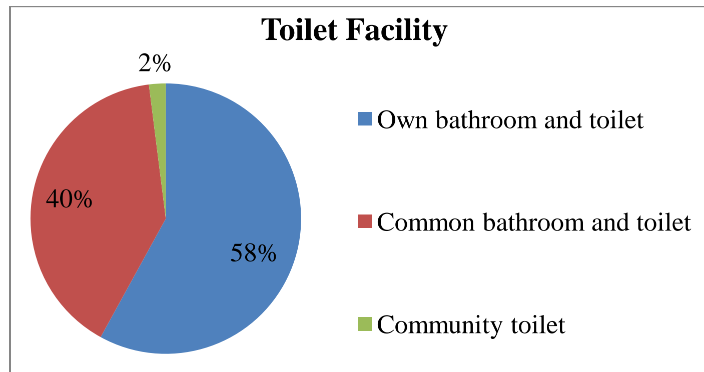


Only two per cent of the families take water from water pipeline and one - one per cent each from public tap and water tanker. The patients use the same water for drinking, bathing and toilet purposes. As per the patients, the quality of water is good except at one location where the patients said that they have to go too far to fetch drinking water as the water available in their community is not drinkable.

4.6.3 Toilet Facility

The availability of toilet and bathroom is very important for a person to live a healthy and dignified life. It is quite obvious from the figure 4.7 that 58 per cent of the patients use their own toilet and bathroom. 40 per cent of them use common toilet and bathroom meant for several families living in a same house or on the same floor of a house (as mentioned earlier). Very few, i.e. only two per cent of them use municipal toilets.

Figure: 4.8

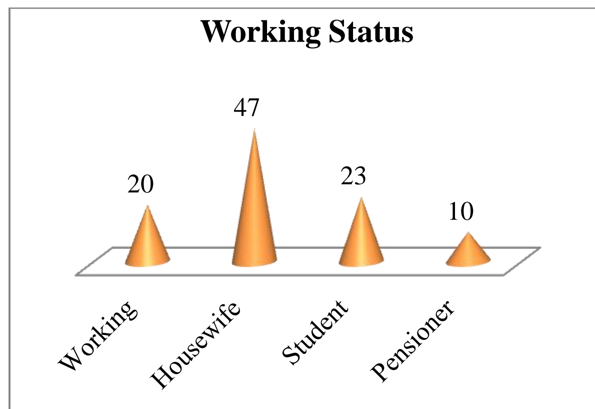


It is important to highlight that none of the respondents defecate in open space. This is a clear indication that the people are aware of importance of cleanliness to maintain good health.

4.7 Working Status of the Patients Attending Mohalla Clinics

Out of the total patients interviewed, 80 per cent don't work they constitute housewives, children or pensioners. As already mentioned earlier that 68 per cent of the women come to Mohalla clinics for one or other kind of services, it is also visible from the figure 4.8 that 47 per cent of them are housewives. Only 20 per cent of the working population comes to Mohalla clinics for treatment. One of the reasons could be the timings of these clinics from 8 Am. to 2 pm. As most of the working population leaves their home for work in the morning hours so they could not utilise the services provided by these clinics.

Figure: 4.9



It is evident from the above fig. that 23 per cent of the patients are studying either in schools or colleges. The data for the children have been collected from their parents (in

case of children below 14 years of age). The reason for less number of students is also the timing of the clinic as the children have to go to the school/college in the morning hours. The children who study in schools visit these clinics after finishing their school (mostly after 12:30 Pm.). Only 10 per cent of the patients are old age patients who are getting one or other kind of pension from the government.

Some of the old patients mentioned that they feel like home in these clinics as they can come, sit and share their problems with other patients as well as with the doctors and feel relieved. There is a kind of trust building between the doctor and patient relationship where the doctors listen to their problems and counsel them whenever required.

4.8 Summary

Mohalla clinics had been established in the slums/ *JJ* clusters but the services are available for all the residents of Delhi without any income criterion. It is evident that from the data that the clinics are being utilised mostly by a large proportion of population in the income category of Rs. 5000- 20,000. It is worth mentioning here the point of view of one of the staff members who said that not all slum dwellers are poor. He added that it is not necessary that those who are living in slums are poor.

Looking at the gender based distribution of the patients, a large chunk of patients coming to these clinics are women, i.e. 68 per cent and the remaining are men. Because of their domestic nature of work, women can come to these clinics as per their convenience which is not possible in case of men who have to go out for work. It is also important to note that 22 per cent of the patients come under the age-group of 51-90 years and 21 per cent of patients fall under the age-group of 31-40 years. These groups are the major contributors to the patient load in Mohalla clinics.

It is evident from the data that these clinics have improved access for vulnerable populations including SCs. A significant amount of patients, i.e. 81 per cent belong to SCs and only 9-9 per cent patients' population was contributed by OBCs and other castes. Hindus are among the major users of these clinics as 90 per cent of the patients attending Mohalla clinics were Hindus.

Migrant population who live in rented house also comes to these clinics in large number. A major segment; 57 per cent of the patients are migrants from the nearby states. Less than half of the total patients are the permanent residents of Delhi. Data show that 44 per cent of the patients own house and live in Delhi since long. More than 95 per cent of the population had access to safe and clean drinking water and the source of water is located within or very close to their homes. Data also show that 58 per cent have their own toilet and 40 per cent uses common toilet for several families. It is also apparent from the given data that only 20 per cent of the working population uses these clinics because of the operational timings of these clinics.

The data illustrate that the services have not yet reached to the most disadvantaged and most underserved population living in the far-flung areas. There is a great need to expand this project and achieve the aim of opening 1000 clinics in order to expand coverage especially for the underserved population.

Chapter 5 - Functioning of Mohalla Clinics

To study the role of Mohalla clinics in delivering health care services in Delhi, it is important to understand the functioning of and services provided by these clinics. The quality of services could be one of the reasons that would determine the health-seeking behaviour of the people living in the neighbourhood. To move further, it is imperative to learn what is health seeking behaviour or health care seeking behaviour.

"Health Care Seeking Behavior (HCSB) refers to decision or an action taken by an individual to maintain, attain, or regain good health and to prevent illness. The decision made by the individual is based on the available health care options like visiting a public or private and modern or traditional health facility, self-medication and use of home remedies or not to utilize the available health services etc" (Chauhan, et. al., 2015, p. 118).

There are several factors affecting health seeking behavior of an individual but the important ones are income level, location of facilities and perceived quality of services. Health seeking behaviour of people is highly dependent on the perception of people regarding the quality of health care services in health centers. "The health seeking behaviour of a community determines how health services are used which in turns determines the health outcomes of populations (Musoke, et. al., 2014, p. 1046). Health-seeking behaviour is also dependent on accessibility, affordability and availability of the services. The services should also be acceptable to the community.

Mohalla clinics have been launched as an innovative intervention to alleviate the barriers to access health care services. These clinics were opened with an aim to provide quality health care services by making the affordable health care services accessible and available to all sections of the society. Although every person has diverse perceptions about quality of services but it was evaluated mostly in terms of the accessibility and affordability of services, availability of infrastructure and medicines, regular presence of health personnel and acceptability of the medical treatment of patients.

5.1 Insurance Coverage

The costs of health care have risen faster than any other services in the economy and faster than real incomes. It has made virtually infeasible for most people to pay directly for any sizable portion of their medical bills when illness strikes (Millman, 1993, p. 40). The literature shows India has the high OOPE on health at 62.6 per cent of total health expenditure. India is one of the world's countries with the highest OOPE which is nearly thrice of global average of 20.5 per cent. Poor government funding on health is one of the important reasons for high OOPE on health (Lahariya, 2018). In current scenario, either free medical care or medical insurance is a necessary requirement for people who are living in urban areas due to higher chances of exposure to disease producing factors such as industrialization, urbanization, pollution, overcrowding, deplorable environmental as well as living conditions and poor standards of health and hygiene.

Like other countries, India doesn't have national health insurance system for all its citizens. The penetration of health insurance in India has been very low. It is estimated that only about three per cent to five per cent of Indians are covered by health insurance. One of the important health insurance schemes launched in early 2008 by Government of India to ensure social security and healthcare assurance for all was the Rashtriya Swasthya Beema Yojna (RSBY). The objectives of the scheme were to provide financial protection against catastrophic health expenditure by reducing OOPE for hospitalization and improving access to quality health care for below poverty line (BPL) households and other vulnerable groups in the unorganized sector[13]. The scheme mainly focuses on inpatient care, predominantly secondary health services. As per the government data, 44 per cent of BPL families; approximately 33 million families were enrolled under this scheme in 2014-15 (GoI, 2015). Government's proclamation towards UHC had significantly increased the funds allocation under this scheme in the financial year 2016-17. This scheme has now been renamed as the National Health Protection Scheme (NHPS). Its coverage had risen from the current level i.e. Rs. 30,000 to Rs. 1, 00,000 per family (Ghosh and Gupta, 2017). As per the government's data, approximately three-fifth

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[13] http://www.rsby.gov.in/about_rsby.aspx (last accessed on June 12, 2018)

of the BPL families (officially) are yet to be covered by the scheme. Ghosh and Gupta found that only 11 per cent of households were enrolled in 2014 which shows that a majority of the poor are still outside its ambit.

Delhi, in particular, has a special scheme; Delhi Government Employees Health Scheme (DGEHS) which was launched in April 1997 aiming to provide comprehensive medical facilities to Delhi Government employees and pensioners and their dependants on the pattern of Central Government Health Scheme.

Also, Delhi got an approval for Quality Healthcare for all scheme from the L-G. Under this scheme, the government of Delhi will ensure that patients coming to its hospitals receive 13 high-end diagnostic tests for free at selected private centres which are not provided at the Delhi government hospitals[14]. The government has also tied up with private hospitals for surgeries where patients can be referred to these hospitals from the government hospitals if their surgery is scheduled after one month or more.

One of the major drawbacks of these schemes is that these schemes focus only on inpatient services, only on secondary health services but majority of the patients require outpatient services which are not covered under any of the schemes. Although medical insurance is a necessity in today's fast moving urban life, very few are medically secure in India.

It is evident from the data that only five per cent of the patients who were interviewed were medically insured and are covered under one or other insurance scheme and a large number of patients, approximately 95 per cent, were uninsured. The minorities and poor have to bear an unnecessary medical expenditure in the absence of insurance. With such low health insurance coverage, the free health services provided by the Mohalla clinics immensely help the uninsured population in reducing the financial burden on health especially in low and middle-income households.

[14] https://www.hindustantimes.com/delhi-news/delhi-scheme-for-quality-healthcare-cleared-here-is-all-you-need-to-know/story-iggxuwRGJ5snSG23rVHIML.html (last accessed on January 17, 2018)

5.2 Pathways of Treatment

In order to understand the health-seeking behaviour and pathways of treatment of the patients, it is important to understand their preference of treatment before and after coming up of Mohalla clinics. It is evident from the figure 5.1 that almost half i.e. 42 per cent of the patients used to go to the public hospitals before coming up of Mohalla clinics. Figure 5.2 clearly shows that after coming up of Mohalla clinics 82 per cent of patients started coming to these clinics. It can be assumed that Mohalla clinics have reduced patients' load in big government hospitals.

Figure: 5.1

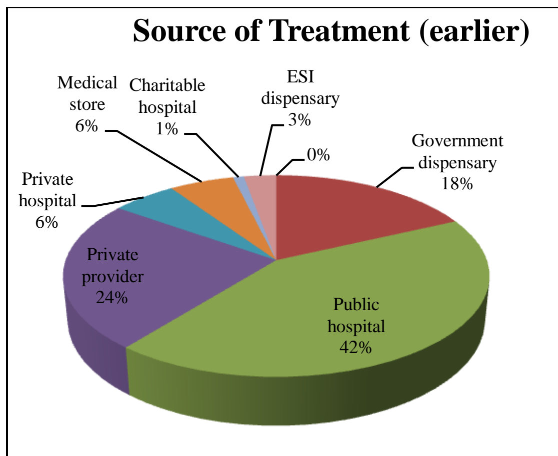
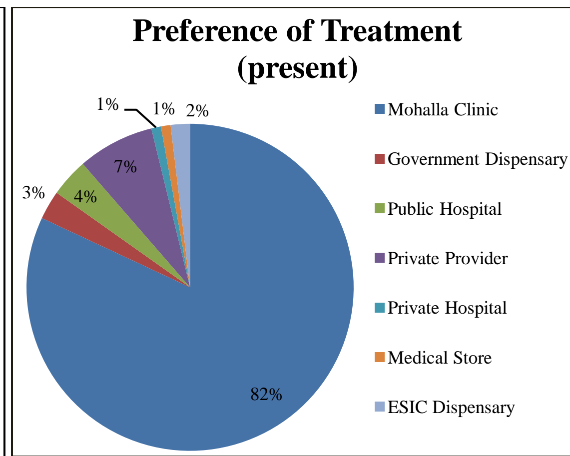


Figure: 5.2



The patients instead of overloading the government hospitals for minor ailments or going to unqualified quacks are now coming to these clinics for their treatment. The other reasons cited by the patients for preferring Mohalla clinics over government hospitals/dispensaries were no transportation and opportunity cost, no wastage of time in traveling and no long queues to seek consultation, availability of consultation, diagnostics (tests only) and medicines under one roof at the clinic level. As Dreze and Sen also mentioned "the government facilities, especially hospitals are in fact not synonymous with free or inexpensive care as they are commonly understood to be. While the consultation is mostly free in such a facility, the other costs associated with treatment of a particular illness can be quite substantial" (Dreze and Sen, 1995 cited in Gupta and Dasgupta, 2013). Many other studies show that the average expenditure associated with government hospitals is higher than the private registered clinics (Gupta and Dasgupta,

2013). But instead of higher expenditure in private clinics, people prefer them. This preference for private providers exists irrespective of the economic class which point out that there are serious problems in the quality of the public health care delivery system, especially at the level of curative care.

After coming up of these clinics, the patients don't have to spend unnecessarily and don't have to go from counter to counter to get consultation, blood test and medicines. Till now 158 Mohalla clinics have come up under this project but there is a need to fully implement this project and achieve the target of 1000 Mohalla clinics in Delhi to expand coverage.

Another important point to highlight here is the reduction in private practice. It has been observed that the private health care had been the dominant mode of provision in urban slums because of their wide presence in Delhi but it is mostly accessible for the poor because of its high cost. Before coming up of Mohalla clinics, private health providers contribute a significant share around 24 per cent in care provisioning. But after the establishment of Mohalla clinics (in the areas visited by the researcher), there is a significant decline in private practice meaning now only seven per cent of the patients are using services of private providers.

Patients who seek care from private health service provider gave many reasons from ease of access to perceived quality of the services for preferring private health providers. As per the patients, the public healthcare system is seen as comparatively inaccessible. Being physically more accessible, people prefer using services provided from private providers rather than seeking care from public health facilities which is far from their locality and where time, travel and opportunity costs are higher.

The data on preference for private health facilities (earlier) show that 24 per cent of the people used to visit private health facilities as the facility was easily accessible and they can walk to the facility anytime. This also indicates the unavailability of public health facility in their vicinity which drives them to seek care from private health providers.

Long distance to reach public health facilities makes life challenging especially for those who are poor and forced to seek health care from the private health providers.

Despite the existing network of health centers, dispensaries, and mobile clinics, poor prefer private facilities which raise questions about the quality of services within this network. Another important reason mentioned by the patients (during their interviews) for preferring private healthcare providers is that the patients are not satisfied with government doctors and the services provided in government hospitals. But with the introduction of Mohalla clinics, not only the private practice had reduced but the visits to government hospitals have also reduced.

These findings get reinforced after the researcher visited to the nearby private practitioners. The private practitioners/quacks/*Bengali* doctor highlighted that there is a serious decline in the number of patients coming to their clinics. As per the doctors/helpers, there is up to 70 per cent of reduction in patient inflow to their clinics. They said in the interview that the patients, who come to these clinics, come only in the evening hours or in case of any emergency as Mohalla clinics run only in the morning hours. Now, the patients prefer to come to Mohalla clinics because of the easy accessibility, free services, and less waiting time in the clinic. Additionally, there is immense reduction in amount of travel time and risk of overcrowding in the government health facilities.

Now, the poorest of the poor get access to the kind of treatment they never get at the government hospitals/dispensaries. As the disposable incomes of the lower and lower middle class are very limited so they have very less to spend on the private health services (from a qualified doctor). Therefore, they would prefer using public health services if it is in their vicinity and consultation, medication and diagnostics services are available without doing unnecessary expenditure.

Now, there is a shift of patients from overcrowded hospitals/dispensaries to less crowded Mohalla clinics. It is evident from the above figure that there is reduction in utilisation of government dispensaries after coming up of the Mohalla clinics. Earlier, 18 per cent of

patients used to go to the government dispensaries but the number has reduced to only three per cent. Patients now prefer coming to Mohalla clinics for minor ailments like cough, cold and fever instead of going directly to big hospitals/dispensaries.

Not only poor patients, but many rich patients have also started coming to Mohalla clinics to seek medical help from these clinics. This would force the government to maintain the standard of the services provided by these clinics. One of the reasons cited by the patients from upper class for preferring these clinics is less waiting time in the queue which in turn leads the doctor to spend sufficient time with each patient. Some of the elderly patients said that they get soothing effect in these clinics as they can freely share their problems with the doctors and get counseling from them. In contrast, the doctors in government hospitals don't have time to listen to them and counsel them in response. In the subsequent section an attempt had also been made to understand the quality of services provided by Mohalla clinics.

5.3 Quality of Services at Mohalla Clinics

With uneven distribution of essential services and obsolete infrastructure in India, ensuring access to healthcare services to every citizen is a distant dream. Also, affordable healthcare is a major blockade for urban poor and middle class people in Delhi. In order to ensure good health, Delhi Governments had introduced several interventions to make health services easily accessible and affordable to all sections of the population with a focus to reduce unnecessary financial expenditure on health and Mohalla clinics are one of those interventions. Mohalla clinics were established to provide easily accessible, affordable and quality health services closer to their homes. Mohalla clinics have been opened to provide hassle-free health services to all where the patients can avail the services at their doorstep (without travelling long distances to reach a government health facility) and without paying anything for using the services. These clinics tackle the health problems of the community within the community and make the life of people easy.

Mohalla clinics have generated a hope among the citizens of Delhi of having easily accessible quality healthcare which can have a potential to improve health of the people.

The quality of services provided by these clinics can be understood under the following themes:

- Type of Services Available
  - Free Consultation
  - Free Blood Test Facility
  - Free Medicines
- Access to Health Services
- Infrastructural Facilities
- Human Resource
- Patients' Satisfaction
  - Patient In-flow and Time Spent by Doctor per Patient
  - Patients' Waiting Time in Clinics v/s Waiting Time in Public Hospitals/Dispensaries
  - Behaviour of the Staff
- Patient Flow Management in the Clinic
- Record Maintenance
- Cleanliness in the Clinics
- Overall Perception of Patient about Mohalla Clinics

5.4 Type of Services Available

All the services i.e. consultation, diagnostic tests and medicines provided by Mohalla clinics are offered under one roof. These services are freely available for all. In the absence of these clinics, the patients would either go to the government dispensaries for consultation and then run around for consultation, medicines and diagnostic tests at different counters or spend unnecessary money in any private health facility.

Picture: 5.1 Services Provided by Mohalla Clinics

5.4.1 Free Consultation

Mohalla clinics are meant to provide primary health care to the patients. Being at the first level of the healthcare delivery system, the clinics provide immediate consultation to the patients. In the clinic, doctor screens the patients and takes a necessary step. The doctor either prescribes required medicines or refers the patient to a polyclinic, if needed, for further consultation and diagnosis. After coming-up of the Mohalla clinics, the process of consultation has become easier as earlier the patients had to wait for hours to seek doctor's consultation in government dispensaries/hospitals but now they get immediate medical attention from a qualified doctors.

The consultation done by the doctors is completely digital using a smart tab. Special software had been installed in the tab making the entire process paperless as well as environment friendly. The electronic tablet records patients' information like name, age, disease, medicines and tests prescribed in last visits including a photograph of each patient minimizes time wastage in searching patients' history in old records. There is an automatic prescription generation system which is connected through *Wi-Fi*. The prescription slip gets printed by a hand held device which has patients' details, name of the disease and prescribed medicines. The pharmacist dispenses the medicines written on the slip.

Picture: 5.2 Doctor Documenting Patient's Details on Smart Tab

This shows that use of technology has hugely reduced the time consumption in writing the prescription. The doctor can utilise the saved time in giving consultation to more patients. This system also helps in maintaining transparency and accountability during the course of treatment making the process of healthcare delivery more efficient.

5.4.2 Free Medicines

These clinics provide free medicines to the patients. A total of 136 essential generic drugs from are mentioned in the list. Doctors complained that these medicines are very less (the list should have more essential drugs) and sometimes even these medicines are not available. The doctors have been told to give only those medicines which are available in the list. In case if a particular medicine is not available then a substitute can be given.

One of the doctor, Doctor A, mentioned that the only benefit of these generic medicines is less chances of pilferage. All the doctors questioned the quality of medicines as these medicines are not as effective as the medicines available in the market. All the doctors were unsatisfied with the listed medicines as they have to restrict themselves to prescribe only those medicines mentioned in the list. The doctors also mentioned that out of listed medicines, many of the medicines are not available in the clinics and the doctors have to send the patients to the nearby dispensary for the medicines. One of the doctors sent many of the patients to the nearby dispensary by saying that *"dispensary me keh dena waha se madam ne bheja hai" ('tell in the dispensary that madam has sent'..).*

The doctors complained that there are some medicines which are very common but are not mentioned in the list for example medicine for skin diseases. Many of the patients come with fungal infection but there is no medicine for fungal infection in the mentioned list so the doctors have to give medicine from the available list which may or may not be as effective as the actual medicine. One of the doctors said that many patients come with the problem of *Chakkar* (head reeling) but there is no medicine for it in the list.

Another problem highlighted by the doctors is that they officially cannot prescribe medicines from outside even for the patients who can afford it. This is to prevent intrusion of private pharmaceutical companies in the government set-up. But as the researcher observed two out of 16 doctors prescribed medicines from medical store after patients' continuous request for an effective medicine, observing patient's affordability and consent to buy medicines from medical store. The doctor wrote the name of the disease and medicine on a *parchi* (slip) of Delhi Government Dispensary. In other case, the paramedic staff asked the patient to buy ORS packet from medical store as these were not available in the clinic.

The MTW or helping staff maintains a buffer stock of the medicines to prevent shortage of medicines. They order the medicines before they finish off. The doctors mentioned that generally they order medicines after every 10-15 days. An indent is prepared which mentions the name of the medicines and quantity required. The MTW has to go to the Nodal dispensary with the indent to get these medicines. Sometimes they get full list of medicines and sometimes they don't. One of the doctor, Doctor A, said because of the shortage of medicines, he has to give medicines for a week only to the patients who require one month medicine like in case of patients with diabetes and BP.

The cases mentioned above are an example of poor management of the stock. ORS is very basic minimum requirement for any government health facility; if it is not available in the Mohalla clinic then the whole concept of primary health care is lost. Also, the medicines for diabetes and BP should be available in large quantities looking at the increasing number of these diseases.

Picture: 5.3 Medicine Dispensing Machine

One of the clinics visited, had an automatic medicine dispensing machine making the process convenient both for the patients as well as staff. The machine was installed by USAID and WISH Foundation. The medicine dispensing machine has the space for 150 medicines as per the doctor. Once the prescription is generated, the doctor gives command to the dispensing machine and the medicine comes out and falls in the box under the machine. The machine also has a feature for self-depletion of medicine stock which saves lot time of the pharmacist which can be utilised for some other purposes.

As per the doctor, technology has made the process of consultation hassle-free. But the doctor also mentioned that this dispensing machine has some limitations. The important one is that the machine cannot dispense less than a strip of 10 tablets in case a patient requires less than 10 tablets. This machine has only those medicines which have to be given in a strip of 10 tablets only like medicines for the diabetics and blood pressure.
Only five out of 158 clinics have this medicine dispensing machine but the machine is not functional in other clinics.

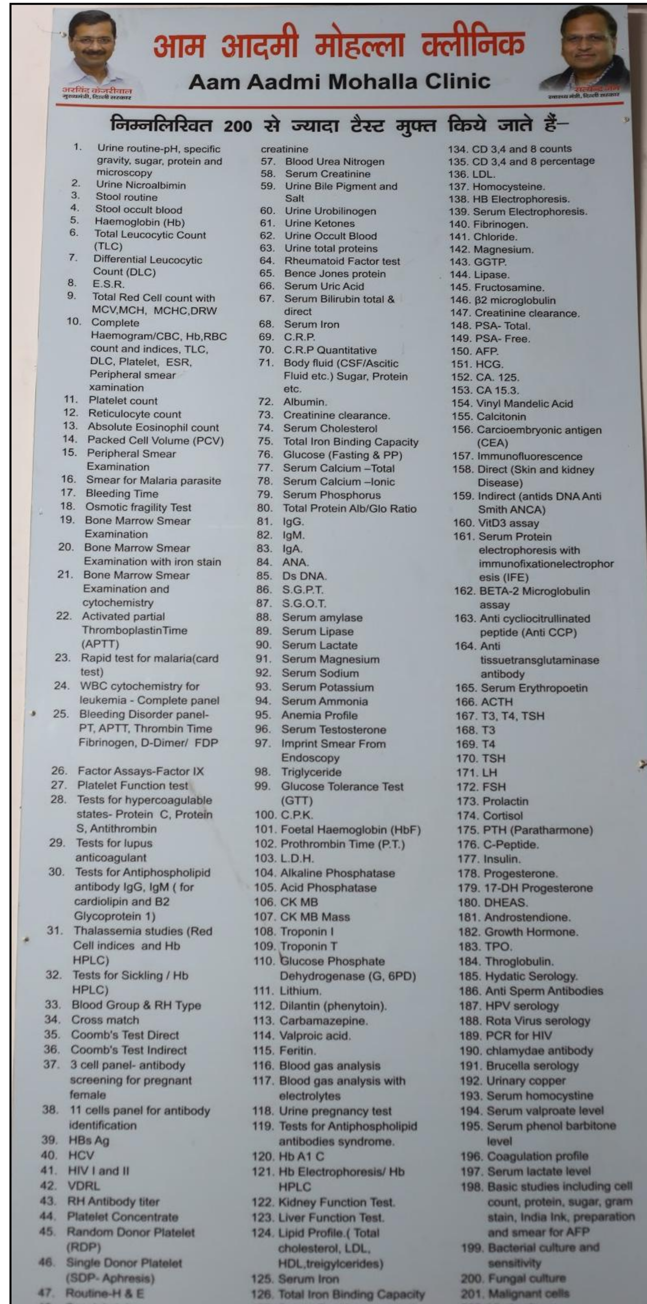
5.4.3 Free Blood Test Facility

As discussed Mohalla clinics offer free services; free consultation, free diagnosis and free medicines. As per the doctors only 25-30 tests are available out of 212 tests mentioned in the list. One out of 16 clinics visited by the researcher didn't have the blood testing facility because of its proximity to the other Mohalla clinic (bigger one). The patients are sent to the other Mohalla clinic which is half to one km. away from this clinic for the blood tests.

Many of the patients come only for the blood tests especially the middle class people. In one of situated in a high socioeconomic colony, many patients from upper class also come for the regular check-ups for BP and blood tests for diabetes and thyroid etc. The doctors in the clinics complained that these patients go to the private doctors for consultation and come to Mohalla clinics for tests prescribed by them in order to save money. All the doctors do blood tests prescribed either by public or private doctors except one. They said that one of the aims of the Mohalla clinic is reduce unnecessary financial burden on patients be it a rich or a poor patient. But sometimes this adds to more problems in identifying who are in real need of these tests. Some patients (especially the educated ones) come without any prescription, tell some random symptoms and ask the doctor to do the blood test especially diabetes, thyroid and Vitamin D test. In this case, it becomes the responsibility of the doctor to assess the patients carefully and then prescribe the tests accordingly without influenced by patient's suggestions.

One of the doctors clearly denied for the blood tests referred by a private doctor as those tests were very expensive. The doctor said that she can't do these tests without a referral from a public hospital. Another reason she gave was that those tests should be prescribed by a specialist only as she is not a specialist, she cannot ask her staff to do the tests. She added that she cannot prescribe those tests without giving any treatment before in the first visit only.

Figure: 5.4 List of Free Blood Test in Mohalla Clinics



In one of the clinics, even the small sugar testing strip was not there since last 15 days. The doctor denied the patient who came for the blood sugar test saying that *"abhi sugar test karne wali strips khatam ho gayi hain jab aa jayengi to kara lena" ('the strips for testing sugar level are not available, when they are available you can get it checked'..)*

5.5 Improvement in Accessibility to Health Services

The inequalities are vivid in terms of access to quality and affordable health services especially among the people living in urban slums, *JJ* clusters and unauthorized colonies. The population living in these colonies is most vulnerable and exposed to many health problems because of the kind of environment in which they live. With poor living conditions, no backup savings, food stocks, or social support system, their vulnerability to illness increases multiple folds. Despite the presence of government hospitals and other health care facilities in the urban areas, the slum dwellers have limited access to these facilities (Gupta and Guin, 2015, p. 246). In spite of the fact that they are the ones who are in need of the health services most, they are not able to utilize even the available health services. Although they often live very close to health facility but generally they have little or no access to quality care.

Now, the scenario has changed after coming up of the Mohalla clinics. All the patients agreed that these clinics have improved access to the health services. The major users among them are those sections of the society who didn't have access to health services earlier. It is noteworthy that the women are the major users of these clinics who earlier used to neglect their health problems because of lack of access to affordable health services in their proximity or lack of time to visit any public hospital or dependency on other family members to take them to the hospitals.

One important observation was because of the presence of female doctors in seven clinics, many women came with gynecological problems which the researcher didn't see in other clinics (where the doctors were male). The doctors there also gave family planning counseling to the woman patients and inform about them about the family planning methods.

Elderly population is one of the most vulnerable sections of the society as they are more prone to fall sick because of their age. These clinics are highly beneficial for them as their dependency on their family members have reduced. Access to health care services for the elderly patients had improved as they are now less dependent on their family

members to visit the health facility. They can directly come to the clinic on their own for their routine check-up, blood tests and regular medicines.

5.6 Status of Infrastructural Facilities

The infrastructure of government health facilities in India is in dismal state, it needs drastic transformation to tackle the emerging challenges and deal with the double burden of diseases (communicable as well as non-communicable diseases). The government hospitals face the problem of lack of resources and infrastructure; there are inadequate numbers of beds, rooms, and medicines. The existing dispensaries in Delhi have comparatively good infrastructure but utilisation of the services has remained poor. The reasons for under-utilization of the services are no clarity on scope of service provision, lack of human resources and other factors. Moreover, the geographical distribution of these dispensaries is not optimal and often these are located close to other specialised health facilities, which are preferred by people. Therefore, the dispensaries, at least in current form, have proven largely inefficient and ineffective[15] (though it would not be right to generalize).

Based on the observations from the field it was found that the clinics have been established in one or two room setting. Out of 16 clinics visited by the researcher, nine clinics have two rooms, five clinics have one room and two clinics have three rooms.

The clinics which had only one room, staff members in that clinic were very frustrated and dissatisfied with the infrastructural facilities in the clinic. The clinics didn't even have proper sitting space for the staff members as well as for the patients. The single room is used by the doctor to examine the patients as well as to keep the medicines. The clinics didn't have an almirah to store the medicines. The medicines were lying on the floor. The same room was used for sample collection. In one of the clinics, Clinic 4, the lab technician was drawing blood sample in standing position.

All the clinics have waiting space with chairs for the patients to sit except the two. In the clinics which don't have separate waiting space, the patients have to sit in the assessment

[15] https://qrius.com/how-successful-was-the-mohalla-clinics-project-by-delhi-government/ (last accessed on June 12, 2018)

room. Sometimes it becomes uncomfortable for the patients to describe their problems in front of other patients. Even in the clinics where there is separate waiting space, the space is insufficient. 13 per cent of the patients complained about the lack of proper waiting room and insufficient space in the clinics. The patients complained that many times they have to stand outside the clinic. All the doctors and staff members in the clinics also complained about lack of space except one where the clinic was very spacious with three rooms. The doctor in the above mentioned clinic was fully satisfied with the infrastructural facilities available in the clinic.

5.7 Human Resource

Health personnel refer to the people employed in a health institution which include medical, para-medical as well as the helpers and multitask workers. To provide quality health service provided to the patients, it is important to have knowledgeable and experienced doctors, and other para-medical staff. Inadequacy of health personnel has always be a problem in Indian health system. There is always a gap between the required staff and the deployed staff in the government health facilities.

As it was shown in the earlier chapters, there is a shortage of staff in MCD dispensaries as well as in state government hospitals and dispensaries. Municipal Corporation of Delhi (MCD) has extremely high shortage of staff in Medical (40 per cent) as well as in para-medical (45 per cent) positions. State Government hospitals and dispensaries also have shortage in Medical positions (25 per cent) and paramedical (31 per cent) positions (Praja Foundation, 2017). Dearth of staff in the healthcare system has a direct impact on the quality of services provided by the government health facilities. Delhi has higher number of doctors and other staff per 1000 population (Lahariya, 2017) but this number is more skewed towards private health facilities. Mohalla clinics have been opened to meet the health needs of the patients and to overcome the shortage of staff by recruiting more doctors.

Nine out of 16 clinics have three staff members, six clinics have four staff members and only one clinic has six staff members including doctor. In the clinics with two staff members (other than doctors), the doctors grumbled about the lack of sufficient staff.

Because of shortage of the pharmacists in many clinics, untrained staffs/Multitask workers (MTWs) are disbursing medicines. Only one clinic has professional pharmacist and in other clinics the helpers or MTWs after providing after some training disburse medicines. Because they can be appointed on lower remuneration than the professional pharmacists, the doctors said it is feasible for appointing MTWs instead of professional pharmacist. Similar is the case with lab technicians. The helpers had been given training to draw blood sample so that they don't have to employ professional lab tech. This is an unethical practice in medical profession. On the one hand, these clinics are helping people to get rid of their diseases, on the other hand risking their lives.

In three out of 16 clinics, ANM are given duty of disbursing the medicines to the patients. Instead of performing their usual duties like field visits and family planning counseling etc, they are engaged in such activities for which they are not trained. In one of the clinics, the MTW (who does the cleaning of the clinic) was disbursing medicines in the absence of the helper (who works as pharmacist in the clinic). While sitting in the clinic, the researcher observed that she gave wrong medicine to one patient by mistake but fortunately doctor saw it and changed it on the spot.

It is evident from the above data that there is no uniformity in the staff recruitment in the Mohalla clinics. Every clinic has different staff structure. In the absence of sufficient human resources, the existing staffs will start feeling overloaded (as the number of patients is increasing day by day). Soon, these clinics will behave like the other government institutions which would directly impact the service delivery.

Also, in the absence of professional and trained staff, these clinics are putting people's lives at risk. As per the researcher there is a need for uniformity in staff recruitment in all the clinics. There is an urgent need of a professional pharmacist and phlebotomist to provide quality services to the patients availing Mohalla clinics.

5.8 Patients' Satisfaction

Patient satisfaction is totally dependent on service quality which conforms to the needs and requirements of the patient. Better the service conformance to the needs and requirements of the patients, the healthier is the service quality and therefore the more is

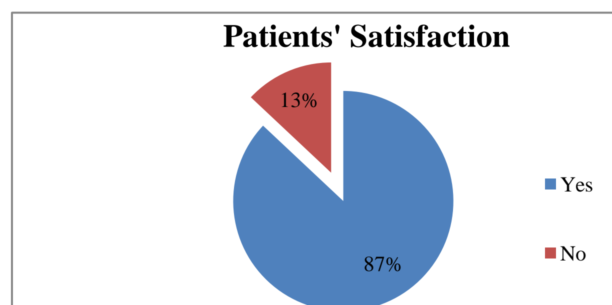
the patient satisfaction and loyalty (Chahal and Kumari, 2010, cited in Maqsood et. al., 2017). Based on the data from the field, patients' level of satisfaction can be understood on the following basis:

- Patient In-flow and Time Spent by Doctor per Patient in Mohalla clinic
- Patients' Waiting Time in Clinic v/s Waiting Time in Public Hospitals
- Behaviour of the Doctors and other Paramedic Staffs in Clinic

Out of all the patients interviewed during the field work, 87 per cent of them said that the services provided by the Mohalla clinics are sufficient and fully satisfactory. They are contented as these clinics had been started in their locality as it is clearly shown in the figure given below. The patients were happy and said that whatever services they are getting are sufficient because earlier they didn't have access to basic services. They had to go to the public hospitals even for the minor ailments like cough and fever. The patients highlighted the challenges in availing services of a government health facility. One of the patients said seeking care at government hospitals is not an easy task. Now, they are getting all the services in their neighbourhood without wastage of time and money.

The remaining 13 per cent of the patients said that services provided by the Mohalla clinics are not sufficient. The reasons given by the patients were: lack of emergency services, OPD timings are not sufficient (from 8 Am. to 2 Pm.), lack of space, no proper first-aid facility and no ambulance services at the clinics. The patient also suggested that there should be a facility for admission in the clinic so that the patient can be stabilized in case of an emergency before referring to the higher level facility.

Figure: 5.3



Above all, it was found that a significant number of the patients feel that they are happy with the services provided by the Mohalla clinic because what they wanted they are getting. Now, for them receiving care at the government health facility becomes hassle-free and at no cost.

5.8.1 Patient In-flow and Time Spent by Doctor per Patient

Mohalla Clinics have added an additional level to the existing healthcare delivery system. Now, these clinics serve as the first contact point for the citizens of Delhi offering basic health services for the minor ailments at the doorstep of the patients. It has been found during the field visits that each clinic has an average patient inflow of 125 patients per day which is a substantial number in a four to six hours OPD time. Only one clinic has a very low patient inflow approximately 70-80 patients per day. The reasons could be its location (as it is at the periphery of the city), population size of the village and existence of big army hospital in their vicinity. All the doctors mentioned that number of patients may vary depending upon the weather conditions. For example, the doctors get more patients in rainy season because of high incidence of dengue, malaria in rainy season. Also, they get more cold and flu patients in winter.

Taking an average of 125 patients per day, if the time spent by a doctor per patient is calculated it comes out to be less than two minutes which is not sufficient to understand patient's problem and prescribe required treatment plan. Such a short consultation time is likely to adversely affect patient care and also increases the stress of the doctor.

There are several reasons why the doctors take less time per patient. One reason could be that the doctor already knew the patient's problem. This is possible in the cases of regular patients who come for regular check-ups and taking routine medicines especially diabetic and BP patients. In contrast, if a new patient comes it takes longer for the doctor to take his/her history, to create his/her profile, to understand his/her problem and generate a prescription. Based on the field work, in only five out of 16 clinics doctors listen to the patients' problems and symptoms carefully and then prescribes the medicines. These five clinics appear to be functioning efficiently and smoothly. As the doctors listen to people patiently and attend to their problems, the satisfaction level of the patients coming to

these clinics is quite high. But in other clinic doctors prescribe the medicines without properly and completely listening to the patients' problems. But patients were still happy (comparatively less satisfied than the other clinics mentioned above) as they are getting free medicines and blood tests.

Another reason is wastage of time in data entry in the smart tab if the doctors are not tech savvy. This reduces the overall time spent by doctor per patient as they waste so much time in data entry. In that case it becomes necessary to give training to the helper or MTW (who have some understanding and command over technology) to make entries in the tab to avoid wastage of doctor's crucial time in understanding the technology. In almost all the clinic except four clinics data entry is done by helper or multitask worker which saves a lot of time of doctors which can be utilised to see more patients and understand their problems carefully. In those clinics, it was found that the helper or the MTW is more efficient than the doctor in using the smart tab, taking out patients' history and making new entries.

The study published in a medical journal on consulting time says that India is listed among the worst in consulting time. In stark contrast, consultation time in first world countries like USA, Sweden and Norway is more than 20 minutes on an average[16]. Mohalla clinics have the potential to tackle this problem if proper soft skill building training is provided to the doctors and other staff members. This training should include developing soft spoken and good listening skill. Mohalla clinics are designed to break the barrier and hierarchy between the doctor and patients and this barrier will break only and only when patients will be given time to ventilate their feelings and share their problems in front of the doctor. For this to happen these skills are the prerequisite, otherwise the AAP's motto of opening these clinics in the community will be lost.

5.8.2 Patients' Waiting Time in the Clinics v/s Waiting Time in Public Hospitals

Patient's waiting time is one of the important factors to measure patient satisfaction and quality of care. The time a patient waits in the clinic before being seen by one of the

[16] https://www.outlookindia.com/website/story/indian-doctors-only-spend-2-minutes-with-patients-which-is-among-the-worst-in-th/304118 (last accessed on November 9, 2017)

clinic medical staff is refer to as the waiting time. Patient's clinic waiting time is an important indicator of quality of services offered by hospitals (Patel and Patel, 2017, p. 858). The amount of time a patient spends in the OPD of a hospital is one of the important factors which determine the utilization of healthcare services. Long waiting hours in OPD is one of the barriers to utilize the available healthcare services in the public hospitals.

Patients spend significant amount of time in the public health facility waiting for consultation and other services to be delivered by health professionals. As per the findings from the field, 33.3 per cent of the patients visited public hospital in the last six months. On being asked about the number of hours spent in the hospital, all the patients said that they spend minimum four to five hours in the hospital. Remaining 66.7 per cent of the patients didn't visit any government hospital in the last six months (as they didn't suffer from any serious ailment). They suffer minor ailments, for which they seek care either from the nearby Mohalla clinics or nearby private health providers.

Figure: 5.4

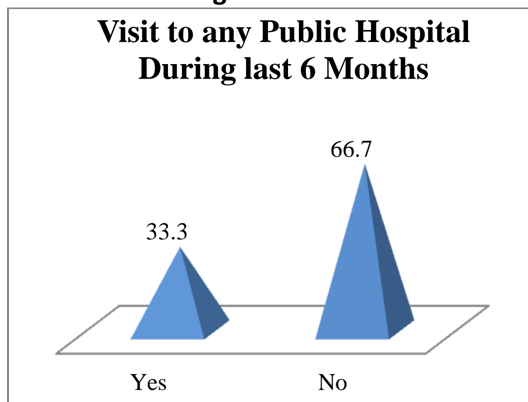
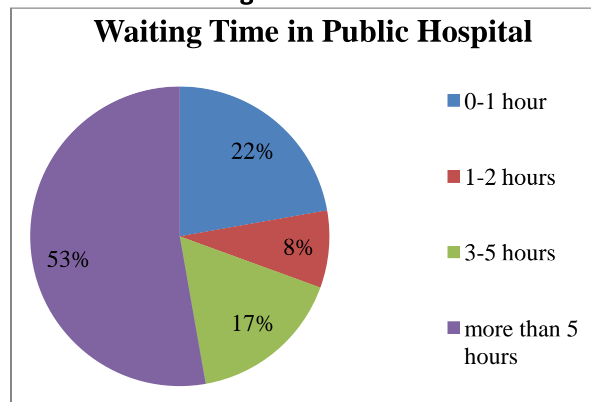


Figure: 5.5

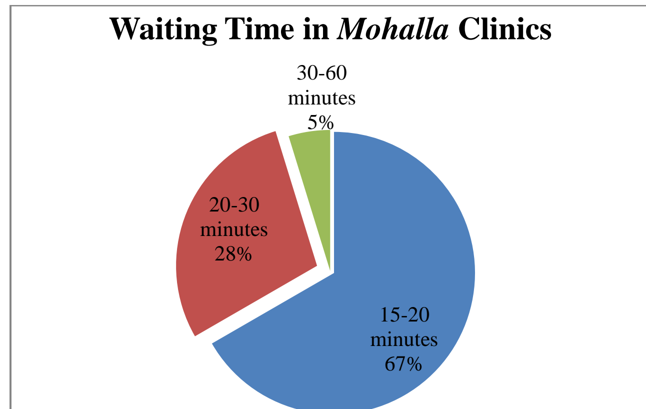


Long waiting time is frustrating for the patients as well as for the doctor. One of the important reasons why people prefer Mohalla clinics is the enormous reduction in waiting time. The waiting time is hugely depends upon the patient load in the clinic. Most of the patients started coming around 10 Am. and then there is a sudden increase in number of patients in the clinic. As mentioned earlier also, these are the patients who finish their work around 10 A.m. (mostly women patients) and come to the clinic. That time they

have to wait for longer time than usual. As the number of patients is very less in the early morning hours (8-10 Am.) patients spend less time in the clinic.

On being asked about the time spent in Mohalla clinics, 67 per cent of the patients said that they spend only 15-20 minutes in the clinic. This time includes waiting time, consultation time and time spent in getting the medicines.

Figure: 5.6



It is apparent from figure 5.6 that 28 per cent of the patients said that they spend 20-30 minutes in the clinic. Only five per cent of the patients said that they spend 30-60 minutes in the clinic. It is important to note here that these are the clinics where the OPD patient inflow is higher than the other clinics because of its locality or the doctor in those clinics spends sufficient time with the patients asking about their previous history and current health problem.

To conclude this, it can be said that there is huge reduction in patients' waiting time in Mohalla clinics as compare to the government hospitals. This is one of the reasons for their high popularity and acceptability for government health facilities among the users.

5.8.3 Behaviour of Doctor and other Paramedic Staff

As mentioned earlier also, patient satisfaction depends upon the quality of services provided by a clinic/hospital. Behaviour of the doctors and other paramedic staff is one of the determinants to understand the quality of services provided by any health facility. Patients would be satisfied if the health care providers like doctors and paramedical staff

are moral in performing their duties and respond to them politely after listening to their problems carefully.

Patients in most of the clinics i.e. 14 out of 16 clinics visited were happy and satisfied with the behaviour of the staff. Many of them said that *"madam, dactor bade achhe hain dhyan se humari baat sunte hain or acchi dawai bhi dete hain. Sarkari aspatal me to dactor adhi pareshani sunte hi dawai likh dete hain or bhej dete hain"('madam, doctor is very good. He listens to our problems carefully and gives good medicines. Doctors in government hospitals listen only half of the problems write down the prescription and send the patients'.)*

The patients had full confidence and trust in the doctors of Mohalla clinics. They share their disease or symptoms with the doctors comfortably without any inhibitions (except some women patients who feel uncomfortable while sharing their gynecological problems with male doctors). In one of the case, a 16 years old girl was very hesitant in sharing her problem of hemorrhoids with a male doctor. She explained her problem to the doctor in a very low voice but the doctor understood her problem and prescribed her medicines. One of the reasons for this hesitation could be the lack of separate examination room. In the absence of a separate assessment room, the patients miss out some important symptoms which could lead to incomplete treatment.

On the other hand, the patients said that sometimes they share their personal problems with the doctors. Elderly patients said that they feel relaxed after sharing their problems with the doctor. In response to this, the doctor listens to the patients carefully and counsels them (if required). The patients have developed trust and confidence in the doctor over a period of time because of their presence in the community.

Because of their popularity, some of the patients also brought their relatives/friends for their treatment at Mohalla clinic. In one case, a patient brought her sister from UP for her treatment of scabies. The patient said that *"hume dactor sahib par vishwas hai isliye hum apni behen ka ilaaj karane use yaha le kar aye hain" (I have trust on the doctor that is why I have brought my sister here for treatment").* In another case, a patient brought her sister to the Mohalla clinic for consultation regarding her infertility.

Patients from remaining two clinics complained about the behaviour of the doctor and other paramedic staff. "Rude behaviour" and "shouting" are the words used by the patients to define the doctors' behaviour. *"Madam, ye doctor itna chillati hai na kya batayein"('madam, the doctor shouted so much what to say').* They come to Mohalla clinic only because they get free treatment without wastage of too much of time. In these clinics, there is a need for the doctors and other staff members to learn how to be empathetic with the patients who are not in a best of their health which would help in improving quality of the services and ultimately the patients' level of satisfaction.

5.9 Record Maintenance

Comprehensive medical record keeping is a foundation in providing efficient and quality patient care as it can provide an entire chronology of events including patients' details, type of illness, diagnostic tests suggested, treatment given and plans for future care. A well-defined medical record provides the history and current state of care pathways of a patient. Record maintenance is one of the time consuming tasks for the health care staff in any health facility.

After introduction of smart tab in the Mohalla clinics, it has reduced the time consumption in keeping patients' data. The doctor keeps the record of the patients in a tab which has special software installed in it. The tab can keep the record of a patient for the last one year. The tab has personal details of the patients, vitals recorded in the last visit, consultation, diagnosis, treatment received and reports of the tests if performed in the last visits. The tab has the photograph of the patient taken during the first visit. The tab also has enough inputs related to health and other determinants. For the registration of a new patient, personal details along with a photograph were taken. The patient's history can be taken out easily in the next visit by knowing his/her name and any of the details mentioned above. After the diagnosis is done, an automatic prescription will generate on the basis of which medicines are disbursed by the assisting staff.

Technology had made the task of record keeping easier and hassle-free and reduced the need for additional human resources. One of the doctors said that she used to write 80-90 reports at the end of the month when she was in a Delhi Government Dispensary (DGD)

but here she has to send only 5-6 small reports that too only through the tab only. This has saved crucial time of the doctors which could be utilised for some constructive work like seeing more patients and giving health education to the patients.

In 11 out of 16 clinics, doctors/helpers use smart tablet for recording patients' data. It was found that in 90 per cent of the clinics data have been entered in the tablet by the helpers or the MTWs. Remaining four clinics use a register to maintain the patients' record. The reasons given by these four clinics were: tablet was stolen few days back, it is not working since last few months and in the other two clinics (porta-cabin) the doctors have never used the tablets. In one of the clinics, the doctor was writing the details on a piece of paper as she said that she is not tech savvy but her helper will do the entry in the tab later. It was found that the clinics which were established in the second round haven't received their smart tab yet and they are still using the old method for record keeping. Here again comes the issue of non-uniformity as some of the clinics using smart tab and some using manual record keeping methods. Looking at the benefits of digitalized data, there is a need to equip all the clinics with smart tab so that the data could be utilised in a purposeful way.

The digital data gives quick access to patients' information and treatment pathways in a readily accessible form. This system can reduce the burden on the health staff in maintaining the patients' record. Earlier a substantial amount of their time was spent in patients' data collection and its management etc. In addition, automation had reduced the possible number of human errors during data entry. Also, as the smart tab ensures health data collection at a population level, the data can be aggregated at the state level and analysed for situational analysis and influencing financing decisions[17]. This data will help the policy makers to devise strategies to improve health status of the population.

5.10 Patient Flow Management in Clinics

The patients' management in any health facility must be the core of the process of healthcare delivery system. A well-organised management of patients' flow ensures that

[17] http://globalhealthgovernance.org/blog/2017/4/3/mohalla-clinics-in-india-a-scalable-model-for-achieving-universal-health-coverage (last accessed on August 24, 2017)

every patient receives timely and high-quality care. Efficient patient flow management remains a pressing issue for most health facilities especially in the government ones.

Based on the field work it was found that only one clinic out of 16 clinics distributes token to avoid chaos among the patients for their turn. The helper distributes the token and patients come according to their token number. Token distribution has an advantage as well as disadvantage. The patients take the token to their home, and come back to clinic after finishing their work so that they don’t have to wait in the clinic. One of the disadvantages is that this creates conflict among the patients because those who sit in the clinic and wait for their turn won’t allow the patients to come and see the doctor before them as they were sitting and waiting for their turn in the clinic itself.

In other clinics, there is no one to manage the patient flow. The patients see the doctor in the order they enter the clinic; the one who enters the clinic first will see the doctor first. In the absence of some mechanism, there is a probability of chaos among the patients as the dominant ones start managing the patients (as observed in the clinics) on their own and give orders to others. Sometimes the patients fight with the other patients and go directly to the doctor without waiting for their turn. A proper and efficient patient management system is very critical to improve the quality of health services provided by public health facilities. There is a need to devise some mechanism to avoid such problems and manage the patient flow efficiently.

5.11 Cleanliness in the Clinics

Cleanliness of the health facilities is one of the key components determining quality of care and patient’s satisfaction. Hygiene and cleanliness of the health facility is important in order to reduce the incidence and spreading of infections. In contrast, unclean and unhygienic environment is a risk to the health of population especially for diseased and already infected people. Additionally, inappropriate management of medical waste can have serious deleterious effects on the health of the people and environment.

As observed during the field work, the newly opened porta cabin clinics are cleaner than the older and rented ones. None of the clinic uses disinfectant procedures and scientific cleaning practices as it requires handsome amount of money for its implementation.

Four out of 16 clinics were sufficiently clean but not at par with the standards of hygiene and cleanliness maintained by private clinics/hospitals. Six were averagely clean and remaining clinics were dirty in terms of cleanliness of the floor, dust and garbage and medical waste. Those clinics were dirty not only from inside but garbage was also collected outside the clinics. There were open drains in front of two of the clinics. Poor hygienic condition in the clinics is detrimental to the safety and health of the patients. The concept of public health fails in such untidy and filthy environmental conditions prevailing inside and outside the clinics. Cleanliness practices would help the health care providers in providing safe and effective care to the patients.

5.12 Summary

Undoubtedly, Mohalla clinics have an undeniable role in changing the health-seeking behaviour of the patients. These clinics are boon especially for women, children and elderly population. This indicates that these clinics being present in the community have improved access to health care for vulnerable population by delivering health services at their doorstep and saving lot of their travelling time. Earlier, it was very challenging for women to visit overcrowded government hospitals with their children and get consultation and treatment from there. Many women with gynecological problems come because of the presence of female doctors in the clinics which earlier they used to avoid. These clinics in a way cater to the health needs of the women as well as their children and thereby helped in improving their health status.

By providing healthcare services in the neighbourhood, the elderly population is also highly benefitted. This had reduced their dependency on their family members for minor ailments and routine check-ups. This can also help in treating many non-communicable diseases like diabetes and hypertension among this population. Appropriate preventive measures can be taken if the patients come in the early stage of their diseases.

One of the blockades to improve access for the women is the lack of separate examination room in the clinics. This could prevent the women from sharing their problem in front of the other patients. Space constraint is one of the major issues highlighted which was also highlighted by the doctors of the clinics which not only

hamper their day-to-day working but also create a barrier between doctor and patients to have an open discussion. Therefore, it is essential to have a separate assessment room so that the patients can share their problems with the doctor without hesitation.

Another important suggestion is to employ a gynecologist in the clinics which would encourage more women patients to come for their gynecological problems. Women avoid going to hospitals for such kind of problems as there is social stigma attached to it. Many of the health problems can be prevented and controlled by creating awareness about the diseases like HIV/AIDS, urinary tract infections and reproductive tract infections. Deployment of gynecologist in the clinics could help in providing health education and spreading awareness about common gynecological problems and their treatment.

There is a need to uniformalize the process of record maintenance by making it completely digitalized. This would help the doctors in preparing treatment plan as well the policy-makers in planning new policies and programs. Mohalla clinics can be proved as an effective intervention to expand health-care coverage of individuals who are disadvantaged, poor, women and elderly people with proper planning and implementation. The ultimate goal of the government should be to scale up the health coverage for all citizens and reach the unreached population of Delhi and these clinics have the potential to reach the unreached.

Chapter 6 - Perception of Doctors about Mohalla Clinics

6.1 Perception of Doctors about Mohalla Clinics

Perception of the person about his/her profession is very important for their job satisfaction and motivation to work. As health sector is labour intensive where quality of patient care services is directly related to worker's satisfaction with their job, motivation and their readiness to apply resources to the task at work place. For doctors, job satisfaction is of utmost importance because it is highly associated with the factors like patient relationships and time pressures associated with managed care[18]. In the government hospitals/dispensaries where there is no reward in return for the services provided by them (apart from their salaries), it becomes important to keep them motivated to work effectively and efficiently.

Mohalla clinics give the doctors an opportunity to work effectively and efficiently for a limited time period of time in a day (8 Am. to 2 Pm.) and get paid accordingly (number of patients seen per day) to keep them motivated. The doctors in these clinics provide first line treatment just like a private practitioner or a family physician in the locality. But one of the major differences was that the services provided by the doctors at the clinics are free of cost.

It was found in the literature review that access to primary healthcare is a major challenge for the urban poor and middle class people in Delhi. One of the doctors, Doctor A, in his interview said that opening up more dispensaries will lead to opening more pathways for pilferage, corruption and inefficiency so there is a need to look for alternate solutions to tackle this problem. Along with increasing budgetary spending on health, Mohalla clinic is one of the innovative ways to meet the health needs of the population of Delhi. The initiative of Mohalla clinics could bring attention towards the crumbling healthcare delivery system and to reform the primary healthcare in Delhi. This chapter is based on the perceptions and experiences of the doctors and other paramedic staffs working in the Mohalla clinics.

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[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5082489/ (last accessed on November 3, 2017)

The interviews were conducted in the 16 Mohalla clinics, three in the New Delhi and one in the East Delhi. All the 16 doctors were interviewed using an interview schedule. The paramedic staff (one from each clinic) was also interviewed formally as well as informally. Interview schedule was used to interview doctors and paramedic staffs. Open-ended questions were asked to seek more and more information from them. Researcher also asked them to share their frank opinion about these clinics so they don't need to give answers to the formal questions only.

6.1.1 Difference between Mohalla Clinics and Existing Health Facilities

One of the doctors, Dr. A (interviewed on November 11th, 2017) stated the difference between Mohalla clinics and other dispensaries; that these clinics provide services through active process as the health services are provided at the doorstep of community. Mohalla clinics are doing active management of the diseases starting from diagnosing to providing medical care by reaching the patients directly in their neighbourhood. On the other hand, in passive management of diseases patients either go to private doctors or visit any government health facility (depending upon the availability and socioeconomic status) for the treatment of diseases. By doing active management, these clinics have the potential to cease the process of disease progression and therefore control spreading of diseases.

One of the other differences between the other government health facilities and Mohalla clinics is that the hospitals form tip of an iceberg whereas Mohalla clinics form base of that iceberg. Mohalla clinics being present within the community can better understand the prevailing problems among the people and suggest appropriate solutions keeping in mind the socioeconomic, psychological, physical, political and environmental conditions of a particular community. Being present in communities, Mohalla clinics have given a platform to the health professionals and the policy makers to understand the communities and prevailing problems in the communities. On the basis of this understanding, appropriate strategies can be designed to tackle these problems. In addition, by studying the dynamic process of disease progression in a community, the health professionals can draft apt health policies and programs for the community.

Government hospital on the other hand is like a window through which the community and its problems can be seen but only from a superficial level. But the root cause of the problems cannot be understood until the government functionaries live within the community and be the part of the community. Mohalla clinics give this opportunity to the health professionals to stay in the community, diagnose the public health problems existing in the community and propose appropriate suggestions. Mohalla clinics allow the doctors to observe the disease phenomenon while sitting in the community via these clinics which help in preventing disease manifestation and progression. As 80-90 per cent of the diseases can be treated at Mohalla clinics itself, these clinics provide only primary level services so the doctors in these clinics are not experts or specialist who can treat fully manifested and severe diseases. But one of the major advantages of these clinics is the doctor can screen the patients in early stage of the disease as every disease has an incubation period which makes this early detection possible. After the early detection, appropriate referral can be made accordingly to the nearby polyclinic or secondary/tertiary hospital for specialised care (if needed). If these clinics function well, they can ease the burden on Delhi's health system, especially on the secondary and tertiary hospitals which are overloaded by patients with minor ailments like cough, cold and fever.

6.1.2 Early Diagnosis of Diseases

Mohalla clinics have a major contribution in early diagnosis of diseases. Patients come in initial stage of their disease (because of its proximity and affordability) which prevents the further progression of disease into a serious disease. It also reduces the chances of spreading the epidemic like conditions especially in case of communicable diseases.

In the absence of free outpatient care and health services people tend to neglect their illness till symptoms appear and develop into a serious disease. Also, by making sure that the patients get early treatment for their ailments, these clinics have the potential to reduce the risk of catastrophic expenditure when the disease gets fully manifested. Thereby by early diagnosing these clinics can reduce families' out-of-pocket expenditure on healthcare.

One of the doctors, Dr. A (interviewed on November 15th, 2017) cited an example of a cancer patient who came at Mohalla clinic in early stage of his disease, the doctor referred him to a specialised hospital for further treatment. He said that by early diagnosing, the doctor had increased life of the patient. In the absence of Mohalla clinics, this patient might not have visited a hospital with the early signs and symptoms which would lead to progression of disease to advance stage and finally delay in receiving treatment. The patient was really thankful to the doctor and he still visits the clinic to meet him. Many of the old patients come to the clinic not only to seek medical help but also to meet the doctor on personal basis.

6.1.3 Doctor-Patient Relationship

Mohalla clinics are designed to break barrier between doctor and patients. Because of the presence to the clinics in neighborhood, the doctors here are like friends of the community (not as a government official). The patients trust the doctors and share their problem with them without any hesitation. In response, they get emotional support along with the scientific advice from the doctors. Earlier, the patients used to take advice regarding their health problems from their family members, friends or relatives (which may or may not be appropriate) but now they can directly visit the qualified doctors sitting in their neighbourhood even for some random or minor symptoms. Doctors at the clinic have sufficient time to chat with the patients and ask the whereabouts unlike the doctors sitting in an impersonal setup like big government hospitals who don't spend sufficient time with the patients and treat them informally (and sometimes insensitively) just like their clients.

6.1.4 Reduction in Unscientific Advice, Quackery and Private Practice

Because of their presence in the locality, people preferred going to quacks/private practitioners before coming of Mohalla clinics. Private practitioners, being qualified doctors, are highly expensive that is out-of-reach of most of the Delhi's population. In contrast, quacks are highly affordable as they offer consultation and medicines in less than Rs. 100 so they were the major care providers in the low-socioeconomic colonies before coming up of these clinics.

These clinics have reduced private practice quackery and unscientific advice people take regarding the disease. Earlier, when there was no Mohalla clinic, the patients used to go to the unqualified quacks/ *Bengali* doctors and get inappropriate/incomplete treatment but after the expansion of Mohalla clinics, the number of quacks have reduced as one of the doctors, Dr. A mentioned in his interview (interviewed on October 28th, 2017) that the private practice and quackery has become zero in his area after coming up of the Mohalla clinics. It seems that the private practitioners and quacks curse Mohalla clinics because the patients started coming to these clinics instead of going to the private practitioners. All the doctors also accepted that there is a huge reduction in the quacks and private doctors in their areas.

6.1.5 Improved Access for Marginalised/Vulnerable Sections of the Society

One of the main advantages of these clinics is it has improved access to health services especially for the vulnerable and excluded sections of the society (as mentioned in earlier chapters). Women and people from lower middle and lower class form the major chunk of patients visiting these clinics. Women are now accessing and utilising the health services even for the minor symptoms. One of the doctors, Dr. A (interviewed on October 19th, 2017) clearly mentioned in his interview that if a mother comes to take the medicine of her child then she would also take medicine for herself even if the symptoms are minor (which they used to avoid earlier).

6.1.6 Understanding the Ecological Triad

A Public Health Doctor, Dr. A (interviewed on November 9th, 2017) explained there is an ecological triad in every community. A disease spreads when the three components; Host, Agent and Environment come in contact with each other. The three components are in complete isolation in elite communities but they closely interact in the low socio-economic communities making these communities more prone to infectious/ communicable diseases.

The doctor appreciated the role of technology in understanding this ecological triad. The smart tab has a great role to play in studying the ecological triad effortlessly. Genesis of disease, different stages of disease/disease pathogenesis can be studied separately using this smart tab. The data generated can be used to draw a spot map to understand the type

of persistent diseases in a particular community so that the precautionary measures can be taken to prevent them to occur in future. Also, the data can be linked with the other departments like water and sanitation to improve the overall health of the people.

6.1.7 Role of Technology

Technology plays a crucial role in minimizing the labour requirement for record keeping and dispensing medicines. The doctors appreciated the idea of using smart tab to record patients' data as it has reduced the requirement of additional human resources (except those who are not tech savvy or who are old and came after their retirement). In Delhi, where there is already a shortage of human resources in health sector, these smart tabs could help fulfilling this gap.

Also, with the coming up of these smart tabs, the government now has access to online health data of a patients that can help in devising preventive health strategies. As the burden has shifted from communicable to non-communicable diseases (NCDs) in India, this data will help in fighting non-communicable diseases. As most of the NCDs are preventable and controllable, a strong primary health care system can provide prompt and correct diagnosis to prepare a treatment plan. Use of these smart tabs had also reduced the wastage of time in extracting manual data.

Additionally, automatic medicine dispensing machine (where it is available) had reduced the requirement for pharmacist in the clinic as the medicines dispense automatically on the command of the doctor given by the smart tab. Therefore, there is an automatic updation of the medicine stock in the machine which has reduced the wastage time in maintaining the stock manually. But the doctor Dr. A (interviewed on October 18th, 2017) notified that these medicine dispensing machines are available only in five clinics and this is the only clinic which has fully functional machine. This is also the reason why this clinic is called as the "Model Mohalla clinic" as it has all the required feature of a model clinic. In the other clinics, either the machine is not working properly or the doctors are not using it.

6.1.8 Job Satisfaction

Job satisfaction among doctors is of major concern as it directly affects patient safety and health service quality[19]. Regarding the job satisfaction, all the doctors were satisfied with the work they are doing. One of the doctors Dr. A (interviewed on October 28th, 2017) said *"not only monetary benefit but working in these clinics gives mental satisfaction. He added, he feels like he is not only treating the patients for their diseases but also doing human service for them"*. Mohalla clinics provide dedicated services to the patients. One of the doctors, Dr. E (interviewed on December 28th, 2017) said that *"I am very satisfied with my job as I am doing something for which I have been sent to this planet. I have also worked in a private hospital but I never had such kind of satisfaction there because the private hospitals are making money but here I have mental contentment. I would love to continue with this job"*.

The doctors also added that they are getting satisfactory remuneration along with job contentment. All the other empanelled doctors were satisfied with the payment model i.e. per patient Rs. 30. On an average, a doctor sees 125 patients per day, so the overall response of the doctors with respect to the payment model was satisfactory. But the response of the one of the doctors' response, Dr. N (interviewed on January 9th, 2018) was not positive as the number of patients (70-80) he sees is very less as compare to the other clinics. As the doctors at Mohalla clinics are empanelled doctors, they are allowed to do private practice so he also does practice in the evening at his residence and has to depend on his income from it. All the other doctors also agreed that they do private practice in the evening hours. A doctor, Dr. B (interviewed on November 18th, 2017) who is a fresh medical graduate is even planning for higher studies; along with private practice he also studies in his spare time.

There is a need to devise mechanisms to keep the doctors motivated which would help in delivering good quality services. One designation-one pay could be one of the ways to tackle this problem.

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5082489/ (last accessed on November 3, 2017)

6.1.9 Shifting of Human Resource from Existing Dispensaries to Mohalla Clinics

Three of the clinics have doctors who had been shifted from Delhi Government Dispensary to Mohalla clinics. They had been shifted to Mohalla clinics because of lack of doctors for these clinics. These doctors get their regular salaries as an employee of Delhi government. They don't receive Rs. 30 per patient as the other doctors get. Three of them Dr. E, M and P (interviewed on January 2nd, 5th and 10th, 2018) were happy as they have to prepare few reports and work less as compare to they had to do in their respective dispensaries.

One of the paramedic staff, P 1 (interviewed on January 10th, 2018) who was working as a Public Health Nurse (PHN) in a dispensary earlier is now working as a pharmacist in the Mohalla clinic was not satisfied with the kind of work he is doing in the clinic. He said that he is over-qualified for dispensing medicines to the patients and this is one of the reasons why he was very frustrated with his job profile. He added that there is no reduction in patient load in hospitals as there is no new appointment of doctors and staff members for these clinics. The existing health facilities already lack health care providers, opening more facilities adds burden on the existing staff and develops frustration among them. Most of the doctors and staff members working in the government dispensaries/hospitals have been shifted to the Mohalla clinics so the problem remains the same.

He added that Mohalla clinics were not required at the first place in a place like Delhi as there are dispensaries after every one km. Delhi government had opened these clinics in hurry and haphazard manner to gain votes and win the MCD election. Rather than opening these clinics, the existing dispensaries could have given more funds and support so that they can become more functional and efficient. Now, these new clinics are draining the money which could have been utilised for the purpose of improving the condition of existing dispensaries.

It is clear from the above discussion doctors are very happy with this shifting as they have to do less work in these clinics but there is feeling of resentment among the other staff members as they have assigned job (in these clinics) which is not as per their job

profile. Instead of unloading the existing health facilities, these clinics are overloading the scarce human resources in those facilities.

6.1.10 Connecting Doctors (including specialists) Working in Mohalla Clinics

In an interview a doctor, Dr. A (interviewed on October 26th, 2017) mentioned that the doctors at Mohalla clinics are not specialists but only general physicians. In order to deal with this problem, they have created a Watsapp groups (which has some specialists) to seek their suggestions. The Health Minister is also a part of this group. If any doctor faces problem in advising or treating patients with a specific disease, they can post their query on the group regarding the disease. The concerned doctor/specialist posts his/her opinion on the group in response to the query.

The doctors also meet on the regular basis to discuss important issues related to Mohalla clinics and problems faced by doctors in delivering services in their respective clinics. But the doctor critiqued the approach of the meeting as these meeting are for name sake as nobody discusses about the important issues, the doctors and the ministers gather only to eat good food, he laughed after saying this. No important discussion happens on how to take these clinics forward.

The above discussion reflects that it is good to have connections among the doctors working in Mohalla clinics and their connections with the specialists and the minister. But there is a need to utilise these connections carefully and skillfully to take maximum advantage out of it. The meeting should be planned with proper agendas and outcomes then only these meetings could lead to fruitful policy decisions.

6.1.11 Working Experience at Mohalla Clinics

Overall, the doctors gave positive feedback regarding Mohalla clinics. All of them said that they have good working experience in these clinics as it gives a good exposure to them which they cannot have in their private practice. One of the doctors Dr. B mentioned (interviewed on November 25th, 2017) that he wouldn’t get such kind of experience in his private practice or while working in any private clinic/hospital. He gets to see more than 100 patients (which is a huge number) with different health problems every day in these clinics which he cannot expect in a private setting. He said that

treating patients suffering from different diseases, coming from different backgrounds and different States gives him a good exposure and great learning experience.

6.1.12 No Night Shifts and Limited Working Hours

One of the doctors, Dr. B (interviewed on November 18th, 2017) stated that he is happy that he doesn't have to do night shifts in these clinics as he had to do in a government hospital earlier. The clinic has a stipulated time i.e. from 8 Am. to 2 Pm. but these hours are flexible depending upon the number of patients coming to the clinic and will of the doctors. The doctor also mentioned that he never closes his clinic before 2:30-2:45 Pm. as his prime motto is to treat patients.

This demonstrates the hectic schedule of doctors in public hospitals with no added benefits. And here why doctors continue to see patients even after the stipulated time is the payment model. As the doctors get their payment on the basis of number of patients seen by them, they keep on seeing patients to increase the number of patients. On the one hand, it is good that patients receive medical care even after mentioned OPD hours but on the other hand there is a possibility of fudging of data. In desire of earning more and more, the doctors can increase the number of patients.

In order to deal with this problem there is a need to have proper monitoring system to prevent data fudging and maintain transparency. There should be some checks and balances to prevent misrepresentation of data which can be very dangerous for the health system in the long run.

6.1.13 Reduced burden in Secondary and Tertiary Care Hospitals

One of the aims for opening the Mohalla clinics was to reduce patient load in secondary and tertiary health facilities. It has been observed that many patients come to these higher level health facilities and overload them even for minor ailments like fever, cough and flu which can be treated at the primary level health facilities like dispensaries. Now, these clinics have added an additional layer to the health system of Delhi which has a potential to reduce patient load in the higher level public hospitals. The patients instead of going directly to the secondary or tertiary hospitals now come to these neighbourhood clinics for medical treatment of the minor ailments before going to these hospitals.

During the field work, it was found that every doctor and paramedic staff accepted that there is a huge reduction in the patient load in secondary and tertiary hospital after coming up of the Mohalla clinics. They agreed that now patients come to these clinics first and then referred to higher level hospitals if required. As per Mr. Satyender Jain, the Health Minister of Delhi, 90-95 per cent of the diseases can be treated outside these hospitals. By treating minor ailments outside these big hospitals, Mohalla clinics have freed the doctors at secondary and tertiary care hospitals to focus on serious diseases and surgeries.

But the overall impression of the doctors and paramedic staff was that there is 30-40 per cent reduction in patient load in secondary and tertiary care hospitals. All the doctors wanted this project of 1000 Mohalla clinics to be completed as soon as possible to make its effect more visible as only 158 clinics (currently functional) are not sufficient to achieve the targets to making the quality health care affordable and accessible to every citizen of Delhi.

6.2 Critical Views about Mohalla Clinics

6.2.1 Focus on Primary Level Care instead of Primary Health Care

"Effective primary health care is more than a simple summation of individual technological interventions. Its power resides in linking different departments and disciplines, integrating elements of disease management, stressing early prevention, and consequently maintaining public health. Primary health care not only deals with early signs and symptoms but it combines promotion and prevention of health in addition to providing care and cure for the diseases" (De Maeseneer et. al., 2008, p.538).

One of the major critiques of the Mohalla clinics highlighted by a public health doctor, Dr. A (interviewed on October 19th, 2017) is its narrow approach which is restricted only to provide primary level services leaving behind the idea of primary health care. These terms primary level services and primary health care look very similar and are used interchangeably but there is a big difference between the two. "Primary Care is a narrower concept of "family doctor-type" services delivered to individuals but Primary

Health Care is a broader term derives from core principles articulated by the World Health Organization and which describes an approach to health policy and service provision that includes both services delivered to individuals (Primary Care services) and population-level "public health-type" functions[20]".

The doctors in these clinics are general physicians only, instead of "social physician" who can protect the people and guide them to a healthier and happier and life (GOI, 1946, p. 18) as imagined by the Bhore Committee. In the absence of social physicians, the general physicians will fail to produce satisfactory results in improving the health status of a community.

The narrow vision of the policy makers and planners targets only the curative services, mostly provided by secondary and tertiary hospitals, without looking at the primary health care. There is a complete neglect of preventive and promotive aspect which forms the basis for primary health care. The current approach lacks integration of curative and preventive services (which was also emphasised by Bhore Committee) which have serious repercussion on the overall health of the community. In the absence of preventive care, the curative care bestowed on the patients may fail to produce long-lasting results. The services provided at the Mohalla clinics are just the peanut services; many more things can be done by integrating them with the services of other departments like water, sanitation etc. and the public health system. By integrating these services, the overall health of the citizens will improve.

In the absence of holistic approach, the policy makers are trapped in the technicalities of controlling diseases. The following statement shows that health is a multi-dimensional phenomenon and the technocentric approaches adopted by policy makers has a repercussion on the health of the people, *"the health of the people is not a standalone phenomenon that can be improved through healthcare alone."* (Bajpai and Saraya, 2012, pp. 24)

Health of the people can be improved by aiming to provide primary health care instead of only primary level care. It has also been observed that health systems aiming towards

[20] https://www.ncbi.nlm.nih.gov/pubmed/17120883 (last accessed on September 12, 2017)

primary health care are more likely to deliver better health outcomes at lower expenditure (De Maeseneer et. al., 2008). So the focus needs to be shifted from narrow approach to a broader approach for providing Primary Health Care and comprehensive health care services as also recommended by the Bhore Committee (GOI, 1946).

6.2.2. Lack of Space in the Clinics

One of the major concerns highlighted by all the doctors, paramedic staff members and patients is the lack of space. There was no proper patient assessment room in the Mohalla clinics. Only nine clinics out of 16 had the assessment room but the rooms lack privacy. Everybody can see and hear the discussion between the doctor and the patients. The other patients either stand along the side of the door or peep through the door while waiting for their turn. This is more problematic for women patients as sometimes they feel uncomfortable while sharing their problems with the doctor in the presence of other patients.

In the absence of proper waiting hall, sometimes patients have to wait outside the clinic even in the extremely hot/cold weather (as observed by researcher). Moreover, there was no proper sitting arrangement in the clinics; every clinic had six chairs only (very less as compare to the patient inflow in the clinics). Everybody raised this problem in their interviews as an important issue especially the elderly and women patients.

6.2.3 Shortage of Human Resource

Deficiency of human resource is one of the major problems in Delhi's health system as also mentioned earlier. Almost every doctor complained about the shortage of staff in the clinic. One doctor, Dr. E (interviewed on January 5th, 2018) also complained about the shortage of doctor. It was a newly opened (porta cabin) clinic; earlier the patients were less but as the people started knowing about this clinic the number of patients increased day by day. She said it becomes very difficult to handle this huge number of patients (150-200 patients in 4-5 hours of OPD) single handedly. Now, it is important to appoint one more doctor so that her burden gets reduced.

Based on the field work it was found that nine out of 16 clinics have three staff members (other than doctor) who are not sufficient to manage the activities in the clinic. In some

clinics even those staff members are not trained enough to do their respective work. In the clinics with only two staff members (other than doctor), the doctors and other staff members grumbled about the lack of staff.

There is a shortage of pharmacist in every clinic. In three out of 16 clinics, ANMs are also given the duty for dispensing medicines to the patients. Moreover, paramedic staffs in the clinic are not professional phlebotomists or pharmacists. Here, unskilled staff had been recruited to do multitask after giving some training on how to draw blood samples, dispense medicines and manage the stock of medicines. As per the doctor, Dr. A (interviewed on October 19th, 2017) MTWs are easily available on the lower wages than the professional phlebotomists and pharmacists so it is economic and viable to hire MTWs rather than the professionals. In some clinics they also go to the nodal dispensaries to collect the medicines.

As none of the clinic has sweeper, either the MTW or the helper does all the cleaning work. These staff members are being recruited in the clinics because they are available at the lower wages than the trained workers.

6.2.4 No Leave Allotment Facility

Taking leave is one of the fundamental rights of every employee but there is no provision of leave for the doctors working in the Mohalla clinics. One of the doctors, Dr. F (interviewed on January 2nd, 2018) criticized the system that there is no leave allotment facility for the doctors who work in these clinics. All the doctors complained that there is no substitute staff if a staff member is on leave. Sometimes, they provide substitute doctor from the nearby dispensary but there is no provision for the other staff in case he/she takes leave. This hampers the work in the clinic. As in one case (the researcher herself observed during her visit on January 9th, 2018), in the absence of the pharmacist/helper, the MTW (barely literate who cleans the clinic) was dispensing medicines based on the color and location of the medicine (as mentioned earlier).

6.2.5 Payment Model

The government of Delhi has a highest allocation of budget, i.e. Rs. 6,729 crore towards the health sector which is approximately 12 per cent of the total budget. The Mohalla clinics draw a substantial amount out of the total health budget for its running and paying salaries to the doctors and other assisting staff. As mentioned earlier, job satisfaction for doctors is very important to keep the doctors motivated and delivering quality health services to the patients. Financial incentives could be one of the factors which can keep them motivated. The Mohalla clinics have derived a new payment model to encourage more and more doctors to get engaged in the project.

In Mohalla clinics, the doctors are being paid Rs. 30 per patient. One of the doctors, Dr. F (interviewed on January 2nd, 2018) said *"madam waise to thik hai but agar 30 Rs. se badakar Sarkaar 40 ya 50 Rs. per patient kar de to jyada thik rahega" ("madam, Rs. 30 is OK but it would be better if the government increases it from Rs. 30 to 40 or 50").* Doctor in one of the clinics was not satisfied with his remuneration. As the number of patients in his clinic is less than the average number of patients in other clinics, he gets less salary. This clinic has a patient inflow of 70-80 per day (average number of patients in Mohalla clinics is 125). The doctor (interviewed on January 9th, 2018) said that he runs a private clinic at his residence in the evening hours to cope up with the low wages.

As per one of the doctor, Dr. F (interviewed on January 2nd, 2018) the payment model is not good enough as most of the other staff members are less paid as compare to the work they do Rs. 8 for helper and Rs 2 for MTW. Their salaries should be increased to keep them motivated and to improve the functioning of the clinics.

6.2.6 Role of Auxiliary Nurse Midwives

One of the doctors, Dr. F (interviewed on January 2nd, 2018) was not happy with the recruitment and working of the ANM. The ANM is not serious about her work in the clinic (ANM in this clinic dispense medicines). She never comes on time and leaves the clinic without information. The work of ANM doesn't match with the working of the Mohalla clinics. One of the staff members, P 2 (interviewed on January 10th, 2018) said

that the posting of ANMs in Mohalla clinics have affected the working of fixed facilities like existing dispensaries. Now they rarely go for the immunization and outreach.

ANM is recruited through linked dispensary and getting the salary from the Delhi government. If they have to recruit ANMs, their recruitment should be done directly by the doctors of Mohalla clinic and that too as an empanelled employee so that they become accountable towards their work like the other staff members.

6.2.7 Lack of Convergence and Coordination among Nodal Dispensaries and Mohalla Clinics

With regard to the medicines supply, the Nodal dispensary from Directorate of Health Services is supposed to supply medicines to the clinics but in reality a staff member from the clinics has to go to the nodal dispensary to get the delivery of the required medicines. The staff has to produce the indent which was prepared in consultation with the doctors at Mohalla clinics. The dispensary either gives the medicines on the same day or takes one or more days to handover the medicines to the clinics.

One doctor, Dr. D (interviewed on 30th December, 2017) said that the dispensary supplies less medicine than the mentioned amount in indent. One of the reasons could be that the dispensary supplies medicines to the other clinics also so they have to cut down from the mentioned amount of medicines. He pointed out that the clinic didn't have Paracetamol syrup since last three days so they are forced to give tablets to the children (making three parts from a 500 mg tablet). The mothers find it difficult to understand that how to divide the tablet in three parts and give it to a small child and if they don't understand it properly then the purpose of giving medicine will be lost.

One of the doctors, Dr. A (interviewed on November 16th, 2017) said that there is a lack of coordination among the staff members of the Nodal dispensary and Mohalla clinics. Staff members from nodal dispensary force the doctor not to give full course of medicine instead give less medicine just to treat the symptoms and thus saving the medicines. Consequently, the nodal dispensaries give less medicine than the amount mentioned in the indent. One of the reasons given by a doctor is staff members from the nodal office are reluctant to go to the office of CDMO to get the medicines (the nodal dispensaries get

medicines from CDMO office). In that case they also have less stock of medicines in their dispensary so they further supply less medicine.

All the doctors mentioned that they maintain a buffer stock to tackle any delay in receiving the medicines. But after the buffer stock is over, either the doctors have to give substitute medicine in place of the original one or ask the patients to come after one or two days. In one of the clinics the doctor, Dr. C said that (interviewed on December 23rd, 2017) because of its proximity to the nodal dispensary, the doctor asks the patients to go there to get the medicines in case of shortage of medicines in the clinic.

6.2.8 Referral from other Dispensaries/Hospitals for Blood Tests

One of the doctors, Dr. A (interviewed on 19th October, 2017) was very annoyed as pregnant women were sent by nearby dispensaries or hospitals to Mohalla clinics for the routine blood tests. Even if the tests are available in the dispensary/hospital, the patients are sent to these clinics. The reasons given by the doctors of the dispensaries are: it would be uncomfortable for the pregnant women to wait in long queues in the dispensaries/hospitals. But in these clinics all the tests are done on the same day and the report will come the next day.

One of the doctors, Dr. B (interviewed on 30th November, 2017) said that sometimes, patients come directly to the clinic for the diagnostic tests to save their time and to avoid heavy patient load in the government hospitals. This disturbs the doctor patient relationship in dispensary as well as in the Mohalla clinics. One of the doctors, Dr. C (interviewed on December 23rd, 2017) was very irritated as patients from private clinics also come for the blood tests to save money as those tests (test for Vitamin D in the body) were very costly.

6.2.9 Role of Technology

All the doctors acknowledged that no doubt technology has reduced the wastage of time and requirement of additional staff to maintain record but it has some loopholes. One of the doctors, Dr. E (interviewed on 2nd January, 2018) said that as she is not savvy, so the technology has no use for her. She gives the details of the patients (written on piece of

paper) to her helper to make entries in the smart tab. Training was given before the tab was given but she doesn't feel comfortable in using it.

One of the doctors, Dr, B (interviewed on 30th November, 2017) said that sometimes it becomes very difficult to find details of the patients in the tab as the patients forget the details given in the first visit especially mobile numbers. The doctor has to make a new entry of the same patient which causes replication of data leads to confusion in future.

In addition, the tab is connected to the prescription printing machine and medicine dispensing machine through a *Wi-Fi* system, in case if the internet wouldn't work, then the whole system would stop working. Many times, if the *Wi-Fi* doesn't work, the doctors write the details in the register and enter the data in the tab later on. In that case, technology instead of saving time leads to wastage of time.

But if we look at the other aspect of using the smart tab, it is a positive step. The smart tab records the patients' details in an efficient way which is saving a lot of time of the doctor and helping staff at the clinics. Now, the consultation and prescription generation is completely digital and paperless making the process eco-friendly. The data entry in the tab can also be done by the helping staff which saves a lot of doctor's time. The saved time of the doctor can be utilised for some productive work or educating the patients about their health. Also, the medical history and details will be available online which can help the doctor to plan the line of treatment for individual patient. This would also help to create a digital health database which can be easily and instantly accessed by the policy-makers and bureaucrats who can utilise the data for policy making and program generation.

6.2.10 Lack of First-aid Facility

All the doctors and staff members raised an important issue of lack of proper first-aid facility in the clinics. There is no facility to deal with emergency and accident cases. Injection facility like Tetanus is also not available in the clinic. Ideally, the clinic should have proper bandaging and stitching facility to deal with minor cuts and wounds but it's not there. Although some of the doctors have kept bandages and some ointments like Betadin for the treatment of minor cuts and wounds etc. but it is not available in all the

clinics One doctor, Dr. A was even doing bandaging of wounded leg of a woman (observed during field work on October 19th, 2017) and the woman also mentioned that now her wound had started healing after three days of the bandaging by the doctor.

6.2.11 Lack of Safety and Security

Among the other problems, five out of 16 doctors complained about lack of safety and security in and outside the clinic as there is no security guard to take care of the clinic. One of the doctors mentioned few incidences where alcoholic patients come inside the clinic and started shouting. He found it very difficult to handle them. The researcher also got to see similar kind of incident during her field work in the clinic 2 (observed on December 2nd, 2017). One patient came inside the clinic and started shouting and asking for cough syrup. The doctor checked him and gave him some medicines but he kept asking for cough syrup, finally the doctor had to give him the syrup so that he would leave the clinic.

One of the staff members, P 1 (interviewed on January 10th, 2018) shared an incident where a tap was also stolen from the clinic as there was no security guard. In other clinic, in the absence of security guard, sometimes the patients misbehave with the doctor. Sometimes, they shout on the doctors unnecessarily. In one of the clinics, clinic 8, the doctor (interviewed on January 4th, 2018) himself had installed a CCTV camera not only for safety purpose but also to show the AAP people that there is heavy patient load in the clinic as they doubted the number of patients seen by the doctor per day. So he installed the camera to keep himself safe from both patients as well as from the AAP people.

6.2.12 Lack of Drinking Water

One of the important problems highlighted by the doctors and other staff members was issue of drinking water in the clinic. The staff members have to purchase water from outside by spending money from their pockets. Two of the doctors said that because of their good terms and relations with the water supplier of that colony, the supplier gives them water for free. But others have to purchase the water bottles for themselves as well as for the patients.

6.2.13 Political Interference

One of the important issues raised by two of the doctors is the political interference of AAP workers. One of the doctors, Dr. E (interviewed on January 2nd, 2018) mentioned that because of the presence of the AAP office in front of the clinic, the party members do the surprise visit and keep an eye on them. Sometimes they come and say *"madam yaha ye kyo nahi hai wo kyo nahi hai, yaha makdi ka jaala kyo laga hai etc.etc." ("Madam, why it is not there, why there is a spider net on the wall")* She said it hampers the functioning of the clinic and reduces our level of motivation to work. Many times they make promises to provide logistics but they never provide. In the other clinic, the doctor, Dr. E (interviewed on January 10th, 2018) was very angry as the patients do unnecessary complaints to the AAP MLA as the MLA office is very close to the clinic. The MLA comes any time and starts showing the power of his position to the staff members in the clinics.

6.2.14 Lack of Uniformity in Mohalla Clinics

All the doctors complained about the lack of uniformity in Mohalla clinics. Some of the clinics are functioning in the rented facilities but some function in the porta cabins. Some of the clinics have sufficient space to run the clinic but some don't even have a separate room for patients' physical examination. Some of the clinics have sufficient staff members but some clinics lack even the pharmacists and phlebotomists. In some of the clinics, the staff members get salaries on time but in some they didn't get salaries since last three months. Some of the clinics have good infrastructure facilities, but some clinics don't even have the almirah to store the medicines. To run the clinics properly there is a need to maintain uniformity among all the clinics.

6.3 Suggestions by the Doctors and other Paramedical Staff

One of the doctors, Dr. A (interviewed on November 11th, 2017) said that an alert integrated system should be set off to provide complete health to the community. The vision of Mohalla clinic should be to provide comprehensive and integrated health services to the community which includes preventive, promotive along with the curative health services. These comprehensive services should be linked with other parallel public

health departments like water, sanitation and sewage in order to improve overall health of the community.

Presently, the project of Mohalla clinic is just a pilot project. The launching of fully fledged project is very important to make its impact visible and measurable. A module should be prepared and replicated in mass scale. The module should be easy to monitor and evaluate. The budget should also be prepared to reduce unnecessary costing and replication of the health services.

The doctor, Dr. A (interviewed on October 28th, 2017) said that the objectives with which the Mohalla clinics have been started should be documented properly and there should be a proper mandate on how to achieve these objectives. The role of the doctors, staff members and other participating authority should be mentioned clearly to ensure their accountability towards the work. The indicators of success should be mentioned clearly and monitored timely and evaluated to improve the efficiency of the clinics.

As mentioned above there is a problem of replication of data. Even though doctors/helpers try to find out the patients' details in the tab but still the patients forget the details given in their last visit (common especially among the elderly and less educated patients). In order to avoid replication of data one of the doctor, Dr. A (interviewed on October 28th, 2017) suggested, patients' details should be linked to the *Aadhar* card so that by entering the *Aadhar* number in the tab, complete details of the patient including particulars about previous visits, tests done, diagnosis, treatment done etc. will come out.

Two of the doctors, Dr. C (interviewed on December 23rd, 2017 and January 10th, 2018) suggested that some user fee should be imposed like Rs. 5 or Rs. 10 so the patients should not take these services for granted like some of the patients throw registration slip and ask for new slip in the next visit. Some patients take unnecessary medicines as most of the elderly patients come and ask for cough syrups.

One of the doctors, Dr. C (interviewed on December 23rd, 2017) said sometimes the patients take medicines from the Mohalla clinic as well as from the dispensary because

the medicines are freely available in both the facilities. She added *"kuch patients ko dawai khane ka shauk hota hai to free ki dawai hone ki wajah se wo dono jagah se dawai le lete hain" ("Some patients like to have medicines and because of the free medicines, they take medicines from both the places; dispensary as well as the clinic"*). This leads to wastage of medicines and therefore wastage of money.

One of the doctors, Dr. F (interviewed on January 2nd, 2018) also highlighted that the salaries of paramedic staff, helper and MTW are not sufficient according to the work done by them. To keep them motivated, their salaries should be increased. In clinics where the number of patients is sufficient, the staff members are happy but in clinics where the number of patients is less, the staff members may not be satisfied and will get frustrated from their job soon.

There is a great need to recruit more staff members as no new staff was recruited for Mohalla clinics. One of the paramedic staff P 1 (interviewed on January 10th, 2018) mentioned that there is already 45 per cent staff shortage in the government departments and opening these clinics had further added to the problem. Recruitment of the trained paramedic staff is one of the key suggestions given by all the doctors.

The Mohalla clinics are started with an aim to reduce agony of the patients by the management of their illness at the early stage. For this, there is a need to break the barrier and bridge the gap between the doctor and patients and Mohalla clinics are trying to do this. For this to achieve, the doctors at the Mohalla clinic should behave empathetically so the patients can share their problem without any hesitation. The doctor should develop soft spoken skill and human touch; then only he/she will be able to win the heart of the patients and become their friend in real sense. One of the doctors, Dr. A recommended (interviewed on November 4th, 2017) that the training should also be given to the doctors to develop these skills; then only the barrier will break.

One of the staff members, P 1 (interviewed on January 10th, 2018) said that actually, the patients are not aware where to go for their illness. They visit government hospitals even

for the minor ailments and overload them so there is a need to educate the patients in order to make them understand where to go for their ailments.

6.4 Summary

It is evident from the data collected during the interviews that there is the mixed perception of the doctors about the Mohalla clinics. All the doctors were very positive about the establishment of these clinics and appreciated this initiative. All of them had suggestions for improvement, meaning all of them wanted these clinics to be there forever. A PHN gave a completely different perception about transferring of health workforce from the existing health facilities to the Mohalla clinics.

It has also been observed that many of the staffs had been transferred from the existing health facilities to these clinics. By transferring the staff from already poorly staff facilities, Mohalla clinics impacted the functioning in the existing health facilities. This would negatively affect the existing health workforce. The issues of idleness among the staff members would start appearing which would reduce their motivation to work.

Also, many of the staff members are not trained to do the kind of work they do. Clinic 14 had a helper who was barely literate but she was distributing the medicines, risking the lives of the patients. In Six out of 16 Clinics, the ANMs have assigned the work of pharmacists which also hampers their outreach work in the field. As they are not authorized to dispense medicines, by doing this they put the lives of the patients in danger. As already mentioned earlier that there is a shortage of staff in the existing health facilities, shifting those staff members to Mohalla clinics will not work for the proper functioning of these clinics. This not only disturbs the routine work in the existing health system but also raises questions on the sustainability of the project. To deal with this problem, it is important to deploy well-trained and well-paid health personnel. This not only will help to uniformalize the clinics in terms of the human resources but also to save people's live by avoiding recruitment of unprofessional staff in the clinics.

Besides this, to minimize workload on and absenteeism among the existing staff, the Delhi government introduced new payment model for these clinics, i.e. to compensate the doctors and other staff members on per patient basis they see. The new payment model

comes with advantages as well as disadvantages. One of the major disadvantages is that there is a possibility that the doctors inflate the number of patients to make more money as they are being paid on per patient basis. To keep a check on such kind of malpractices, it is mandatory to have a proper monitoring mechanism. This would also help in utilising the limited financial resources in a more efficient manner.

One of the major limitations of these clinics is focus on curative care only overlooking the preventive and promotive aspect as Lahariya[21] also mentioned that "under pressure from populist politics, these clinics are ending up equating holistic health care with curative care. Ignoring preventive and promotive care is a complete disregard to the social determinants of health which have a major contribution in determining the health status of an individual. By neglecting this aspect, these clinics will become medicine dispensers.

Another pertinent issue related to these clinics is lack of uniformity in the kind of health facility (rented and porta cabin) as well as in the staff structure in the Mohalla clinics. Out of 158 clinics, 102 are in rented premises and remaining 56 are in pre-fabricated porta cabins. The rented premises and porta cabin structure in itself raises a question about the sustainability of these clinics. These porta-cabins give a feeling of temporariness. The sustainability of these clinics is at risk in case the government changes in the next election. As these clinics become popular among the residents of Delhi, the withdrawal of these clinics by the next government would seriously impact the health-seeking behaviour of the patients who now are completely dependent on these clinics for their day-to-day illness.

In order to avoid this problem in future, it is important for the present government to build consensus with the other political parties and all the stakeholders by engaging with them. Keeping in mind the current scenario, there is a great need to ensure financial as well as political sustainability of these clinics not only in the current times but also in future.

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[21] http://www.hindustantimes.com/delhi-news/delhi-s-Mohalla-clinics-popular-among-locals-lancet-report/story-pT7iDQdEgP4DfiyFG6UtVK.html (last accessed on August 24, 2017)

Chapter 7 - Perception of Patients about Mohalla Clinics

7.1 Patients' Experiences at Mohalla Clinics

Mohalla Clinics is one of the progressive initiatives taken by Delhi government aiming to provide quality healthcare services free of cost within the locality where the people live. Mohalla clinics have been started with an aim to treat everyday illnesses at the community level thereby reducing burden on big government hospitals. Mohalla clinics become popular among the residents of Delhi as these clinics serve a large population who cannot afford expensive healthcare services provided by private hospitals. During the field visits, it was found that every individual had different perception about Mohalla clinics but one thing was common that all the patients were happy and satisfied with the services provided by these clinics.

To understand the perceptions of patients about Mohalla clinics, 105 exit interviews were conducted in 16 clinics using an interview schedule. To capture the experiences of patients at these clinics, in-depth interviews of the patients were also conducted. The sample of patients was a mix of all age groups and gender. The sample includes 34 male and 71 female respondents. Based on the age-groups, the sample includes:

Table: 7.1 Age-wise Patients' Distribution

Age-Group	No. of Respondents
Below 14 years	26
15-25 years	15
26-40 years	26
41-60 years	28
Above 60 years	10

If we look at the economic status of the sample, most of the patients, i.e. 45 per cent of the patients fall under the Category 2 with an income range from Rs. 5000-10,000. Another big chunk of patients fall under the Category 3 with an income between Rs. 11000- 20,000. About nine per cent of patients fall under the income group Rs. 21,000 and above (Category 4) and only three per cent of patients fall under the income group Rs. 0-5000 (Category 1).

The sample varies across different social groups like Scheduled Castes (81 per cent), Scheduled Tribe (one per cent), Other Backward Castes (nine per cent) and others (nine per cent). Most of the respondents, i.e. 66 out of 105 have studied up to primary level and 23 up to secondary level. Very few (only 16 per cent) have studied up to higher secondary and above. The experiences and perceptions captured in the interviews are broadly classified under following sub-themes:

7.1.1 Reduction in Financial Burden

Many times, for poor the health services remain inaccessible just because they can't afford to pay for the healthcare. Those who do use these services suffer financial hardship or impoverishment to an extent they have to sale their asset and/or borrow money, because they have to pay (Dror, Putten-Rademaker, and Koren, 2008; Xu et al., 2003). This situation leads to inequitable access to healthcare (Berma et. al., 2010) and limits the overall health outcomes to be better of a country (Hooda, 2017).

To meet the health services needs, they have to spend for consultation, medicines and diagnostics out of their own pocket. In India, outpatient spending as a proportion of total OOPE for healthcare is stood around 67 per cent in 2011-2012 (Hooda, 2017). It has been estimated that of the total OOPE, 53.46 per cent was spent on medicines and 9.95 per cent was spent on diagnostics (including medicines and diagnostics as a part of package component). 82.29 per cent of the total OOP medicines expenditure and 67 per cent of total OOP diagnostic expenditure was for outpatient treatment (MoHFW, December 2016).

High OOPE on healthcare has serious impact for well-being of households in India, as it thrusts a substantial population even the well-off to abysmal poverty levels. It pushes 50.6 million, i.e. approximately 3.5 per cent people below poverty line. It also further deepens the poverty for already poor people (Hooda, 2017). High OOPE on illness not only impoverish the family, but also make the economic recovery challenging. This has been described as a 'poverty ratchet' (Chambers, 2006) or 'medical poverty trap' (Whitehead et. al., 2001, Cited in Bajpai et. al., 2017)

All the patients were very happy as by providing free services which include consultation, diagnostic tests and medicines at one location, these clinics have reduced their financial burden on health not only by reducing direct cost (expenditure on consultation, blood tests and medicines) but indirect cost (travelling expenses) also. This has also reduced the opportunity cost (wage loss when a patient has to travel to any government health facility) the patients have to pay in order to visit a government health facility especially who are daily wage laborers.

7.1.2 Free Medicines

A huge expenditure of the families' wealth is on medicines which can be one of the major factors responsible for pushing people below poverty. Providing free medicines to patients can be one of the major steps to reduce OOPE which can minimize the impoverishment due to payment on health. As the OOPE on purchasing medicine is very high, by making the free medicines available in Mohalla clinics had minimized huge amount of expenditure on medicines.

A patient (interviewed on November 30th, 2018) said that earlier either the patients have to queue up in the endless queues waiting for number of hours to get even basic medicines (availability of medicines is also uncertain) or they have to take multiple trips to get free medicines from government hospitals. It is very challenging for elderly or female patients to stand in queues for long. Even after spending hours in queues and facing inconvenience, many times patients had to come back without taking medicines because of heavy load of the patients at the medicine counter or come with half set of medicines. In both the cases they have to purchase medicines from the nearby medical stores spending money from their own pocket. The patients who cannot afford to purchase medicines wait for their turn to get the medicines.

These clinics had dramatically reduced the waiting time as all the medicines are available free of cost in the clinic itself. A patient (interviewed on October 31st, 2017) said that visiting a government hospital and ensuring that you have full set of medicines in your hand takes up almost half of the day. I had to wait for hours in long queues to get free medicines from the hospital. Also, most of the time all the medicines prescribed by

doctors are not available at the hospital's medicine counter. So, instead of waiting for hours in long queues I come back after consulting the doctor and take medicines from the chemist shop. He said that after coming up of these clinics, I don't have to run here and there for free medicines as I get all the medicines from the clinic itself. It can be said that these clinics have overcome these problems and eased the process of getting free medicines from a government health facility.

7.1.3 Free Blood Tests

One of the key components of these clinics is free blood testing. In government hospitals, people have to run around for most essential blood tests like blood sugar test. A number of tests are available for free but some are available on subsidised rate in the hospitals. Many times, patients have to take multiple trips to get these tests done. Some of the tests are available every day but some tests are available on some particular days. Patients have to wait for weeks and even months to get these tests done. In case of any emergency if poor patients are asked to get those tests done from private labs, these labs charge unreasonably high even for the basic blood tests which not only adds financial burden but physical strain on the patients.

Making the free tests available at the clinics had reduced the families' OOPE on health especially on poor and lower middle class families. Also, timely diagnosis will help in providing prompt and timely treatment to patients. This will further reduce the catastrophic expenditure on health in case serious diseases.

The importance of free blood tests has been highlighted by many patients during their interviews. The patients at the clinic said that they don't have to visit the government hospital multiple times for consultation and blood tests (one day for consultation, another day for blood tests and third visit to collect the report as it is not possible to get consultation and tests done in a single day because of heavy patient load). Also, patients have to go to the government hospital multiple times if more than one test is prescribed as some specialised tests are done only on particular days for example thyroid test. If a patient is advised for thyroid and blood sugar test then he/she has to visit the health facility. But all the tests are available in the clinic itself.

The Mohalla clinics have the facility of more than 200 blood tests. The lab technician/helper in clinic takes out the blood and representatives from a private lab (empanelled with Delhi government) collect the samples everyday and deliver the report next day. All the important and basic tests can be done on the spot on the same day. So the patients don't have to run here and there for simple blood tests like blood sugar.

The patients acknowledged Mohalla clinics as a good initiative not only for free treatment but also for free blood tests. A patient (38 years old) (interviewed on January 9th, 2018) who is suffering from thyroid since last few years said that her routine thyroid test costs her around Rs. 300-350 per test. But now after coming up of these clinics, she doesn't have to spend money on blood test. Moreover, she had also started taking treatment for her thyroid from the clinic itself. She comes here after every two or three months for her routine check-up and blood test and get the report next day without spending anything. Now, it becomes easier for her to get the test done because of opening of the clinic in her locality which is just five minutes distance from her home. She said that now visit the clinic not only for blood tests only but for minor ailments also.

Another patient (35 years old) (interviewed on November 16th, 2017) said that earlier she used to avoid minor illnesses because it takes lot of time to travel and seek care from the nearby public hospital. Also, travelling to the hospital costs her Rs. 20 per side from the auto rickshaw (as it is the only mode for traveling to the hospital). She added to visit a hospital she had to get up early in the morning and prepare herself physically as well as mentally to deal with the hectic process of getting treatment from the hospital. In addition to this, she had to leave her children at home to visit hospital. If she takes medicine from medical store, it costs her around Rs. 70-80. But now because of the presence of the clinic in her vicinity, she can go and seek care as per her convenient timing (between 8 Am - 2 Pm). Her life has become trouble-free after coming up of these clinics in the neighborhood. Thus, Mohalla clinics have removed such kind of impediments and reduced unnecessary financial burden on the diagnostic tests.

7.1.4 Reduction in Traveling time and Opportunity Cost

As mentioned earlier visiting a government hospital requires not less than half a day including traveling, registration, seeking consultation and getting medicines. Many of the

patients mentioned visiting a government hospital as a frightening experience. Mohalla clinics in contrast provide trouble-free access to healthcare services. The patients at these clinics talk about reduction in traveling time due to its presence in the community. Patients don't have to travel long distances in order to get free consultation and medicines. They can walk into the health facility without spending on traveling.

One of the patients (41 years old) (interviewed on November 20th, 2017) said that there was a huge wastage of time in getting the registration done. He added that he had to wait in long queues (because of the heavy load of patients) to get the registration done every time he visits health facility even for the follow up visits. But these clinics are highly beneficial in a sense that there is no wastage of time in registration as it is done by the doctor himself/herself. Other patients said that many things have changed since Mohalla clinic had come in their vicinity including their health seeking behaviour.

7.1.5 Benefits for Women

In India, the health of women is directly linked to their status in society. As a result of their lower status in the society, they face discrimination in the allocation of household resources including food and access to health services (Velkoff and Adlakha, 1998). This makes the women to avoid seeking care for their illness unless it becomes serious. In this way, Mohalla clinics are highly advantageous for female patients as these clinics are accessible to them to seek free medical care.

After interviewing many women during the field work, it becomes clearer that many women neglect symptoms of their minor illness and avoid going to public hospital. As the duty of domestic chores always falls upon woman of the family, she never gets time to take care of her own health and well-being. Many women don't even consider their illness as illness. As they have to depend on their husbands or other family members for taking them to the hospital, they ignore their illness. Also looking at the overcrowding in the government hospitals, it is very challenging for women especially with children, to spend hours to seek doctor's consultation in a government hospital. With the establishment of these clinics in their neighbourhood, there is an immense reduction in travel time and risk of facing overcrowding at the government hospitals.

Another woman (32 years old) (interviewed on November 28th, 2017) was very happy as a Mohalla clinic was established just a 5-minutes distance from her home. She said that before setting up of this clinic in our locality, our lives were very difficult as seeking care from a government hospital is very challenging because of the heavy load of the patients in the hospitals. Moreover, the quality of the services is also not good. The never-ending waiting in the endless queues of hospitals was extremely painful and frustrating for a housewife like me who has to take care of the family too. But now these clinics provide quick access to medical care through a hassle-free process.

A woman (28 years old) (interviewed on October 31st, 2017) said *"I can't leave my kids alone in the home for hours as a visit to any public health facility takes almost a full day. Also, it is not safe to leave them with neighbors. So I usually avoid going to hospital/dispensary or if I feel that the problem is increasing, I first try home remedies or take medicine from nearby chemist shop before visiting any doctor. Here, I can come without any tension as it is close to my house and I can come and go back in a short period of time. As the consultation and medicines are available free of cost, I prefer to come here for myself as well as for my children".*

All the female patients interviewed at different Mohalla clinics highlighted the importance of making these services available at the doorstep as they don't have to run towards big hospital for trivial issues like cough, cold, fever and body pain etc. Earlier, the women had to leave their children at home to visit the health facility because either the health facility is far from the house or they are not in a condition to carry the children to the hospital due to their illness. It was found that around 70 per cent of patients at the Mohalla clinics are women, children and elderly making it very clear that large number of female patients are utilising these clinics.

7.1.6 Antenatal Care and Postnatal Care for Pregnant Women

Mohalla clinics are boon for pregnant women because of their presence in the community. They can come for ANC, PNC, routine blood tests, assessment of nutritional status and iron folic and calcium supplements. Visiting a government hospital for routine check-ups is a nightmare for many of the pregnant women because of the heavy patient

load there. But these clinics have curtailed their problem by providing all these services at their doorstep.

Pregnant women from nearby areas/colonies come to these clinics for their routine blood tests. Three pregnant women (23, 25 and 26 years old) (interviewed on 18th November 17) living in the nearby *JJ* colony came together to the clinic for their routine blood tests. All of them used to go for their Ante-Natal Checkup to Safdarjung hospital earlier but the doctor there suggested them to go the nearby Mohalla clinic for blood tests to avoid inconvenience at the hospital in long queues.

One of them mentioned that during her previous pregnancy she had to stand in long queues for hours, roam around here and there for blood tests. Furthermore, she had to do it alone as her husband is a daily wage laborer and he cannot afford to spend his full day in the hospital with her. Now, she comes to the clinic not only for blood tests but also for treatment of minor ailments. Sometimes, she also brings her first child to take his medicine for cold and fever.

All of them said that these clinics have made their lives easier and simpler and made the process of routine check-up hassle free. They said that they feel safe and secure as they don’t have to travel alone a long distance and don’t have to wait in long queues of the hospitals to get a simple blood test done.

7.1.7 Boon for Elderly and Destitute Patients

Because of their age, income insecurity and isolation, elderly population is more vulnerable to fall sick and also this is the population which lacks adequate access to quality healthcare. As per the UN Report elderly women are likely to be most vulnerable than elderly men due to their longer life expectancy and meager or no income. Their vulnerability increases with age and widowhood[22].

As already mentioned earlier, 70 per cent of patients at Mohalla clinics are women, children and elderly and 30 per cent are repeat consultations. The elderly population contributes a major chunk of the patients in these clinics mostly with non-communicable

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[22] https://www.google.com/amp/s/thewire.in/politics/elderly-population-demographics-india/amp/ (last accessed on September 29, 2017)

diseases like diabetes, hypertension and age-related ailments like joints pain. These patients are required to visit the health facility regularly not only for medicines but for routine check-ups. These clinics have improved access to healthcare for this section of the society.

Old patients suffering from diabetes and blood pressure related issues can get their routine check-up done and seek hassle free medical treatment from these clinics. They also get their monthly medicines from these clinics free of cost. (Sometimes, because of shortage of medicines in the clinic, the doctor gives medicine for 15 days instead of a month medicines but there is a surety that they will get the medicines after 15 days) The old patients interviewed at different locations mentioned free medicines as one of the important benefits among others because this has reduced their dependency on their children for taking them to the hospital and purchasing medicines for them.

These clinics are providing access to those who are left unattended by their family members and following is the example. A 60 years old destitute woman (interviewed on January 9th, 2018) who was thrown out of the home by her son now lives on her own in a *jhuggi*. Sometimes, her daughter gives her food but most of the times she sits near *Peerbaba Dargah* to get food. She is suffering from diabetes and hypertension and she comes to the clinic regularly for her routine check-up. She said that "*beti mere pass to khane ke bhi paise nahi hain kabhi pass ki dargah pe kha leti hu or kabhi meri beti khana de jati hai. To batao private clinic se dawai kaise le paungi. Jabse ye khula hai yahi aati hu test k liye or dawai ke liye bhi"* (*"daughter, I don't even have money to eat, sometimes I eat at the nearby tomb and sometimes my daughter gives me food. Then tell me how can I take medicine from a private clinic? I started coming to this clinic since the time it was started for the tests as well as to take medicines").*

She said that earlier it was very tough for her to go alone to the nearby government hospital to take medicines as it is far from her house and waiting there in long queues add to her problems. But now she can come alone to the clinic for her treatment. She added that her life has become easier after opening of the clinic near her *jhuggi*. She appreciated the doctor and said that the doctor listens to her problems carefully and gives good

medicines. Many times she shares her problems with the doctor and receives emotional support from the doctor along with the medical care.

These clinics have given access to those who are completely neglected by their families and can't even think of going to a government hospital leave about seeking care from private doctors. These clinics have eased the process of seeking medical care not only for women and children but for elderly also. Besides, Health Management Information System (HMIS) that maintains patients' records in the smart tab helps in better monitoring and predicting health trends in non-communicable diseases that will further facilitate in scaling up preventive measures.

7.1.8 Affluent and Middle Income Families using services of Mohalla Clinics

It was found that while poor come to Mohalla clinics for treatment of their ailments, the people from middle and affluent class families also come for routine medical check-ups and preventive measures like for blood pressure measurement and blood tests for diabetes.

It was observed during the field work that many of the patients come from the middle/upper class families. A patient (22 years old) (interviewed on November 18th, 2017) who works in a private limited company said that earlier they (he and his family) used to go to a private doctor who charges them Rs.500 per visit; moreover he prescribes all the medicines from outside. This means a visit to a private doctor costs them around Rs. 1000 but now they don't have to spend even a single penny for consultation and medicines.

Many expensive tests are available free of cost for example calcium tests. One of the patients (40 years old) (interviewed on 18th November, 17) whose husband owns a general store is suffering from body pain from the past few years. A private doctor prescribed her calcium test. She said as the test was very expensive, she came for the first time for the test only. But now her children are also coming for the treatment of minor ailments like cough, cold and fever etc.

Many of the upper class families are also utilising the services provided by these clinics particularly the diagnostic services. Based on the observations from a Mohalla clinic,

opened in a high-class society, it was found that people from big flats and houses are also coming mostly for blood tests like thyroid, diabetes and lipid and calcium level. The doctor in the clinic said that she gets patients even from big bungalows also. Therefore, it can be said that the middle and elite class have started reposing their faith on the public healthcare system again with the establishment of these Mohalla clinics.

7.1.9 Check on Quackery and Private Practice

Lack of access to primary health care provides conducive environment for self-medication, growth of quacks and private practitioners. It could miss out many serious diseases like symptoms of heart attack could be confused with gastric problems. The daily wage laborers who live in the poorer neighbourhoods are more vulnerable to catch diseases but they are the one who lack access to public health facilities and become the easy prey for the quacks. They further may not be able to travel to a far-off dispensary or a government hospital because of the opportunity cost for seeking care. Also, due to their nature of work associated with daily wage income the only option available to them is to go to the nearby quack or *Bengali* doctor. As it is also mentioned in Rakku's story "poverty is seen both as the primary source of ill-health and as a force which renders the poor majority powerless to make effective use of the official health system, and powerless also to change it" (Zurbrigg, 1984, p. 13).

The Mohalla clinics have weeded out the unqualified quacks and their existence and dominance is reducing day by day after opening of these clinics. These clinics are now drawing a large number of people into the government health system who would otherwise go to unqualified quacks or medical stores. If the quality medical care is made available for free then the people will stop visiting these quacks. Also, opening of these clinics in the community reduced the need for self-medication and also assisted the doctor in detecting serious diseases at a very early stage.

One of the patients (20 years old) (interviewed on December 2nd 2017) said *"earlier I used to take medicine from the nearby chemist shop which charges around Rs. 100-150 for three doses. But now I directly come here even for the minor ailments like headache, cough and cold".* These clinics have reduced the number of patients going to the chemist

shops/quacks as also acknowledged by the doctors at Mohalla clinics and the nearby *Bengali*/private clinics (visited on 13th November, 2017) in the nearby slum.

One patient (15 years old) (interviewed on October 28th, 2017) said that he had been taking medicines for his stomach ache and fever initially from a medical store and later from a private clinic. He had already spent Rs. 700-800 before coming to this clinic but he didn't get any relief. He came to the clinic one day before the interview; the doctor gave him some medicines and asked him to come next day for the blood test (as the test need to be done empty stomach). These clinics are beneficial not only in providing treatment for diseases but also in making proper diagnosis before prescribing any treatment.

7.1.10 Services at Mohalla Clinics v/s Services in Government Hospitals

For many of the patients, a government hospital/dispensary can be very intimidating place. It is very difficult for an illiterate or barely literate person to navigate a bigger health facility. Also, the condition of government hospitals is appallingly, they are inadequately staffed and lack good infrastructure. Those who can afford can go to private doctors but the poor population is left to the mercy of these hospitals. The pathetic condition of government hospitals makes people shift towards private hospitals. Before privatization, every sick person used to go to government hospitals but as the condition of hospitals deteriorated, people are forced to switch to private healthcare providers which are not only expensive but also unaffordable for most of the people.

The doctors don't have time to patiently listen to patients and attend to their problems as they are in constant pressure to see the patients quickly on/before the OPD timings get over. This has a repercussion on their behaviour; they behave badly with the patients which increases anger and frustration among the patients. Despite extremely rude and discourteous behaviour of the doctors and poor quality of services at government hospitals, poor patients continue to rush-in in desire to seek free healthcare for their everyday illnesses. As the government hospitals/dispensaries are unable to meet the demands of the population of Delhi, Mohalla clinics are proved to be a boon for the people who lost confidence in the government health system. These clinics have saved

them from facing the anxiety of consulting a doctor at government hospital and receiving trouble-free treatment. In addition, by treating everyday illnesses at the clinic level, these clinics will free up the doctors at hospitals to focus on complex diseases and surgeries.

A patient (33 years old) (interviewed on 23rd November 2017) said that doctors at government hospitals do not spend sufficient time with the patients to listen to their problems. She added *"madam unke to nakhre hi itne hote hain kya batau". Kafi baar to poora din nikal jata hai or number bhi nahi aata token dekar bhej dete hain ke kal aana" ("madam, they show their tantrums what to say. Many times, the whole day gets wasted but the turn doesn't come. Sometimes, they give token and ask to come the next day").* But here, in the clinic, the doctor listens to our problems carefully and spend sufficient time with the patients. Because of less patient load, the doctors at these clinics can spend sufficient time with the patients to understand their problems and prescribing appropriate treatment.

Another patient alleged that only friends and family members of doctors and hospital staff get proper care in government hospitals. The doctors see patients who are known to them or other hospital staff without following any token number. It is very challenging for a common man to get good quality care there, unless he knows someone in the hospital staff. He said *"sarkari aspatal ke dactar apni jaankari wale marizo ko jaldi dekhte hain" ("the doctors in government hospital see patients early who are known to them").* But these Mohallaclinics have saved the patients from going through this ordeal in government hospitals.

The doctors at Mohalla Clinic are more courteous unlike doctors at big government hospitals who are always in hurry. One of the patients (45 years old) (interviewed on October 28th, 2018) said that doctor in the clinic spend sufficient time with the patients because they live in the same community. He added that he understands the problem of the community and gives medical advice in our own language so that we can understand it properly. Being in the same community since the beginning of this clinic, the doctor knows each and every patient personally.

A good doctor-patient relationship is a must for a successful treatment plan. As the doctors in these clinics behave with the patients like a friend, the patients had developed confidence in them which cannot be expected from doctors at big hospitals.

7.1.11 Counseling and Emotional Support

In the absence of Mohalla clinics, patients used to share their health problems with their family members, friends or neighbors and get unscientific sometimes irrational advice from them for their illnesses. They avoid going to a doctor because of a fear of big hospitals and hesitation that whether the doctors would understand their problem or not. The patients talked about their fear of visiting big hospitals and why they prefer to deal with their suffering on their own. Many resorted to seek treatment from quacks/chemist shops/private doctors in their localities.

But after coming up of these Mohalla clinics, patients have started coming to these clinics without giving a second thought. They had developed trust in government doctors as well as in government health system which earlier wasn't there because of the terrible behaviour of the health professionals and deplorable quality of services at the government hospitals. Now, the patients come directly to the clinics and share even their minute problems with the doctors without any hesitation because of the friendly behavior the doctors at the clinic.

Some of the old patients also mentioned that doctors in these clinics are like their friends; visiting these clinic gives them soothing effect and home like feeling. One of the patients (65 years old) (interviewed on October 25th, 2017) said that many times he shares his personal problems with the doctor and the doctor counsels him and give him emotional support not only for his medical condition but also for his psychological condition. These clinics have been established with intent to deal with health problems of the community by providing healthcare at the community level itself but with further improvement these clinics can become counseling centres which has been a neglected part of healthcare in India.

7.1.12. No Formal Requirements for Visiting Mohalla Clinics

It is quite obvious that to visit big government hospital, patients need to prepare themselves both physically as well as psychologically. They have to get up early in the morning to arrive at the hospital on time (mostly before time). They have to reach the registration counter before opening it so that they don't have to wait for long to get the registration done. As many of the patients fear visiting a government hospital, they have to prepare psychologically also to deal with the hectic process of seeking care at big hospitals.

One of the young patients (25 years old) (interviewed on October 25th, 2017) said "*being in the same community I can walk into the clinic without any preparation (like getting up early in the morning and wearing formal clothes) and without spending money. To visit a government hospital, I have to dress properly because hospital is a formal institution but here I can come in any comfortable clothes. He added that these clinics have reduced the wastage of time in traveling to the big hospitals that was a matter of concern for working people like me as it adds to the frustration to travel a long distance in a crowded public transport with an ailing condition".*

As he is working in a company, he can come early in the morning, take medicine and can go to his office (if he wants to) on time without losing his salary. His life has become easier after coming up of these clinics in his locality. The daily wage earners are also benefitted from these clinics as they don't have to lose their wages because of long waiting hours in public hospitals to seek consultation from a doctor.

7.1.13 Patients from All around the Country

Government hospitals in Delhi cater to the needs of not only the citizens of Delhi but also floating and migratory population from the nearby states which constituted significant patient load. Similarly, now the Mohalla clinics are also serving the health needs of this population. These clinics have become so popular that patients from neighbouring states are also coming to utilise the health care services provided by them.

Many of the elderly patients interviewed at different locations are relaxed now as they get medicines for their joints pain free of cost that too in their neighbourhood. One of the

patients (80 years old) (interviewed on January 9th, 2018) said that he had spent around Rs. 25,000 in his village for the treatment of his knee joint pain but he didn't get any relief. His son brought him here for his treatment. He thought to take him to the clinic for his problem of joints pain. He is taking medicine from this clinic from the last one month and now he has some relief in pain. Earlier, he had to depend on his son to take him to the ESI dispensary (that was too far) but now he can directly go to the clinic and get his medicines. He mentioned about the *pudia* (calcium powder sachet) which is very effective in relieving the pain.

The calcium powder given by the doctor at the Mohalla clinics is a magical remedy for many old patients who come with joints pain. Actually, the calcium powder is given (once is a week) to strengthen the bones and joints but the patients think that it will help in relieving their pain so they ask for additional sachet thinking that it will help in relieving their pain quickly.

One of the old patients brought her sister (40 years old) to the clinic from Uttar Pradesh (interviewed on January 9th, 2018) to seek doctor's advice on her infertility. She said that her sister is married since last 15 years but couldn't conceive in these years. The doctor asked her to come with her old medical records when the patient visited for the first time. She came with the records so that the doctor could tell her about what the problem is and what can be done.

The patients had developed trust in the doctor and Mohalla clinic to an extent that they bring their relatives even from outside Delhi. The patients are confident that the advice they get from the doctor will be reliable and this is the reason why patients from different states are coming not only for treatment but also to seek medical advice.

7.2 Critical Views about Mohalla Clinics

Almost all the patients were contended after opening up of these clinics in their locality. Only one among all the patients (interviewed on November 4th, 2017) said that instead of opening these clinics, the government should try to improve facilities at the existing public hospitals/dispensaries. The patient said that he has an ESI card but ESI dispensary is too far from my residence and getting treatment from the dispensary is a complex

process. He said that the condition of the existing public dispensaries/hospitals is abysmal. Long waiting time due to heavy patient load, poor quality of services including consultation, behaviour of doctor and hospital staff, non-availability of medicines are some of the major issues highlighted by him while utilising services at any government health facility.

In three out of sixteen clinics visited by the researcher, the patients complained about the behaviour of doctors. One of the patients (25 years old) complained that the doctor never listens to the patients' problems carefully. She said "as soon as you start telling your symptoms, she starts writing on the prescription slip just by listening only one symptom. She never listens to your problem completely and carefully. She keeps on saying *"zara ruk jao, chup raho, sochne to do, likhne do" ("just wait, keep quiet, let me think, let me write").*

Another patient in an informal discussion (45 years old) (on January 5th, 2018) said *"madam thik se sunti bhi nahi hai jaise hi bolne lago kehti hai ruk jao ruk jao. Pata nahi fir itna soch soch ke kya likhti hai parchi pe ya to ye nayi hai isliye ya inhe kuch aata nhi hai"("Madam, she doesn't even listen carefully, as soon as we start saying she says wait. Don't know what she writes on the slip after thinking so much. Either she is new or she doesn't know anything")*. (She started laughing after saying this).

The above incidence shows that the listening skills of the doctor play an important role in patient's satisfaction. It is very important to spend sufficient time with patients and their family members and listen to their concerns carefully to satisfy them. No doubt, acquiring skills take time as it is a continuous learning process but the patients start judging doctors even on the basis of their behaviour. Sometimes, they also start questioning their skills and knowledge if they feel dissatisfied (as it is evident in the above statement). The unpleasant behaviour of the doctors in government health facilities could lead to loss of respect among the patients. On the other hand, compassionate and humble behaviour could be very rewarding for them as the patients come to the doctors with full faith and trust and if they get satisfactory response from the doctor, they feel contented.

In another clinic, one patient complained that the doctor take too much time for tea break. She takes about half an hour break while the patients sit outside the clinic and wait for their turn. Another patient in an informal discussion (on January 4th, 2018) shared that the doctor is very rude to the patients. She added *"Madam, ye doctor itna chillati hai na kya batayein" ("madam, this doctor shouts a lot what to say").*

It is said that the behaviour of the doctor can treat half of the patient's problems but such behaviour of the doctors instead of reducing, exaggerate patients' problems. Such instances remind of the typical government hospital where the patient is just a client not a human being. The anger of the doctor is a sign of deep healthcare crisis where the doctors are overburdened and unable to cope up with heavy patients' flow. This shows the careless attitude and insensitive behaviour of the doctor towards the patients. As the services in Mohalla clinics are free, the doctors think that by giving them free medicines, they are doing some favour to the patients.

These clinics have been opened keeping in mind the importance of human touch and soft spoken skills of the doctors which have the power to treat the illness of the patients but if the doctors behave in such a manner and cannot attend to the patients empathetically then the motto of opening these clinics would vanish.

7.3 Suggestions by the Patients to Improve Services at Mohalla Clinics

All the patients said that Mohalla clinics are boon for them. They mentioned that these clinics are far better and cleaner than the other government health facilities. All of them said that what they wanted they are getting from these clinic i.e. free consultation, free medicines and free blood tests and that too at their doorstep what else they want. But some of the patients have few suggestions like more doctors should be employed to deal with the increasing number of patients coming to the clinics. As more and more patients are using these clinics now, it becomes difficult for one doctor to look after all the patients. If the situation remains the same, then these doctors will also start behaving like the doctors at the government hospitals.

Some of them suggested that specialised services like eye, dental and ear, gynecology should be started in the later stage of this project of Mohalla clinics so that they don't

have to visit bigger hospitals for minor ear or tooth pain. As the doctors at these clinics are not specialists, they cannot treat specialized illnesses so some specialists should also be employed in the clinic itself.

Many of them suggested that the emergency services should be provided via these clinics like stabilization of the patients in trauma cases and tetanus injection. Admission facility should also be started for illnesses like dehydration so that the glucose drip can be provided at the clinic level and the patients don't have to rush to bigger hospital for such ailments.

7.4 Summary

Despite having four different Municipal Corporations, there are many areas which remain uncovered and underserved. These clinics, by providing access to this population, have tried to improve primary healthcare and expand health coverage especially to the underserved areas. Apart from free routine consultation services, these clinics provide free medicines and diagnostic tests. This initiative would help poor people in reducing their financial burden on health and unnecessary wastage of time in seeking care at big hospitals.

A visit to a Mohalla clinic takes not more than half an hour because of its presence in the community. In contrast, a visit to a government hospital costs them a lot not only in terms of money but also in terms of time consumption. Sometimes, to avoid wastage of time and wages, people especially urban poor tend to go to unqualified quacks (as they are easily reachable) and seek unscientific advice which not only causes financial losses but also the exaggeration of disease symptoms.

These clinics by providing primary health services at the community level are trying to address the issue of overcrowding in the higher level health facilities. These clinics by catering the local health needs of the people have reduced the quackery/unqualified practice at the community level. By treating minor ailments at the local level, these clinics are expected to spare doctors at government hospitals to focus on severe diseases and surgeries.

These clinics have become immensely popular not only among the inhabitants of Delhi but also among the people from the other states as they provide basic services to all. The responses of the patients clearly demonstrate the growing expectations of the patients from these clinics.

The Delhi government promised to open 1000 Mohalla clinics, 158 clinics had already been operationalized. Now, the government aims to set up 530 more Mohalla Clinics and 230 clinics in schools by October 2018 (Delhi Budget Analysis 2018-19). The Deputy Chief Minister Mr. Manish Sisodia in the First Outcome Report presented in Delhi Assembly mentioned that 32 lakh patients have availed healthcare services from the Mohalla clinics. To increase the utilization of these clinics, the government should incorporate the suggestions given by the patients. One of the important suggestions is to recruit more doctors in clinics otherwise, looking at the growing demand for health services and increasing number of patients per clinic, the doctors will become overburdened and start behaving just like the doctors at government hospitals which would ultimately affect their efficiency.

Chapter 8 - Politics of Mohalla Clinics

8.1 Political Dimension of Mohalla Clinics

Health is a state subject, as and when there is a new political party, they come up with newer ideas and most often populist agendas. In India, education and health are the two social sectors, which receive minimum budgetary allocation. However, every time a new government, they come up with new schemes and health programs, like different health insurance schemes. While researching on Mohalla Clinics which was the initiative of Aam Aadmi Party (AAP) government, it would be interesting to observe the politics behind the opening and running of Mohalla Clinics, the nature of opposition and the critique. Since there were not many interviews, which were conducted with the policy makers and political leaders, this chapter is based on newspaper articles, media reports and a key informant interview (interview taken on July 9th, 2018).

The present Aam Aadmi Party government under the Chief Minister Mr. Arvind Kejriwal had initiated an innovative project, i.e. opening of Mohalla clinics to improve access to primary health care services and achieve the goal of universal health coverage in Delhi. These clinics were started to fulfil the electoral promise made by the present AAP government in Delhi. Undoubtedly, the opening of these clinics is a political move to gain political fame of the voters of Delhi but these clinics are capable of meeting the health needs of the people, make basic healthcare accessible and decongest higher level health facilities (Lahariya, 2016). Now, these clinics have gained popularity among the masses of Delhi in a short span of time.

The first Mohalla clinic was inaugurated by Delhi's Chief Minister Mr. Arvind Kejriwal in Rajiv Gandhi *JJ* Punjabi Bagh, a relief camp in Peeragarhi on 19th July 2015. The Chief Minister and other AAP Ministers termed it as a "revolutionary step" in health care[23]. Lahariya envisions that these clinics have set the background to bring cleanliness-health-education-sanitation-social sectors (C-H-E-S-S or CHESS) as an alternative to Bijli-Sadak-Paani (B-S-P) as electoral agenda and political discourse in India (Lahariya,

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[23] https://www.thehindu.com/news/national/other-states/Deadline-for-1000-mohalla-clinics-extended-by-a-year/article14994688.ece (last accessed on September 25, 2017)

2017). In the last three years, Mohalla clinics have brought health to public and political discourse as health is higher on the political agenda for this government.

Many Indian states like Maharashtra, Gujarat, Karnataka, Madhya Pradesh, and a few municipal corporations (i.e. Pune) governed by different political parties have shown interest in establishing variant of these clinics in their respective states. The politicians and political leaders have felt the pulse of people and realized that there is a huge demand from the community for the health services provided by these clinics.

Because of its popularity amongst the people, some of the states have already established modified versions of these clinics. One of the variant was established in Hyderabad with a different name; Basti Dawakhana which provide diagnosis and treatment for minor illnesses free of cost[24]. Government of Karnataka under Siddaramaiah had also decided to establish these clinics to expand extended health centres in slums and labour colonies across the state[25]. In order to provide cheaper medical treatment to economically-weaker sections of the society, the Bharatiya Janata Party (BJP) also launched a special health centre (Janata Clinic) in the Indore city. The 'Janata Clinic' is another variant of the Mohalla clinic which is a BJP's initiative and the state government doesn't have any role to play in it[26].

Not only in India but Mohalla clinics have gained appreciation from all around the world. By aligning with the goal of achieving universal access to primary healthcare services, these clinics appear to put this strategy into operation (Sharma, 2016). Former secretary-general of United Nation Kofi Annan and former WHO director general Dr. Gro Harlem Brundtland had also praised the initiative of Mohalla clinics[27] with some suggestions for

[24]https://scroll.in/pulse/877313/after-delhi-and-kerala-hyderabad-bolsters-primary-healthcare-with-new-basti-dawakhanas (last accessed on May 14, 2018)

[25]https://timesofindia.indiatimes.com/city/bengaluru/Karnataka-to-replicate-Delhis-Mohalla-clinics/articleshow/55095782.cms (last accessed on May 27, 2018)

[26]https://www.financialexpress.com/india-news/bjp-launches-first-janata-clinic-in-indore/1211061/ (last accessed on June 18, 2018)

[27]http://www.hindustantimes.com/delhi-news/7-reasons-why-world-leaders-are-talking-about-delhi-s-Mohalla-clinics/story-sw4lUjQQ2rj2ZA6ISCUbtM.html (last accessed on February 8, 2018)

improvement. Annan in a letter to Kejriwal said that the project could be a model for all Indian states “embarking on the UHC (Universal Health Care) journeys”. He recommended that there is a need to undertake a formal evaluation of the Mohalla Clinics programme, improve management information systems for maintaining patients’ records and better monitoring, and scaling up preventive and community based services to reform the project[28]. UK’s one of the oldest medical journals, The Lancet also praised the concept[29] but suggested some recommendations for like community monitoring.

Because of its recognition both nationally as well as globally, the Mohalla clinic project has become eyesore for the opposition political parties. Regardless of their popularity and strengths of primary healthcare model, Mohalla clinics received criticism from the opposition parties; Congress as well as BJP for the policy and operational gaps.

8.2 Criticism from Different Political Parties and Key Informants about Mohalla Clinics

8.2.1 Lack of Monitoring

The BJP highlighted lack of monitoring in the project which led to fudging of the number of patients coming to the clinics. Doctors give inflated number of patients, they see per day to get more money[30]. In one of the clinics, a doctors reportedly earned Rs.1.8 lakh a month from Mohalla clinics. In other clinics, a doctor saw 533 patients in four hours between 9 am and 1 pm translating to an average of over two patient consultations in a minute. This raises a question on accountability of care provided to the patients. In this regard, present L-G Baijal also sought great “transparency and quality healthcare”[31].

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[28] http://www.hindustantimes.com/delhi-news/Mohalla-clinics-pat-from-kofi-anan-is-fine-but-will-govt-resolve-these-four-problems/story-o9n8QNHFbfnbuTBkp0vKSP.html (last accessed on September 20, 2017)

[29] http://www.hindustantimes.com/delhi-news/absent-doctors-no-medicines-now-volunteers-will-monitor-aap-s-mohalla-clinics/story-5jz5S8q7tQa17a4YKdndkI.html (last accessed on September 20, 2017)

[30] http://www.hindustantimes.com/delhi-news/two-years-of-aap-govt-model-clinics-give-healthcare-a-new-face/story-eMbSLNOenJ56CcCi7XcBZP.html (last accessed on September 20, 2017)

[31] https://blogs.timesofindia.indiatimes.com/jibber-jabber/can-the-mohalla-clinic-model-replace-government-dispensaries-quacks-and-expensive-private-healthcare-in-urban-areas/ (last accessed on September 20, 2017)

8.2.2 Allegations of Corruption and Nepotism

Both the parties have alleged AAP for corruption and nepotism[32]. The Congress party alleged that the AAP government had violated the norms in the government by extending pecuniary benefits to its own party workers in the Mohalla clinic project[33]. The Congress blamed the AAP government for indulging in massive corruption and one of the Congress leader even accused Mohalla clinics run under the AAP government as a big scam[34]. The party said that "it is not just a scam, but a flawed policy"[35]. The party accused them for favoring their own workers and supporters by renting their buildings for opening of these clinics. The AAP was blamed for not adopting any transparent mechanism for selection of the sites for Mohalla clinics. Also, the rent of Mohalla clinics is inflated as compared to the market value.

One of the doctors, Doctor A (interviewed on October 26th, 2017) also raised this issue that the AAP leaders favour their relatives/known for the recruitment of staff at the higher level. Many of them have recruited their relatives even at the supervisory level. He added that they don't have any knowledge about the health system of Delhi but still they are in the health policy making process and supervision of Mohalla clinics. He further added that they (their relatives/known) receive high pay cheques than the doctors who are doing hard work.

One of the key informant in his interview said that the job of the doctors employed in these clinics is not a *sarkari naukri* (government job) then why are they working in these clinics. There is no uniformity in selection criteria for doctors. There is no clarity on the qualification, experience of doctors and from where they have completed their qualification. Nobody knows who select them and from where these 158 doctors came (in

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[32] http://indiatoday.intoday.in/story/aap-Mohalla-clinics-medicines-arvind-kejriwal-satyender-jain/1/867540.html (last accessed on February 8, 2018)

[33] https://thewire.in/politics/congress-aap-mohalla-clinics (last accessed on September 25, 2017)

[34] https://www.financialexpress.com/india-news/arvind-kejriwals-aap-mohalla-clinics-are-a-big-scam-alleges-delhi-congress-chief-ajay-maken/833204/ (last accessed on September 29, 2017)

[35] http://indianexpress.com/article/delhi/congress-complaint-stalled-new-clinics-infuriated-aap-4823245/ (last accessed on September 1, 2017)

158 clinics). He said "there was no competitive exam held for the selection of the doctors; they have created job markets for fools. He added *"Jin doctoro ke pass pehle ek-do patients aate the ab wo 50-50 hazar kama rahe hain" ("the doctors who receive only one or two patients earlier, now they are earning Rs. 50,000")*

He added that AAP is generating employment by hiring their own party workers by opening these clinics. Most of the paramedic staffs are either their relatives or *karyakartas* (workers). The quality of doctors is not good, they are highly careless, negligent and don't treat the patients completely.

8.2.3 Unqualified Staff

The opposition had also criticized these clinics for not recruiting qualified staff. In the clinics, the untrained helpers or auxiliary nursing mid-wife dispense medicines in place of a professional pharmacist[36] and by doing this, they are putting people's lives at risk.

8.2.4 Questionable Quality of Blood Tests

The Delhi assembly's BJP members also questioned the quality of tests done by the empanelled private labs. They complained that the diagnostic test results reported by the empanelled private labs were delivering wrong results[37].

8.2.5 Empanelment of Doctors gives Space for Private Practice

The opposition criticized that empanelling private doctors on a part-time, per-patient basis leads to conflict of interest issues such as referral to private practice and rushing patients for increasing the number of patients to get more money as they are being paid on per patient basis.

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[36] http://www.news18.com/news/politics/kejriwals-promise-of-1000-Mohalla-clinics-reality-check-a-year-later-1373707.html (last accessed on September 5, 2017)

[37] https://blogs.timesofindia.indiatimes.com/jibber-jabber/can-the-mohalla-clinic-model-replace-government-dispensaries-quacks-and-expensive-private-healthcare-in-urban-areas/ (last accessed on September 5, 2017)

8.2.6 Lack of Public Health Approach

Mohalla clinics only provide first-aid kind of services; patients don't get specialized care as the doctors employed in these clinics are general physicians. These clinics provide generic medicines only for minor ailments. These doctors in the clinics distribute free medicines to the people with random symptoms. People come to these clinics with minor symptoms like cold, get low quality medicines and feel happy because everything is free. That is why he emphasised that nothing should come free of cost. As people are getting services for free, they cannot ask for quality. A minimum amount of user fee should be asked from the patients as nobody is so poor that they cannot afford to pay a meager of amount fee.

The Congress accused the AAP Mohalla Clinic policy for lacking a public health perspective. They said that these clinics do not provide first line defense mechanism against prevention of outbreaks and are equipped to provide only OPD support of very rudimentary type. The party also lodged a complaint with the Central Vigilance Commission with a charge that the mishandling of the project has weakened the public health delivery system in the national capital[38].

8.2.7 No Immunization Facility

AAP is saying that these clinics provide one window services, but these clinics don't have the facility of immunization. People still have to go to the dispensaries for immunization. If they don't provide primary health care services, then how can they say it as one window services?

8.2.8 Working Hours of the Clinics

The Mohalla clinics run only for four hours daily (but now six hours) leaving large number of patients out of coverage. This causes inconvenience for those who are in need of medical emergency. They either have to miss their work, take a half day off from office or lose their wages or take off from schools to go to a doctor.

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[38] https://thewire.in/68042/congress-aap-mohalla-clinics/ (last accessed on September 25, 2017)

8.2.9 No Referral Linkages

As per Congress party there are no referral linkages to other dispensaries and hospitals under Delhi government for the management of those patients who cannot be treated at these clinics.

8.2.10 Undermining Existing Health Infrastructure

Congress accused Delhi government for transferring staff from existing dispensaries to the Mohalla clinics built by them. By doing this, AAP government undermined the existing health facilities for their Party Propaganda. As the existing dispensaries working with better infrastructure, offer great range of services and the public is already aware of their presence, the government should have made efforts to strengthen the existing infrastructure. They blamed the government for not doing a gap analysis for opening of Mohalla clinics as many of them have been started in the close proximity to the other government dispensaries which weakens the existence of existing dispensary.

One of the key informants (interviewed on July 10th, 2018) raised serious questions on existence of Mohalla clinics in Delhi. He said "looking at the vast health infrastructure, Delhi doesn't need such kind of clinics where there are dispensaries and private clinics exist at every other street corner, these clinics is just a duplication of existing health facilities. Not only a large number of dispensaries but Delhi has more than 50 big government hospitals which provide specialised care free of cost to the poor people. But instead of going to those hospitals, people are using these clinics as they exist in their vicinity. Human being is a lazy animal; they want everything close to them so that they don't have to make any effort. Because of their proximity, people are using these clinics for minor or even for arbitrary symptoms. He added that these clinics might have been useful in rural areas where the distance from home to health facilities is huge. Or they should have been opened 10-15 years back when the health system was not vastly expanded in Delhi.

The diseases have always been there even before coming up of these clinics. It is important to understand how people used to manage their diseases in the past when these clinics were not there. Instead of using specialised services why people are going to these

clinics. He said *“This government is making people dependent on such sub-standard medical services”*.

8.2.11 No Uniform Mechanism for Record Maintenance

The Congress also raised a question on record maintenance that there is no proper mechanism to record patients’ details and their prescription. In some clinics, the prescription is being given on *Kachchi parchi* (rough slip), in other clinics on the smart tab and at some places in registers so the basis of reimbursement is not clear.

8.2.12 Lack of Community Participation

Congress raises an important issue of lack of community participation in the Mohalla clinic project. There is no place for community participation and monitoring in the project which could help in combating diseases.

Other issues raised are: name, qualification and photo of the doctors are not displayed in the clinics, untrained people disbursing medicines, no proper place to store medicines and no transparency on the medicine stock. Also, the premises of the clinics are unsuitable for public health institution as many of the clinics are being operated in dirty and small premises.

While Congress launched this report (DPCC, 2016) on one side and BJP-controlled MCD threatened to remove the two roadside porta-cabins saying that they did not have requisite permissions but they also function as clinics. But Health Minister of Delhi Mr. Satyendra Jain claimed that temporary structures did not need permissions[39].

8.2.13 High Influx of Migrants for Free Health Services

One of the key informants said these clinics attract high influx of patients from the neighbouring states in desire of free health services. This would increase the population of Delhi and ultimately add burden on the existing health system and

[39] https://scroll.in/pulse/817225/the-congress-and-aap-are-fighting-over-delhis-mohalla-clinics-and-thats-a-good-thing (last accessed on July 2, 2018)

8.2.14 Doctor-Driven Project

A key informant criticized the project for being a doctor-driven project where the patients have no role to play. Doctors are at the core of the project and patients are just users of services. This shows that there is lack of community participation in this project.

He highlighted that the intent of the government is good but the implementation of the project is poor. It was not a systematically done exercise as Mohalla clinics have been opened in great haste without any proper planning. The only advantage of these clinics is that they are near to the people's residence.

8.3 Current Situation and Challenges for Sustainability of the Mohalla Clinics

The Mohalla clinic project is highly politicised in the current times. The project is facing challenges for its political and financial sustainability. As a particular ruling party initiated this project, other political parties are raising questions for its sustenance and sustainability. There have been obstacles not only for setting up of new clinics but for the sustainability of the existing Mohalla clinics in the current times.

L-G, being the constitutional head of Delhi is responsible to take all the administrative decisions and the Central government (run by BJP) controls the power of L-G. There are instances of tussle between the former L-G, Mr. Najeeb Jung and Chief Minister of Delhi, Mr. Arvind Kejriwal which had affected the project badly. Many times AAP-ruled Delhi government blamed former L-G and BJP run MCD for delaying clearance for proposed sites for the clinics[40]. The BJP-led municipal corporations had also issued notices of encroachment to the Delhi government[41].

As L-G and the DDA (run by the Centre) control the allotment of land, there have been conflicts among them and the Delhi government. This delayed the allocation of land for opening of new clinics. Some of the other issues are delay in official approval procedures

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[40] http://www.news18.com/news/politics/kejriwals-promise-of-1000-Mohalla-clinics-reality-check-a-year-later-1373707.html (last accessed on September 12, 2017)

[41] http://www.thehindu.com/news/cities/Delhi/A-year-on-are-mohalla-clinics-running-out-of-steam/article16947215.ece (last accessed on September 12, 2017)

and internal strife between the Delhi government and municipal corporations over land. The government also failed to get land for the clinics at school after the L-G's disagreement[42].

Because of all the issues mentioned above, the project faced a serious setback and the timeline for setting up of 1000 Mohalla clinics has been shifted. The AAP claimed that the project of establishing 1,000 Mohalla clinics could not be completed in the stipulated time due to interference from the L-G.

It was also observed that many of the newly opened clinics are lying vacant, unattended and non-operational ever since it opened. The party also alleged that some of the newly built clinics are not operational due to the L-G's reluctance to give the necessary permissions and the IAS officers' strike[43]. Instead of discussing the matter of clearance, the L-G gave excuses saying that there is no such file pending with the L-G's office. The L-G also refused to meet the AAP Members of Legislative Assembly (MLAs). Also, false allegations have been made on AAP MLAs that they have blocked the Raj Niwas.

The Delhi government is also facing problems in continuing with the services provided by the existing clinics. The important blood tests conducted in Mohalla clinics and polyclinics, are likely to end due to non-floating of lab tenders. The recent strike of IAS officers led to the non-floating of lab tenders. The lab tenders were approved by the Delhi cabinet on December 12th, 2017 but the clearance is still pending[44]. In the absence of lab facilities, the clinics will not be able to function properly and the patients will again start going to the big hospitals for tests.

Also, many of the doctors complained that the Delhi government has failed to compensate the doctors fully for their services. The doctors don't get their payment on

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[42] http://www.developmentchannel.org/2017/09/01/delhi-community-clinic-scheme-may-be-dying/ (last accessed on September 12, 2017)

[43] https://www.thequint.com/videos/news-videos/delhi-mohalla-clinics-bad-condition-ground-report (last accessed on July 2, 2018)

[44] https://www.drugtodayonline.com/medical-news/nation/7355-diagnostic-lab-tests-may-stop-in-mohalla-polyclinics-jain.html (last accessed on June 13, 2018)

time. The doctors interviewed in the clinics also raised this issue of non-payment of their salaries since last three months as their contract didn't get renewed (till October-December).

One of the key informant said that the future of the project of Mohalla clinics is not bright. He added that you will soon hear news about shortage of medicines in the clinics and doctors are giving expired, poor quality and ineffective medicines.

The chief minister also wrote on Twitter that "poor people are treated in the Mohalla clinics. Any help towards setting up these clinics is an act of virtue. Everybody should come forward for the cause leaving behind party politics". But the opposition is putting obstacles in his way of achieving his target.

8.4 Health and Wellness Centres: Duplication of Existing PHCs and Mohalla Clinics

Although the Mohalla clinics received criticism from both the opposition parties in Delhi, the Central government is planning to open similar kind of clinics; Health and Wellness Centres all over the country to meet the goal of Universal Health Coverage (UHC).

Undoubtedly, the Mohalla clinics become immensely popular among the underserved population and have the potential to meet their health needs. But the project also faces criticism for not being able to achieve the target of opening 1000 clinics by 2016. As mentioned above, there are several reasons for the delay which include paucity of land, lack of quality checks, and absence of mid-course improvements along with other things. As the model has some limitations in fulfilling the existing gaps, it embraces an immense potential for replication.

The Central government seeks to establish similar kind of community clinics in the form of Health and Wellness Centres under Ayushman Bharat Program community clinics which can offer a robust network of primary level facilities. The Government of India announced this Program in the Union budget 2018-19 to fulfil the goal of UHC which was mentioned in the National Health Policy 2017 (NHP-2017). It has two components; first is Health and Wellness Centers, and the other one is National Health Protection Scheme. The aim of this Program is to increase accessibility, availability and

affordability of primary, secondary and tertiary care health services in India (Lahariya, 2017).

The Ayushman Bharat Program aspires to set up 1.5 lakh wellness centers by 2022 and government can save its resources by leveraging from the already running 'Mohalla Clinics'. Since community participation is one of the ten guiding principles of formulation of UHC in India, there are clear intersections between 'Mohalla Clinics' and a universal health care scheme[45].

Finance Minister, Mr. Arun Jaitley in his budget speech said *"these clinics will bring health care system closer to the homes of people. These centres will provide comprehensive health care, including for non-communicable diseases and maternal and child health services. These centres will also provide free essential drugs and diagnostic services"*. The MoHFW estimates that each Health and Wellness Centre will cost about Rs. 17 lakhs in setting up and running of the centre in the first year and approximately Rs. 7.5 lakhs per year in subsequent years. This expenditure is in addition to what is already being spent to run the existing sub-centres. Also, this cost doesn't include the cost of diagnostics, medicines, and information system and referral consultations. On estimating the annual cost to run each centre, it is found to be Rs. 10 lakhs. Estimating the cost to run 1, 50,000 clinics, it comes out to be Rs. 15,000 crore. After inclusion of the cost of diagnostics, medicines and information system, the more reasonable cost is Rs. 20 lakh per year per centre. So the annual expenditure on the scheme will be Rs 30,000 crore[46].

The proposed Health and Wellness Centres are supposed to be the first contact point for communities with the public health system. These centres become the better versions of existing health sub-centres and PHCs. The centres will provide primary and outpatient

[45] https://thenewleam.com/2018/06/route-universal-health-must-involve-community/ (last accessed on July 2, 2018)

[46] https://scroll.in/pulse/870405/in-new-health-and-wellness-centres-india-has-a-good-plan-for-primary-care-backed-by-little-action (last accessed on July 2, 2018)

care. The referral will be made to secondary and tertiary health care only if required[47]. The concept is almost similar to the concept of Mohalla clinics then why the government want to open these clinics, is a big question. Isn't it that the Central government is playing vote bank politics just like AAP (as mentioned by the other political parties)?

8.5 Few Suggestions (Based on the Key Informant Interview)

- There should be a proper monitoring of the project in terms of functionality, medicine stock and quality of services provided by the doctors.
- There should be a proper checks and balance in the project (by doing regular audits) to avoid pilferage of medicines.
- Post-medication assessment of the patients should be done at a regular interval to assess the quality of treatment received at these clinics.
- All patients' data should be digitalized and electronically recorded as there is no proper mechanism for recording the data.
- Selection of the staff should be done through a proper system or by conducting some competitive exams
- Performance audit of the doctors should be done at regular intervals to evaluate them and the quality of services provided by them.
- Imposition of user fee is important to have a connectivity and reciprocation in relationship with the government. Government is accountable to provide health services and if the people pay for these services a link will be established between them (as a consumer) with the government.

8.6 Summary

No doubt, these clinics are duplication of existing sub-centres or PHCs but they don't come under any of the category because of their gaps mentioned above. But opening of another set of clinics; Health and Wellness Centres (which is just another duplication of services) is not a viable solution to fill these gaps. Replication of similar kind of clinics would add financial burden on the government and also draws scarce resources from the

[47]https://scroll.in/pulse/870405/in-new-health-and-wellness-centres-india-has-a-good-plan-for-primary-care-backed-by-little-action (last accessed on July 2, 2018)

system. As already mentioned, health care delivery system of Delhi is very complex, these replications will complicate the system even more and exhausts the existing resources (financial as well as human resources). After coming up of these clinics, the problem of convergence and coordination among the different health care providers will arise.

Many hurdles had been put in the past to impede the expansion of these clinics and development of the project not only by the opposition parties but by the Lieutenant Governor (L-G) and other agencies like MCD and Delhi Development Authority (DDA) also. Delhi, being under the control of L-G for its administrative decisions, is facing problems in getting his approval of land for setting up of new clinics. The project is also facing challenges in sustaining the existing Mohalla clinics. There is a need gain confidence of the L-G and seek consensus of the other political parties to achieve the aims of the project to build 1000 Mohalla clinics across Delhi. The project can only be supported by them if the government takes steps to fill the existing gaps.

One of the major limitations of these clinics is lack of integrated/public heath approach (as also highlighted by one of the doctors working in Mohalla clinics). These clinics instead of providing holistic care deliver only medical services. These clinics have a narrow focus on treating illnesses rather than improving health which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[48] (as per WHO's definition of health). There is a need for the government to expand their vision and realize that health is a social phenomenon and Mohalla clinic is a social institution which cannot be studied in isolation from the societal conditions in which it operates.

Another major drawback of the Mohalla clinics is introduction of private labs for the blood investigations. The existing lab could have been strengthened instead of giving tenders to the private labs. If the private sector is given space, there is a need to put check and balances to regularize their services. In the absence of any monitoring mechanism, these labs will start generating profits out of the limited public resources.

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[48] http://www.who.int/about/mission/en/ (last accessed on July 2, 2018)

No doubt, the lab facilities at these clinics are catering to the needs of a large population. The patients who were interviewed in Mohalla clinics highlighted the importance of free blood testing as they don't have to go the private labs and spend unnecessary on blood tests. The free diagnostic services are highly advantageous for ageing population because of their more vulnerability to fall sick. These tests will also help in early diagnosis of diseases especially in diagnosing non-communicable diseases. With proper monitoring and evaluation, these diagnostic facilities in Mohalla clinics can function well and cater to the unmet need for diagnostics of the population of Delhi.

Also, the empanelment of doctors promotes privatization. This will add risk of higher healthcare cost as the doctors are not recruited on fixed salaries but on per patient basis, so there is a possibility to inflate the number of patients. As they are also allowed to do private practice, there is a possibility that the doctor would call patients to their private clinics in the non-working hours and charge unnecessarily high amount which would ultimately adds to the out-of-pocket burden on the families especially on the poor families. The doctors at the clinics were happy with the system of empanelment as they have fewer responsibilities and don't have do night duties in these clinics. In limited hours, they earn a handsome amount of money. This empanelment on the other hand has an advantage that it keeps the doctors happy and satisfied which have a positive effect on their behaviour and quality of services provided by them.

Instead of empanelling, the doctors could be recruited on permanent basis to ingrain a sense of accountability among them. This will bring them in line with the system of government dispensaries/hospitals and also uniformalize these clinics. Additional benefits can be provided to the doctors keep them motivated and satisfied.

Opposition parties criticized Mohalla clinics for undermining the existing health facilities. But with some improvements these clinics can serve a large population for treatment of minor ailments and screening for serious illnesses. For the success of this project, there is a need to have a proper referral system. If the referral services are poor then these clinics will work in silos and there is no point in establishing these clinics only for the minor illnesses.

Looking at the sorry state of the public health services, Mohalla clinics are boon for the residents of Delhi. Some of the major problems in the existing health facilities in Delhi are overcrowding, long waiting time, poor quality of service delivery and uncertain availability of medicines which leads to dissatisfaction among the people for the public health facilities. These clinics by adding another layer to Delhi's health system have increased geographical access to health services. Not only geographical access but these clinics have made the health services accessible. Mohalla clinics are proving to be a boon for the residents of Delhi especially for elderly, women and children as good quality free health services are available to them at one spot without travelling long distances and with no waiting in long queues.

As all the services delivered by these clinics are free, these clinics have reduced the cost in seeking health care. By starting these clinics in the neighbourhood of the people, these clinics have also reduced the traveling and opportunity cost that incur while visiting any other government health facility. So it can be concluded that the services provided by Mohalla clinics are highly cost effective. These clinics are highly beneficial in early diagnosis of the diseases (as also mentioned in the earlier chapters) and appropriate referral will be made (if required) to the higher level health facilities like polyclinics as they cannot provide specialised services. Polyclinics form the second layer after Mohalla clinics which provide specialised services like gynecology, orthopedic, pediatric, ENT etc. In case of serious illnesses or surgeries, patients can further referred to the secondary and tertiary level hospitals. For this to happen there is a need to have a strong public health infrastructure.

It is clear that the referral system is in place (Congress blamed the lack of proper referral system) in Delhi. But the referral system will function properly if the referral facilities (within the existing health system) are strengthened. Steps should be taken to strengthen the existing health infrastructure and improve the quality of services at the existing health facilities.

One of the steps suggested by the key informants improve the quality of services is imposition of user charges. A small amount of user fee should be charged so that the

patients should not take these services for granted. But imposition of user fees in public health care facilities is anti-poor and proves fatal for the public health system (Dilip and Duggal, 2004). It has been observed that for many of the people, especially the poor, user fee is one of the barriers in accessing health services. User fee further decreases the access to health services for more vulnerable sections like women, children, the scheduled castes and the scheduled tribes in India. Imposition of user charges on patients is a clear indication of commercializing the public health services. This has a serious implication for equity and access to healthcare (Bajpai, 2014). User fee do not lead to a more affordable system, instead they create advantages for the rich and healthy and make matters worse for poor and sick (Bajpai and Saraya, 2010). As many of the people reported no/low cost to user as a major advantage of using the public health care facilities, imposition of user fee is not an appropriate suggestion as per the Indian conditions.

Chapter 9 - Summary and Discussion

India with a population of 132.42 Crores needs a robust health care system to cater the health needs of population. It has a three-tier healthcare delivery system where primary health centre forms the first point of contact for individuals, families, and communities with the national health system. While in the rural areas, primary healthcare is provided through a network of Primary Health Centre (PHCs) and Sub-centre (SCs) in urban areas it is provided through the Urban Health Posts and Urban Family Welfare Centre (UFWCs). Secondary healthcare forms the second tier of the health system where patients are referred from primary health centers for specialized care and treatment. And tertiary health care is provided through the means of medical colleges and research institutions where high tech. diagnostics, medical, surgical as well as intensive care services are available.

India is rapidly urbanizing and this rapid urbanization has always also resulted in proliferation of slum and increase in slum population in the urban areas. This rise in slum population poses huge challenge for the government to provide quality health care services. This increase in population of slums and informal settlements has given rise to urban poverty and greater inequalities in income. These settlements are characterized by shortage of basic services and poor infrastructure. It includes poor housing, shortage of water supply, sewage, drainage and sanitation facilities, solid waste management, affordable housing, health and education etc. It has also been observed that urban populations exhibit more variation in poverty, morbidity, mortality, and nutritional status compared to rural communities (Basta, 1977; Bradley et. al., 1992, cited in Kumar and Mohanty, 2011). Therefore people living in these areas don’t constitute a homogeneous population and similarly they have varying needs and demands.

Due to the high heterogeneity of the population in the urban areas, people have different needs and expectations from the urban health care delivery systems. Most often the needs of urban poor get overlooked and the present health system is unable to fulfill their need which further raises the issues of exclusion and enhanced vulnerabilities. Many studies shows that despite of an increase in income and closer geographic proximity to medical

facilities, the urban poor are more vulnerable compared to their rural counterparts. Because of their low socioeconomic status, there is a high dependency on the public health facilities. But the extremely weak public sector with poor quality of care becomes the reason that the poor seek care from the private sector (Mahal et. al., 2001. cited in Balarajan et. al., 2011). This highlights the shortcomings of the public sector which gives more space to the private practitioners/unqualified health providers in the health system including quacks. Further, financial constraints restrict urban poor to seek medical care from qualified private providers and finally they end up visiting unqualified quacks. Opening doors for the private providers further degrades the quality of services provided by public dispensaries/hospitals.

Urban health in India faces critical challenges like poor infrastructure, shortage of human resources, fragmented and uncoordinated health service delivery, insufficient coordination amongst multiple agencies, suboptimal financing, migrant population, high level of inequalities and inequities, etc. (Lahariya et. al., 2016). Even after acknowledging all these problems in the past, urban health had received very limited attention from the policy-makers in India. It got attention only in the last few years when it was realized that solutions to tackle the challenges in the rural areas are not sufficient to deal with the challenges in the urban areas.

With an aim to meet the health needs of the people living in urban areas, the National Urban Health Mission (NUHM) was launched as a part of National Health Mission (NHM). As a result Urban health got due attention in the 12th Five Year Plan. Notwithstanding these measures equitable access to quality health services at an affordable price remains an unfulfilled desire.

9.1 Understanding Urban Health in Delhi

Delhi, being the capital of country has a complex and fragmented health system run by multiple central and state government agencies and municipal corporations. There is always an ambiguity in their roles and responsibilities and the boundaries of these institutions which further leads to complexity in health care provisioning. In addition the private providers and voluntary organizations also play an important role in delivering

health services in Delhi. Health is a state subject in India and is considered as every human's right. The three tier system of health care delivery covers the primary, secondary and tertiary care needs of the population. Though the public hospitals are the dominant healthcare service providers and their services are utilized by a significant proportion of the population a large number of people spend money on both minor and major ailments and often go into debts for any emergency medical treatment. High costs of treatment in the private sector are one of the reasons for high debt. The poor not only have a higher exposure to health threats, but also often times can only cope with disease by burdening their family – socially and financially (Butsch et. al., 2012).

Studies show that due to non-functional primary health services in urban areas of Delhi and also neighboring states, people end up visiting the tertiary hospitals even for simple ailments, in turn putting burden on them (National Urban Health Mission: Framework for implementation, 2013). As Lahariya also mentioned that lack of functioning or poor functioning of primary health care systems in Delhi increased the patient burden on secondary and tertiary care services (Lahariya, 2016). Because of this high demand of secondary and tertiary care patients (As many as 10,000 patients reach the hospital's OPD daily[49]), the public hospitals face challenges like deficient infrastructure and poor maintenance, poor hospital management, poor quality of services, long queues for consultation, shortage of doctors, unavailability of medicines and insufficient lab equipments make the people to move towards the private sector. Therefore, controlling the flow of patients between the three levels, of health system is the biggest challenge faced by Delhi's health care delivery system.

9.2 Objectives of the Study

The current study was taken up to understand the basis for entry of Mohalla Clinics in the existing healthcare delivery system in Delhi. This study intends to study the role of Mohalla Clinics in delivering health care services in Delhi. In particular the study aims to understand perception and experience of doctors and other paramedic staff working in Mohalla Clinics. The study also aims to understand different perception and experience

[49] https://www.hindustantimes.com/delhi-news/with-over-10-000-opd-patients-many-die-waiting-at-crowded-aiims/story-uIOPzEwsBRNEgvxQrumqoJ.html (last accessed on July 2, 2018)

of patients regarding accessibility, utilization and quality of health services provided by Mohalla Clinic.

9.3 Methodology and Methods

The study includes primary data collection by visiting 16 Mohalla Clinics across Delhi. Data collection was done using the mixed method approach to have a broader and deeper understanding of research problems. The doctors and paramedic staff at all the 16 clinics were interviewed using an interview schedule to meet the research objectives. To understand the patients' perceptions, 105 Exit interviews were taken in four Mohalla Clinics. Observation has also been used as a direct method for data collection.

9.4 Origin of Mohalla Clinics

In the year 2014, the manifesto of newly elected Aam Aadmi Party in Delhi promised to ensure primary health care to the residents of Delhi by bringing the care closer to their homes and to reduce their financial burden on health. The Mohalla clinics were initiated with an aim to improve the delivery of healthcare services in slums/*JJ* clusters and urban villages. This was to reduce the burden on tertiary care institutions and also to provide health care services in the community. By establishing a good referral system with the higher level health facilities, the government is trying to free secondary and tertiary care for serious illnesses and surgeries. Also, by providing access to quality healthcare services at the doorstep of those who were earlier out of the purview of government's coverage, these clinics have tried to narrow down the disparities that exists in health care in Delhi.

The government, by launching these clinics, is moving a step ahead towards achieving the goal of Universal Health Care, which has three important components i.e. increasing population coverage, increasing availability of quality health services and financial protection and efficiency. By expanding the healthcare service delivery in these areas which were difficult to reach earlier and reducing financial burden of the families living in these areas, Mohalla clinics have made a substantial progress in this direction.

The Mohalla Clinics have added another layer to the three layered health system in Delhi. Because of its political origin, it gets a convenient entry in the existing health care delivery system. The clinics are called populist clinics but they have the potential to meet the health needs of residents of Delhi.

The origin of these clinics can be traced back to 1980s when the National Health System, the Sistema Único de Saúde (SUS) brought Family Health Strategy (FHS) in Brazil. To achieve the UHC, the system had invested substantially in expanding access to health care for all citizens. The healthcare management is decentralized where the municipalities are accountable for most of primary care services. Most of the common medications and publicly financed health services are universally accessible and free of cost at the point of service for all citizens. The interdisciplinary healthcare teams; FHS teams form the core of the Program. Each team covers a population of up to 1000 households. These teams leave no gap and overlap between catchment areas and facilitate access through first-contact care by organizing themselves geographically near people's homes (Rocha and Soares, 2010).

Similarly, the mobile vans or mobile medical units in Delhi also provide basic health care to the marginalized population at the community level based on their felt needs. The aim of these vans is to reach the unreached/underserved and vulnerable population (Lahariya, 2017).

9.5 Findings

The study found that people across the social strata are using the services of Mohalla clinics. Most of the patients (45 per cent) attending Mohalla clinics fall under the category 2 income group who earn Rs. 5000-10000 per month. Almost equal number of patients (43 per cent) falls under the Category 3 where the overall household income falls between Rs. 11,000-20,000. Very few i.e. 9 per cent of the households fall under Category 4 who come to Mohalla clinics for any of the health related problems. Only 3 per cent of the households use Mohalla clinics which belong to the income group that ranges from Rs. 0-5000 (Category 1). Findings also show that only 20 per cent of the

working population utilizes the services provided by these clinics. Other 80 per cent were housewife, children and pensioners.

The findings show that 68 per cent of the female patients attend Mohalla clinics for treatment of their illnesses in contrast to only 32 per cent of the male patients. If we look at the distribution of patients based on the age-group, it was found that around 22 per cent of the patients coming to these clinics are elderly patients, i.e. in the age-group of 51-90 years. Almost equal number of patients (21 per cent) falls under the age group of 31-40 years.

It was also found during the fieldwork that 81 per cent of the patients utilizing the services provided by the Mohalla clinics belong to the scheduled caste category and 9 per cent of the patients from Other Backward Caste (OBC) and 9 per cent of patients from other caste groups (upper caste) use these clinics. It is necessary to highlight that Muslims, Jaats and Yadavs come under the category of OBC group. Scheduled Tribes (STs) contribute only one per cent to the patients utilizing services provided by the Mohalla Clinics.

If we look at the place of origin, it was found that 43 per cent of patients were residents of Delhi and remaining 57 per cent of the population is migrated from different states who are utilising the services of Mohalla Clinics. Findings show that 55 per cent of population lives in rented accommodation.

To understand the health-seeking behavior of the patients, 105 interviews were conducted. The findings reveal that 42 per cent of the patients used to go to the public hospitals before coming up of Mohalla clinics. But after coming up of Mohalla clinics 82 per cent of patients started coming to these clinics. The findings from the fieldwork show that earlier, 18 per cent of patients used to go to the government dispensaries but the number has reduced to only three per cent.

It was also found that before coming up of Mohalla clinics, private health providers contribute a significant share, approximately 24 per cent, in care provisioning. But after the establishment of Mohalla clinics, there is a significant decline in private practice now only seven per cent of the patients are using services of private providers.

Attempts have also been made to understand the functioning of Mohalla clinics. As mentioned 16 clinics had been visited during the fieldwork out of those, nine clinics have two rooms, five clinics have one room and two clinics have three rooms. The clinic with single room is used by the doctor to examine the patients as well as to keep the medicines. These clinics didn't have an Almirah to store the medicines. The medicines were lying on the floor. The same room was used for sample collection. All the clinics have waiting space with chairs for the patients to sit except the two. In the clinics which don't have separate waiting space, the patients wait for their turn sitting in the assessment room. All the doctors and 13 per cent of the patients complained about the lack of proper waiting room and insufficient space in the clinics.

As mentioned earlier, these clinics provide free consultation, free blood test facility and free medicines at one spot. The clinics provide medicines from 136 essential generic drugs for minor ailments. The clinics have a facility of 212 free blood tests which are freely available. A contract has been given to an empanelled lab which collects blood sample from the clinics and delivers report the very next day.

With respect to human resources, nine out of 16 clinics have three staff members, six clinics have four staff members and only one clinic has six staff members including doctor. Because of shortage of the pharmacists in many clinics, untrained staffs/Multitask workers (MTWs) are disbursing medicines. Only one clinic had professional pharmacist and in other clinics the helpers or MTWs after some training disburse medicines. Similar is the case with lab technicians. The helpers had been given training to draw blood sample so that they don't have to employ professional lab tech. In three out of 16 clinics, ANM are given duty of disbursing the medicines to the patients.

Out of all the patients interviewed, 87 per cent said that the services provided by the Mohalla clinics are sufficient and fully satisfactory. The other 13 per cent gave the following reasons for dissatisfaction: lack of emergency services, OPD timings are not sufficient (from 8 Am. to 2 Pm.), lack of space, no proper first-aid facility and no ambulance services at the clinics. The satisfaction level was understood on the basis of: patient in-flow and time spent by doctor per patient, patients' waiting time in clinics v/s

waiting time in public hospitals/dispensaries, behaviour of the staff and patient flow management in the clinic.

Fifty three per cent of the patients said that they spend more than 5 hours in a government hospital and this is one of the reasons for dissatisfaction from the government hospitals. But in the Mohalla clinics, 67 per cent of the patients said that most of the time they spend 15-20 minutes in the clinics which includes waiting as well as consultation time.

Patients in most of the clinics i.e. 14 out of 16 clinics visited by the researcher were happy and satisfied with the behavior of the staff. In one of the other two clinics, the doctor was rude and used to shout on the patients and takes long breaks during the working hours. In other clinic, the doctor doesn't listen to the patients' problem carefully instead start writing the prescription just listening to half of their problems.

Smart tab is used for maintaining records of the patients in 12 out of 16 clinics. In remaining 4 clinics, registers were used for keeping patients details. It was also found during the interviews that the clinics which were started in second round have never been given the smart tab. They use the old methods for record keeping.

9.6 Analysis

9.6.1 Analysing Patients' Perspective

Bringing the primary health care closer to people where they live was also one of the objectives of Mohalla Clinics and also to ensure that they get treatment from professional doctors.

The findings show that these neighborhood clinics provide consultation, diagnostics and medicines free of cost. As the doctors sitting in these clinics are general physicians, patients only with the minor ailments are treated at this level. The referral is made to the higher level polyclinics for specialized care like orthopedics, gynecology, ophthalmology and pediatrics etc. providing free medicines and blood test services at the community level, these clinics have improved access to health care services especially among the vulnerable sections of the society. By treating minor ailments at the community level, these clinics have the potential to reduce patients' load in the government hospitals.

The study also found that these clinics receive appreciation and positive responses from the people as they get health care at their doorstep. Not only urban poor population but these clinics are being utilized by a significant population who belong to middle and even upper middle class. The kind of services utilized by these sections is different; middle and upper class use diagnostic services and lower class uses curative as well as diagnostic services. Looking at the extensive utilization of these clinics, as the Deputy Chief Minister Mr. Manish Sisodia in the first outcome report presented in Delhi Assembly mentioned that 32 lakh patients have availed healthcare services from the Mohalla clinics, it can be said that the patients have now developed trust in the government health facilities[50].

Mohalla clinics have been designed to break barrier between doctor and patients. Doctors, being present in the proximity of the patients have built a good relationship with the patients which have helped in improving their experience at public health facilities which wasn't there earlier at the public hospitals. These clinics have helped in establishing good doctor-patient relationship instead of a complex and hierarchical association. Clinical care not only requires skills of diagnosing and treating but it also requires skills for interpersonal care like qualities of integrity, honesty, respect, empathy, compassion and altruism (Paul and Bhatia, 2015). The doctors at these clinics not only offer the medical services but also provide counseling services. By talking and spending more time with the patients, they have developed a relationship of mutual trust and respect with the patients. This is one of the reasons for the popularity of these clinics.

Other than doctors' behavior patient's waiting time is another important factor to measure patient satisfaction and quality of care. Patient's clinic waiting time is an important indicator of quality of services offered by hospitals (Patel and Patel, 2017, p. 858). One of the reasons for dissatisfaction from the existing health facilities was a long waiting time in the hospitals to seek consultation even for the minor ailments. Longer the waiting time, more the patients feel dissatisfied. Mohalla clinics have reduced the waiting time to maximum of half an hour. Earlier, the patients used to spend minimum of 5-6 hours in a

[50] http://www.dnaindia.com/delhi/report-work-on-new-mohalla-clinics-picks-up-pace-health-department-identifies-80-sites-in-delhi-2607875 (last accessed on July 5, 2018)

government hospital but at Mohalla clinics the patients come and avail healthcare services in a short duration of time. Now, the patients don't have to rush to big government hospitals for minor illnesses like cough, fever and cold.

As far as cost is concerned, there is no cost (direct as well as indirect) incurred for accessing these services. Because of their presence in the community, there is no or very low associated transportation cost. As the services are available free of cost, there is no expenditure on consultation, diagnostics and medicines. Due to non-availability of the medicines and diagnostic facilities at the government hospitals, patients had to spend out of their pocket. It has been estimated that of the total OOPE, 53.46 per cent was spent on medicines and 9.95 per cent was spent on diagnostics. 82.29 per cent of the total OOP medicines expenditure and 67 per cent of total OOP diagnostic expenditure was for outpatient treatment (Household Health Expenditures in India, 2013-14). But these clinics by making these services available free of cost have the potential to drastically reduce the OOPE especially for the poor families.

Another major contribution of Mohalla clinics is improved access for vulnerable sections of society. The evidences show that the poor, a majority of those who are socially marginalized, get the least access to preventive and curative health services (Baru et. al, 2010, p. 56). A large number of patients visiting these clinics are women, children, and elderly and who belong to scheduled caste category. This high patient influx from these categories demonstrates that these clinics have improved access for these sections of people. Elderly patients appreciated that these clinics have reduced their dependency on others. Now, they can go to the clinic on their own and seek medical care without any support and financial burden. Women, now don't have to depend on their husbands to go to the doctor leaving their children alone at home.

9.6.2 Analyzing Doctors' perspective

Doctors highlighted the differences between the existing dispensaries and PHCs. One of the major differences is management of diseases in these facilities. Mohalla clinics do active management of diseases by reaching the patients directly in their neighborhood instead of patients coming to the health facilities. Also, because of their presence in the community, these clinics have the potential to catch the root cause of diseases in that

particular community. Being present in the community, the doctors have a good exposure of diverse type of patients and diseases. Each doctor gets to see more than 100 patients a day which is a big number compared to the number of patients in private practice. As the doctors get their remuneration based on the number of patients they see every day, all of them were found to be quite satisfied with what they get for the service provision. The doctor gets Rs. 30 per patient. And if a doctor sees 100 patients (on an average per day) meaning he/she earns Rs. 3000 per month and around Rs. 75,000 per month which is much more than what a doctor earns in a government hospital.

The doctors also highlighted that they earn good amount of money by working for limited number of hours i.e. only for 5-6 hours. But if they go to work in a government institution, they have to work for long hours and do night shifts. The doctors (who had been shifted from the nearby dispensaries to these clinics) also highlighted that in Mohalla clinics, they have to make only 5-6 reports instead of 70-80 reports as they had to make in their respective dispensaries. In private practice also, they don't get this huge number of patients and such high remuneration. And after coming up of these clinics, the number of patients has further reduced. This fact has also been accepted by the private practitioners and quacks in the localities where the Mohalla clinics have started.

The doctors highlighted the importance of Mohalla Clinics in reducing the private practice and number of quacks in the localities. As these services are close to the people and available at free of cost, the people instead of going to private practitioners or quacks directly come to these clinics even with the minor symptoms. This not only helps in early diagnosis of diseases possible but also reduces OOPE on health in treating the serious diseases.

Technology can play an important role in proper functioning of the clinics (if used properly). The digitalization of data has reduced the requirement for additional staff for record maintenance. The automatic prescription generation had made the consultation completely digitalized and paperless making the whole process environment-friendly. Also, the online data can be utilized by the doctors and policy makers to understand the prevailing problems in those communities. On the basis of this understanding, appropriate strategies can be designed to devise strategies for the health problems. In

addition, by studying the dynamic process of disease progression in a community (by using the digital data), the health professionals can draft apt health policies and programs for the community.

One out of 16 clinics visited was also equipped with automatic medicine dispensing machine. It had reduced the burden on the doctor as well as on the pharmacist. Because of some of its limitations (discussed in earlier chapters), the machine cannot completely replace the pharmacist. No doubt, the machine plays some role in online medicine stock management but an additional workforce is required to do the data entry and physical stock management.

Analyzing the perspective of doctors and patients shows numerous advantages of these clinics. However, only one out of 16 doctors at Mohalla clinics critiqued the project for lack of public health approach. Mohalla clinics have limited attention on population or public health services and focuses only on clinical or curative services. These clinics provide “primary level care” instead of providing “primary health care”. By focusing only on medical care, these clinics completely failed to provide primary health care of which preventive care is an integral part.

In order to improve health outcome, there is a need to view health from a public health perspective which focuses on delivering services at population/public level rather than individual based clinical health. It also becomes necessary to understand health from a holistic perspective to achieve better health outcome where health is not merely absence of disease or infirmity but it is a state of complete physical, mental and social well-being.

Mohalla clinics have also been criticized by the doctors for lack of space and human resources in the clinics. The clinics were established in either two or three rooms with no sufficient waiting hall. Many times the patients have to wait outside the clinics in extreme conditions like hot, cold and rainy weather. Sometimes, the doctor cannot do proper check-up of the patients because of the lack of proper assessment room. This is very critical issue in case of female patients who may not tell the doctors all the symptoms in the presence of other patients which leads to incomplete history and further treatment.

Not only space, but these clinics lack drinking water facility. In all the clinics, the doctors and paramedic staffs arrange water for themselves, either by paying from their own pockets or by bringing water from their homes. Two of the doctors said that because of their good terms and relations with the water supplier of that colony, the supplier gives them water for free. Water is a necessity for everyone to live; in the absence of such basic amenities, the clinics will not run properly. These facilities should be made available by the government in all the clinics, if the staff pays for water their own pockets then it is not a sustainable idea and the clinics wouldn't work for long.

The doctors complained about lack of coordination among the staff members of nodal dispensaries and Mohalla clinics. The nodal dispensaries supplies medicines to Mohalla clinics. The clinics give indent which mentions the name of the medicines and quantity required after every 10-15 days, depending upon the requirement. The doctors complained that sometimes the dispensaries supply medicines on time and sometimes they delay. Also, sometimes they give required quantity of medicines but most often they supply lesser quantity of medicines than required. Many times the doctors had to give medicines to the patients for a week only instead of a month, especially to the patients with diabetes and blood pressure.

The doctors and paramedic staff complained about the lack of uniformity in the Mohalla clinics. The clinics run in rented premises (102 clinics) as well as in porta cabins (56 clinics). Salaries/remuneration of the staff is not fixed. Doctors in four out of 16 clinics are not the regular doctors employed for Mohalla clinics; they have been shifted from the nearby dispensaries to these clinics. This not only affects the functioning of the existing health facility but the doctors also find it difficult to build rapport with the community because of the shifting of doctors.

One out of all the paramedic staff interviewed was not satisfied with the coming up of Mohalla clinics. He said that these clinics were not required looking at the vast infrastructure of Delhi. Instead of starting completely new health facilities, the government should have strengthened the existing ones. The staff from the existing dispensaries had been shifted to these clinics which is hampering the functioning in the

dispensaries. The government had open these clinics in haste to win the election without any planning so he is unsure about the future of these clinics after this government.

9.6.3 Political Dimension of Mohalla clinics

It is true that the AAP government have brought the public healthcare to the vanguard of state politics by opening these clinics. As discussed in the previous chapter, because of political origin of Mohalla clinics, they receive lot of criticism from different opposition parties. Mohalla clinic is a good initiative appreciated not only in India but internationally. But many hurdles had been put in its way not only by the opposition parties but by the Lieutenant Governor too to halt its progression. While on the one hand permission didn't granted for opening of new clinics, on the other hands allegations had been made for land encroachment and threatening had been given to demolish the existing one. This is the clear indication of a political rift between the parties but it is affecting the functioning of the project. The opposition parties are undermining the efforts of the ruling party because of its fresh origin. The other two parties were ruling India since independence; suddenly a new party comes and won the election which raises the anxiety among these parties. The opposition parties feel insecure about their existence after coming up of the new party (AAP). This could be one of the reasons for critiquing Mohalla clinics as it is initiated by a new political party. Both the parties acknowledged the lack of access to health care for urban poor but they don't want to popularize the other party (that too with recent origin).

Looking at the poor access to health care for the urban poor, the contribution of Mohalla clinics in Delhi is important in the present situation. Looking at the insufficient primary health care services in the urban areas particularly in the urban slums, there is a need for robust health system to meet the health needs of the citizens of Delhi. The government, by launching these clinics, is taking a step ahead in the direction of achieving the goal of Universal Health Coverage by increasing population coverage, increasing availability of quality health services and financial protection and efficiency. Mohalla clinics have made a substantial progress in this direction.

9.7 Critical Evaluation of Mohalla Clinics

9.7.1 Lack of Public Health Approach

These clinics can be analyzed from varying perspectives. By launching Mohalla clinics, the Delhi government had taken a step towards achieving UHC for all. These clinics not only have improved geographical access for the people but also improved access to health services for the most deprived and vulnerable population living in the underserved areas. These clinics are highly beneficial for the ones who are most vulnerable and prone to illness and are out of coverage of the government's programs.

By providing quality health care services at the doorstep of the people, these clinics encourage people to seek health care at an early stage of the onset of diseases that too from qualified doctors. Those people who used to avoid going to a health facility because of lack of access to health care facilities due to distance of the health facility, wastage of time in traveling, long waiting time in seeking care, loss of wages etc. now come to the clinics with early symptoms.

Mohalla clinics have contributed in changing the health-seeking behavior of this population as the patients come in early stage of the disease progression. As 80-90 per cent of the health problems can be treated at the primary level, these clinics have reduced their OOPE on health for serious diseases during the later stages due to non availability of the treatment during the early stage of onset of disease.

Notwithstanding the benefits discussed, Mohalla clinics have failed in providing comprehensive health care. Health care includes medical care as well as pro-preventive care. These clinics are highly criticized for their narrow individual based clinical approach instead of population based public health approach. The inadequate priority to public health and low investment in public health services, like water and sanitation in these clinics culminate into diseases which will add burden to the health system. For this to achieve, holistic (health systems) approach is a must. Also, to have a better health outcome of the population, there is a need to strengthen the health system and create linkages with other public health departments.

Mohalla clinics have generated a ray of hope for the poorest section of the society to have access to quality healthcare that too at their doorstep. These clinics are capable of improving the way people think about their health thereby their health seeking behavior.

However, one of the biggest critiques of Mohalla clinics is their narrow approach. These clinics deliver only primary level care instead of primary health care. The focus of these clinics is to provide 'medical care' (curative services) to the patients i.e. consultation, medicines and diagnostic tests and there is a complete neglect of 'public health' which is an important component of Primary Health Care. The target of these clinics is to treat more and more patients for their illnesses without looking at the root cause of the problem which lies within their socioeconomic and physical environmental conditions. The clinics deliver only curative services as against the promise to provide primary health care. There is a need to understand that pumping more and more money and medicines in the health system without doing any actual need assessment, wouldn't work to strengthen the health system. An integrated approach is a must to improve health status of the population. No doubt, these clinics are treating a large population but in the absence of promotive and preventive services, curative services are only peanut services.

Lahariya in his article had also highlighted that these clinics have limited focus on public health services. These clinics focus on personal or curative, diagnostic and a few on preventive health services (Lahariya 2017, p.6). These clinics provide only personal health services completely overlooking population health.

Mohalla clinics have limited linkage with community and outreach services (Lahariya 2017, p.6). There is complete neglect of promotive and preventive aspect in the kind of health services provided by these clinics. Community participation is nil in the process of need assessment which is a prerequisite to improve health of any community. One of the major drawbacks of these clinics is that they do not fulfill the requirements of providing primary health care as they do not cover the public health services such as sanitation, drinking water, importance of hygiene, and awareness about nutrition (Lahariya, 2017).

It has been recognized that a strong and effective primary health care services is a foundation of a robust health system. Mohalla clinics form the lowest level of the health

system and provide first-contact primary health services. These clinics can offer wide range of services rather than just curative and diagnostic services and strengthen the health system. Being at the community level, clinics can address the social determinants of health by providing preventive and promotive services through the public health system. So these clinics have the potential to fill the gaps in existing health system by delivering preventive, promotive, curative, diagnostic and rehabilitative services rather than just medical care. By doing proper planning and implementation, it can offer access to comprehensive services to improve, maintain and restore people's health. Instead of using these clinics for a particular political party agenda, use them for developing personal connection with the patients, the doctors can treat the patients beyond the health system for e.g. in case of ageing and destitute patients.

9.7.2 No Measures to Strengthen Existing Health Facilities

The clinics have been opened in addition to the existing health facilities where the existing health facilities are still lacking in infrastructure as well as in human resources. Setting up of a completely new parallel system leads to exhaustion of available resource in terms of both human as well as financial resource from the system. Human resources are finite and they have been transferred from the existing health system to these clinics. It has been observed that staff members from primary health centers are deployed at these clinics hampering the work at the PHCs. These clinics have also drained the budget under the health sector which could have been utilized for strengthening of the existing health system. Since Delhi has a vast network of health infrastructure, the attempts should have been made to strengthen the existing infrastructure as they are better equipped, offer a good range of services and people are already aware about their presence and location rather than setting up a completely new system.

9.7.3 Lack of Coordination among Multiple Agencies Delivering Health Services

An efficient referral system provides access to treatment and skills by linking different levels of care through appropriate referrals[51]. The poor referral linkages is one of the major reasons for overburdened government hospitals in Delhi; people with minor

[51] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4972360/#pone.0159793.ref009 (last accessed on July 4, 2018)

ailments come to higher level hospitals troubling themselves and putting pressure on health facilities. There is no coordination between the multiple agencies delivering health services in Delhi. The Mohalla clinics can form the basis for efficient referral linkages to the higher level health facilities only when there is coordination among all the agencies delivering health services. In the absence of good coordination among different agencies providing health services and functional referral system, the success of the Mohalla clinics is going to be a challenge.

9.7.4 No Utilization of the Health Data at Policy Level

The android-based smart tab is very helpful in creating digital record. It had been designed in such a way that it collects and collates wide range of data including patients' photograph and personal details, disease profile, vitals and medicines/treatment prescribed in the last one year. The health workers and the government can access and retrieve the medical data easily to keep track of patients' visits and understand the trends of diseases, prescriptions and lab tests prescribed. The data can be aggregated and fed into a centralized system for situational analysis to influence the policy and financing decisions. This would also help in devising preventive health strategies especially for non-communicable diseases. But the motto with which it was launched would not be achieved if the data remain with the doctors and at the most cloud at a point without being analyzed by the policy makers.

9.7.5 Replication of Data

It has been observed during the field work that many times patients forget their contact details given in the first visit during the registration. The problem is more with old age patients who tend to forget their mobile number in the follow-up visit. In that case, the doctor creates a new profile leading to replication of data which further makes the analysis difficult. The replication can be avoided if the doctor fills more than one identification column to make the recognition easier. One of the easiest ways is to link patient's profile with his/her unique Aadhar Card number which cannot be duplicated.

9.7.6 Lack of Uniformity in the Infrastructural Facilities

The Mohalla clinics are low cost dispensaries but there is a lack of uniformity among these clinics. Some of the clinics have been started in the rented accommodation and some in pre-fabricated porta-cabins. Most of the clinics are running in two rooms setting and very few of them work in three-room facility. Lack of space in the clinics which are working in two rooms facility, find it difficult to run the clinic efficiently. In the absence of proper waiting room, patients have to wait outside even in the adverse conditions like extreme hot/cold.

9.7.7 Less Time Spent per Patient

It was found during the fieldwork that on an average a doctor sees 125 patients per day and the operational timing of the clinics is from 8 a.m. to 2 p.m. If the time spent by a doctor per patient is calculated it comes out to be less than two minutes (it is also highlighted in a newspaper article[52]). Also, this time includes the time for registration, consultation and medicine disbursement. If a doctor needs to understand patients' problem carefully, the doctor has to spend sufficient time with patients. If we look the above calculation, less than two minutes is not sufficient to understand patient's problems and diagnose patients' problem and prescribe required medicines or suggest if any test required. Such a short consultation time is likely to adversely affect patient care and also increases the stress of the doctor.

9.7.8 No Proper Assessment Room

In all the clinics, there was no proper evaluation room which makes the patients uncomfortable to share their problems with the doctor in front of the other patients especially the female patients. In one case where a 20 years old woman had a problem of irregular menstrual cycle, she couldn't tell anything to the doctor as other patients were also sitting next to her. Finally, she had to call her husband to tell the doctor about her problem. In another case where a woman had severe back pain, the doctor wanted to see the exact point on the spine from where the pain arises but couldn't see it because the

[52] https://scroll.in/pulse/817225/the-congress-and-aap-are-fighting-over-delhis-mohalla-clinics-and-thats-a-good-thing (last accessed on July 2, 2018)

woman was feeling shy in lifting her shirt to show him that point in front of other patients sitting in the clinic. Therefore, the doctor couldn't diagnose it properly, in the absence of a proper assessment room and gave her a diclofenac tablet (a painkiller) to reduce her pain.

9.7.9 Lack of Proper Medicines Storage Facility

In almost all the clinics, there is no proper medicines storage facility because of dearth of the space (except one). Two out of 16 clinics didn't even have the almirah to keep the medicines properly. Medicines were lying on the floor causing obstruction in the normal functioning of the doctor and other staff members.

9.7.10 Lack of Proper First-aid Facility

One of the major limitations of these clinics is the absence of proper first-aid facility. Being in the community, it is mandatory to have a proper first-aid chamber/room so that patients with minor injuries, cuts, burns and bites can walk-in the clinic and directly get treated. In addition to this, these clinics do not offer any emergency care like stabilization of the fracture or major injury after accident which requires urgent attention. For stabilization, there is no need for highly qualified health professionals; an MBBS doctor can very well do it.

Also, there is no facility for treatment of the patients suffering from diarrhea who require admission for dehydration via glucose drip. This process isn't a difficult process and also it doesn't require any special equipment, being a primary health centre the clinic can have this facility so that the patients don't have to run to the secondary and tertiary hospitals for treatment of diarrhea.

9.7.11 Non-Uniform Staff Structure

There is always a staff crunch in health system of Delhi as it has to cater to a large population. In order to meet the increasing demands of staff in the Mohalla clinics, either staff members have to be shifted from the nearby permanent health facilities to these clinics or multi tasks has to be assigned to a staff member. Four clinics have the doctors from the nearby government health facilities (mostly from the Delhi Government

Dispensary) and a Public Health Nurse was shifted to the clinic in the absence of pharmacist. Sometimes the staff members are shifted for a short period of time and sometimes for longer duration.

Moreover, there is no homogeneity in the staff structure. As mentioned, the clinics should have a qualified medical doctor, Auxiliary nurse Midwife (ANM), a pharmacist and a helper (Lahariya, 2017) but only one out of 16 clinics visited has a pharmacist and in the other clinics medicines had been dispense either by ANM or lab technician or helper. ANMs instead of doing field work and carry out door-to-door to counsel pregnant women, vaccination of children and awareness generation on different issues are dispensing medicines in the Mohalla clinics. In six out of 16 clinics, ANMs had been shifted from the nearby dispensaries to work as pharmacists or helpers.

In one of the clinics, an unqualified staff (the cleaner) was dispensing the medicines in the absence of helper cum pharmacist. The roles and responsibilities of the staff members are also very ambiguous as there is no clarity on who does what? In one of the clinics, a helper who had studied merely till 8th standard dispenses medicines along with cleaning the clinic. As they are not authorized to dispense medicines, there is a violation of norm.

In one clinic, the helper was given some training to draw blood sample. The reason given by the doctor was as the professional lab technicians ask for more money, he had recruited her after giving some training. But she was not skilled enough to draw blood as observed in a case where she inserted needle of the syringe thrice to find out vein but she couldn't find in the end. Giving this responsibility to a person who is not qualified and skilled to do the task is deliberately risking the lives of patients.

9.7.12 Same Designation – Different Pay (Erratic Payment Model)

The payment model has advantages as well as disadvantages. The private doctors have been recruited to at "fee for service" basis. They are being paid Rs. 30 per patient as consultation charges and a helper is given Rs. 10 per patient. The staff members are being paid based on the patients they see and amount of work they do.

In this scenario, the doctors who get less number of patients critiqued the payment model. One out of 16 doctors gets only 70-80 patients per day so the amount he gets is less as compare to the other doctors who see on an average 100-150 patients per day. He does private practice in the evening to compensate for it. This type of payment model could impact the motivation level of the doctors and this will ultimately reflect on their behavior. They will start losing interest in their work because of being paid differently for the same kind of work.

9.7.13 Lack of Proper Monitoring and Quality Assurance Mechanism

In order to run a system efficiently, there is a need to have a proper regulatory mechanism which can keep checks and balances on all the components of the system. In the absence of it the system would shatter. The pitiable condition of the public healthcare system is because it is dismally funded, it provides deplorable and sub-standard quality services which are being poorly monitored. To keep a check on quality of the services provided by these clinics, there is a need for periodic monitoring. Active community participation is also mandatory to maintain and improve the quality of services. This can only become possible when the middle class families also start utilizing the services of the Mohalla Clinics. They would create continuous pressure on the system so if the quality of services doesn't improve; they will not allow degrading it either.

Even for the payment model, there is no monitoring mechanism. There is a possibility for them to inflate the number of patients in order to earn more money. There is a chance of unnecessarily calling the patients repeatedly for follow-up especially in case of patients suffering from respiratory diseases, diabetes and hypertension (as observed during the field work). They can increase the number of patients per day. Therefore there is a need to keep a check on these issues in order to avoid malpractices.

9.7.14 Limited Timings of Opening and Closing of the Clinics

The clinics were started with an aim to treat minor ailments at the community level thus reducing patient load in the government hospitals. For this to achieve, the timing of opening and closing of the clinics matters a lot. One of the major shortcomings of these clinics is the limited timings of the clinics i.e. from 9 am to 1 pm initially but now from 8

Am to 2 Pm. In the hours other than operational hours, patients either have to visit a quack/*Bengali* doctor (who is most preferred by the urban poor because of their low fee) or a private practitioner (for those who can afford to pay the exorbitant consultation fee) or emergency of a government hospital (in a worst case scenario). If the patients are visiting other health facilities for minor ailments despite of the presence of a Mohalla clinic in their vicinity, then the motto of opening these clinics would be defeated.

9.7.15 Lack of Basic Amenities

In almost all the clinics, there was no provision of drinking water by the government. Doctors themselves have to make arrangements for water either they have to bring it from their home or they have to purchase from nearby shops and pay from their own pockets even for patients. The doctors said that the requirement for water is less in winters but they face more difficulties in summers.

Toilets in the clinics are available only for the doctors and other clinic staff members but patients are not allowed to use them. It was observed during the field visit that patients were denied using the toilet in the clinics. On being asked by a staff member, she said that they will make the toilet dirty just like they do in government hospitals. Because of the unhygienic hospital environment and dirty toilets, the perception of staff members has altered for the clinics also. For them poor patients will always make the environment dirty whether they visit government hospitals or the clinics. While the clinics were opened with an objective to provide primary health care but in the absence of the basic amenities like water and toilet facility, the target would not be achieved.

To end this, I would say that it is one of the good initiatives taken by AAP government other than education. Looking at the high demand of health needs of Delhites, these clinics are catering to the needs of a significant proportion of population. The progress of the project should not be impeded due to the political rivalries among the opposition parties. Also the aim of 1000 clinics is very much unachievable dream of the AAP if they want. These clinics have the potential to revolutionize Delhi's health system with some improvement as discussed in the previous chapters.

9.8 Limitations of the Study

The study was conducted by interviewing the patients who visited the clinics and outside the clinics who used the services therefore the respondents include the users of the clinics but there is no reporting of the perceptions of the non-users of the clinics. Due to shortage of time visits couldn't be made in the nearby communities/slums/villages to understand the reasons for not using the clinics. Within a limited frame given for M. Phil an attempt has been made to understand the perception of the patients about Mohalla clinics and experiences with respect to the services provided by these clinics.

The study does not intend to generalize the results; however, it hopes to do justice with the shared perceptions and experiences of urban poor at the Mohalla clinics by representing them. The study also tried to capture the experiences of the doctors/paramedical staff.

At a few places, interviews were conducted in front of doctors/staff members (due to lack of space and noisy surrounding outside the clinic) that might have caused change in their responses. The responses to the questions like behavior of the doctor/paramedical staff, quality of the services were dubious. But the informal discussions have revealed most of the information. Sometimes, the patients were reluctant to share their personal information. The indirect questions in the form of probing were asked to elicit information regarding earning per month, serious illness in past, expenditure on health etc. These patients had a perception in mind that these clinics are meant only for the poor patients so they tried to hide their socioeconomic status thinking that they would be robbed off from using the services provided by these clinics.

There is always a possibility of recall bias as patients less likely to recall information regarding their illness in the last few months until or unless there was any major illness or a case of hospitalization. This is more common among the elderly people and children who are more likely to fall sick with minor ailment too often than the young population.

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Annexure - Fieldwork at Glance

Clinic	Type of Clinic	Infrastructural Facilities	Human Resource	Qualification of Doctor	Job Satisfaction	Patients' inflow	Patients' Record	Services offered
1	Rented	2 rooms + Waiting Hall	Doctor, Lab tech. & MTW (paid on per patient basis)	Dr. A MBBS, MPH (Retired from New Delhi Municipal Council)	Yes	100-120	Tablet	Consultation Diagnosis & Medicines
2	Rented	2 rooms + Waiting Hall	Doctor, Lab tech. & MTW (paid on per patient basis)	Dr. B MBBS (worked in hospitals as JR)	Yes	125-150	Tablet	Consultation Diagnosis & Medicines
3	Rented	2 rooms + Waiting Hall	Doctor, Lab tech. ANM & Helper (paid on per patient basis)	Dr. C MBBS (not the regular one & working in a nearby dispensary)	Yes	130-150	Register (Tab not working)	Consultation Diagnosis & Medicines
4	Rented	1 room + Waiting Hall, no almirah for medicines	Doctor, Lab tech. MTW (paid on per patient basis)	Dr. D MBBS (worked in a private hospitals)	Yes	150-180	Tablet	Consultation Diagnosis & Medicines
5	Rented	3 rooms + Waiting Hall	Doctor, Lab Tech, ANM & MTW (paid on per patient basis)	Dr. E MBBS (worked in a nearby dispensary)	Yes	80-100	Paper (Data entry by helper later)	Consultation Diagnosis & Medicines
6	Rented	2 rooms + Waiting Hall & kitchen	Doctor, ANM MTW & helper (paid on per patient basis)	Dr. F MBBS (worked in a nursing home & private practice)	Average	Approx. 100	Tablet	Consultation Diagnosis & Medicines
7	Inside a temple	2 rooms + Waiting Hall	Doctor, ANM, helper & MTW (paid on per patient basis)	Dr. G MBBS (Retired)	Average	100-150	Tablet	Consultation Diagnosis & Medicines
8	Rented	2 rooms + Waiting Hall	Doctor, Helper & MTW (paid on per patient basis)	Dr. H MBBS (worked in a private hospitals)	Yes	150-155	Tablet	Consultation Diagnosis & Medicines
9	Rented	2 rooms + Waiting Hall	Doctor, Lab tech, Helper & MTW (paid on per patient basis)	Dr. I MBBS (worked in a nearby dispensary)	Yes	Approx. 150	Tablet	Consultation Diagnosis & Medicines
10	Rented	2 rooms + Waiting Hall	Doctor, Helper cum Lab tech. & MTW (paid on per patient basis)	Dr. J MBBS (worked in a private hospitals)	Yes	100-150	Tablet	Consultation Diagnosis & Medicines
11	Rented	1 room + Waiting Hall	Doctor, Lab tech, Helper (paid on per patient basis)	Dr. K MBBS (worked as CMO at IGI Airport)	Yes	100-150	Tablet	Consultation Diagnosis & Medicines
12	Rented	2 rooms + Waiting Hall	Doctor, Lab tech, Helper (paid on per patient basis)	Dr. L MBBS (worked in a private hospitals)	Average	100-120	Tablet	Consultation Diagnosis & Medicines
13	Porta cabin	1 room + Waiting Hall	Doctor, Lab tech, ANM, Pharmacist, Nursing Order & MTW (fixed salary)	Dr. M MBBS (Worked in RCH program)	Average	150-200	Register	Consultation Diagnosis & Medicines
14	Rented	2 rooms + Waiting Hall	Doctor, Helper & Lab tech. (paid on per patient basis)	Dr. N MBBS (Private practitioner)	Average	70-80	Tablet	Consultation Diagnosis & Medicines
15	Rented	1 room + Waiting Hall, no almirah for medicines	Doctor, MTW, ANM & Helper (paid on per patient basis)	Dr. O MBBS (worked in a public hospitals)	Yes	120-130	Register (Tab stolen)	Consultation Diagnosis & Medicines
16	Porta cabin	1 room + Waiting Hall	Doctor, Public Health Nurse and Nursing Orderly (fixed salary)	Dr. P MBBS (Worked in nearby dispensary)	Average	150-200	Register	Consultation & Medicines

Appendix 1- Interview Schedule for the Patients

Clinic/ Location……..……….

Sample No: …………….

I. Personal Details

1. Name of the Respondent: Gender: Male-1 Female-2
   Age:
2. Religion: Hindu-1 Muslim-2 Christian-3
   Other-4
3. Social Group: SC-1 ST-2 OBC-3
   Other-4
4. Marital Status: Never Married-1 Currently Married-2 Widowed-3 Separated-4 Other-5
5. Educational Status: Illiterate-1 Literate below Primary Level-2 Middle-3
   Secondary-4 Higher Secondary-5 Graduate and Above-6
6. Demographic Details of the Family:

So. No.	Name of the Patient	Family members of the Respondent	Sex	Age	Marital Status	Educational Status	Occupation	Income (Rs.)

II. Migration and Domicile issues

7. Place of Origin: Village: …………………….... District: ……………………………... State: ……………………………….
Sector: Rural-1 Urban-2

8. How long have you been staying in the city? Since Birth-0 Less than 2 years-1 3-5 years-2 6-8 years-3 9-11 years-4 More than 12 years-5
9. Reasons for Migration: Unemployment in village-1 Low Agriculture yield-2 Lack of work for survival-3 Natural Disaster-4 Lack of healthcare facilities-5 Any other reasons-6
10. Quality of Healthcare services in home town: Good-1 Average-2 Poor-3 Inaccessible-4 Can't Say-5

III. Current Living Conditions in the city

11. Ownership of the house: Own-1 Rented-2 Live near construction site-3 Any other-4
12. Type of house: Tin-1 Corrugated sheet-2 Cement or concrete-3 Half *Kaccha* and half *Pacca*-4 Any other-5
13. How many rooms the house has? One-1 Two-2 Three-3 More than three-4
14. Toilet facility: Own toilet-1 Common toilet-2 Municipal toilet-3 Open defecation-4 No Response-5
15. Bathing and washing facility: In the open-1 *Mori*-2 Bathroom-3 Common Bathroom-4 No Response-5
16. Source of drinking water: Public tap-1 Personal tap-2 Tanker-3 Water pipeline from the roadside-4 Private tap for several families-5 Other source-6
17. Source of bathing water and washing clothes: Public tap-1 Personal tap-2 Tanker-3 Water pipeline from the roadside-4 Private tap for several families-5 Other source-6
18. Does your area have proper drainage system? Yes-1 No-2
19. Asset owned: No asset-1 Small machines-2 Television-3 Vehicles-4
(If vehicle, kind of vehicle) More than one asset-5

20. Type of fuel used: Kerosene-1 Cooking Gas-2 Wood-3 Coal-4

IV. Working Conditions

21. Whether working? Yes-1 No-2

If working, then current Occupation: Government-1 Private-2 Organised-3 Informal-4 Self-employed-5

If not working, then whether- Housewife-1 Student-2 Retired-3

22. What are your normal working hours? 6-8 hours-1 8-10 hours-2 10-12 hours-3
23. How much do you earn? Below Rs. 5000-1 Rs. 5000-10,000-2 Rs.10,000-20,000-3 Above 20,000-4
24. How do you get your wages if working? Daily-1 Weekly-2 Monthly-3

V. Information on Pathways of Treatment

1. Had you been suffering from any illness in the last six months? Yes-1 No-2

   (a) If yes then did you take the treatment? Yes-1 No-2

Name	**Name of the disease**	**Place of treatment**	**Duration of treatment**	**Money spent on treatment**	**Tests done**	**Remarks** Dissatisfied/ Costly treatment/ Time consuming

(b) If no, then reasons for not taking the treatment

i. Lack of money
ii. Long distance from home to health facility
iii. No one advised

iv. No one in the family to look after

2. From which of the following sources of care did you receive care at any time during the illness? *Mohalla* clinic-1 Government Dispensary-2 Public Hospital-3 Private (qualified) Practitioner-4 Private Hospital-5 Quack-6 Medical Store-7 Charitable Hospital-8 Indigenous/Folk medicine-9 Faith Healer-10 ESI Dispensary-11
3. Where do you prefer to go for the treatment? *Mohalla* clinic-1 Government Dispensary-2 Public Hospital-3 Private (qualified) Practitioner-4 Private Hospital-5 Quack-6 Medical Store-7 Charitable Hospital-8 Indigenous/Folk medicine-9 Faith Healer-10 ESI Dispensary-11
4. Where do you actually go for the treatment? *Mohalla* clinic-1 Government Dispensary-2 Public Hospital-3 Private (qualified) Practitioner-4 Private Hospital-5 Quack-6 Medical Store-7 Charitable Hospital-8 Indigenous/Folk medicine-9 Faith Healer-10 ESI Dispensary-11
5. What is the actual pathway and sequence of getting the treatment? *Mohalla* clinic-1 Government Dispensary-2 Public Hospital-3 Private (qualified) Practitioner-4 Private Hospital-5 Quack-6 Medical Store-7 Charitable Hospital-8 Indigenous/Folk medicine-9 Faith Healer-10 ESI Dispensary-11
6. Do you face any challenges in accessing healthcare services in your area? Yes-1 No-2

   If yes, then what?

VI. Patient's current health problem and seeking care

7. What is the health problem you are suffering from? Please specify.

   Fever-1 Cough and cold-2 Backache and Bodyache-3 Diarrhea- 4 Dengue-5 Malaria-6 Chikungunea-7 Diabetes-8 Blood pressure related issues-9 UTI/RTI/STI-10 Others-11 More than one symptoms-12

8. Did you visit any other health care provider for the same problem? Yes-1 No-2
9. If yes then which provider? *Mohalla* clinic-1 Government Dispensary-2 Public Hospital-3 Private (qualified) Practitioner-4 Private Hospital-5 Quack-6 Medical Store-7 Charitable Hospital-8 Indigenous/Folk medicine-9 Faith Healer-10
10. If private provider, then how much did you spend on the treatment of this particular health problem? Rs. 0-200-1 Rs. 200-500-2 Rs. 500-1000-3 Rs. 1000-5000-4 Rs. 5000 and above-5
11. Consultancy-
12. Diagnosis-
13. Medicines-
14. Inpatient services-
15. Outpatient services-

VII. Experience at *Mohalla* Clinic

16. How frequently do you visit to *Mohalla* clinic? Weekly-1 Once in a month-2 Once in three months-3 Half yearly-4 Not fixed-5
17. How much time did you spend in *Mohalla* clinic today or in the last visit? 15-20 minutes-1 20 minutes to half an hour-2 Half an hour to an hour-3 More than an hour-4
18. What are the common health-problems for which they go to the *Mohalla* clinic? Fever-1 Cough and cold-2 Bodyache-3 Diarrhea- 4 Dengue-5 Malaria-6 Chikungunea-7 Diabetes-8 Blood pressure related issues-9 UTI/RTI/STI-10 Others-11 More than one symptoms-12
19. How do you feel the behaviour of the staff members of the *Mohalla* clinics? Good-1 Better than the dispensary staff-2 Average-3 Poor-4

20. How do you find the services at the *Mohalla* clinic? Satisfactory-1 Unsatisfactory-2 Average-3 Can't say-4 Poor-5
21. Do you think that *Mohalla* clinics have improved accessibility to healthcare services?Yes-1 No-2

If yes, then how?

If no, why?

22. Do you find comfortable in telling your symptoms in front of the other patients? Yes-1 No-2

If no, why?

23. Did the doctor spend as much time with you as you wanted and listen to everything you say? As much as wanted-1 Almost as much-2 Less than wanted-3 A lot less than wanted-4 Don't know-5 Refused-6
24. During the visit, did you understand everything the doctor said? Everything-1 Most-2 Some-3 Only a little-4 Don't know-5 Refused-6
25. Did you take all medicines recommended or prescribed by the doctor? Yes-1 No-2 If no, then why?
26. How much confidence and trust did you have in the doctor treating you? Great deal-1 A fair amount-2 Not too much-3 None at all-4 Don't know-5 Refused-6
27. Did the doctor treat you with respect and dignity? Great deal-1 A fair amount-2 Not too much-3 None at all-4 Don't know-5 Refused-6
28. Do you find *Mohalla* clinics beneficial for the residents of Delhi? Yes-1 No-3

If yes, then how?

If no, then why?

29. Do you have any insurance? Yes-1 No-2

If yes, then which insurance? What kind of health problems the insurance covers?

30. Any suggestions for improvement

VIII. Public Services

31. How far is the nearest dispensary from the house? Less than 2 kms-1 3-5 kms-2 6-8 Kms-3 More than 8 Kms-4
32. Did anybody in your family visit public hospital in the last one year? Yes-1 No-2

    (a) If yes, then for what purpose?

i. In-patient Services iv. Treatment for Major illness
ii. Immunization v. Maternal services/Delivery
iii. Contraceptive Counseling vi. Treatment for Minor illness

(b) How many hours did you spend when you last visited the government facility? 0-1 hour-1 1-2 hours-2 3-5 hours-3 More than 5 hours-4

(c) How did you find the services at government hospitals? Satisfactory-1 Unsatisfactory-2 Average-3 Can't say anything-4 Poor-5

If No, then please give reasons: Long distance-1 Long waiting time-2 Loss of wages-3 Non-availability of doctors-4 Non-availability of medicines-5 Unfriendly behaviour of the staff members-6 Other reasons-7

33. Did any health personnel visit your family in the last six months? Yes-1 No-2

    If yes, then for what purpose

i. Immunization/Polio drops iv. Malaria and Tuberculosis
ii. Awareness on AIDS/STDs v. Family Planning Counseling
iii. Maternal Care vi. Women related diseases

34. Suggestions for improvement for public health facilities

Appendix 2- Interview Guide for Health Personnel

Personal Details

1. Current occupation/designation in the clinic-
2. Academic qualification (specialization if any)-
3. Place originally you belong to
4. Where was your former work located?
5. How and why *Mohalla* clinics come?
6. When did you join this clinic?

Concept and Origin of Mohalla Clinics

7. What is the concept behind the origin of *Mohalla* clinic and its position in the existing Healthcare delivery system?
8. What is the role of *Mohalla* clinic in delivering healthcare services?
9. Do these clinics have reduced waiting hours and patient load in the government secondary and tertiary care hospitals? Yes-1 No-2

Working Experience at *Mohalla* Clinics

10. How many hours per weeks do you usually work at this clinic?
11. What type of work do you usually do at this clinic?
12. How much are you paid? Average income?
13. Additional benefits other than salary?
14. Any delays in receiving salary?
15. What is your opinion about the AAP model of payment in *Mohalla* clinics?
16. Are you satisfied with the payment model? If no, then why? If yes, then why?
17. Is there any limitation in the payment model? Give suggestions for improvement, If any
18. Are you satisfied with your income?
19. How many patients do you attend every day?
20. Do you remember any interesting case? If yes, then explain
21. Human resource available in the clinic
22. Do you think the human resource available in the clinic is sufficient?
23. Services available at the clinic
24. Do you think the services provided by the *Mohalla* clinics are satisfactory for the patients
25. Your experience at *Mohalla* clinic? Is it different from working in other facility? If yes, then how?
26. Challenges faced by you in providing healthcare to the patients

Referral System

27. What is the Referral system from *Mohalla* clinic?
28. Nearest referral unit/polyclinic for higher level care
29. What are the other Outreach services provided by the *Mohalla* clinics? Please elaborate
30. Does *Mohalla* clinic become Outreach service for the government hospitals

Categories of Patients and Type of Ailments They Come With

31. Common ailments patients come with
32. Process of receiving the care once the patient comes for the first time in the clinic
33. Do the patients follow your advice and tell you everything by taking you in confidence?
34. Which category (age/sex/caste/economic background wise) of patient generally falls ill?
35. Which category of patient generally visits *Mohalla* clinic?
36. At what stage of illness patients come to the clinic?

Patients' Preference for Treatment

37. What is the patients' preference for receiving treatment
38. Why do they prefer to receive treatment from one health facility and avoid other health facilities
39. Do the patients prefer to go to private practitioners? If yes, then why?

Supply Chain of Medicines

40. Medicine and other equipment procurement system
41. Who manages the Medicine and other equipment procurement system
42. Is there any delay in procurement of medicines and equipments in the clinic? If yes, then why?
43. How do you manage in case of delays?
44. Whether the number of medicines and tests available are same as shared in the Manifesto? If no, then why?

Political Debates around *Mohalla* Clinics

45. Do you have knowledge and understanding of the Political debates around *Mohalla* clinics? If yes, then what?

Suggestions for improvement of *Mohalla* Clinics

Appendix 3 - Checklist for Observation

1. Location of the clinic
2. Is there a board displaying the name of the clinic
3. Type of facility (permanent/porta-cabin/rented/government facility)
4. Cleanliness of the clinic: Is environmental disinfectant used, clinic littered with garbage/smelling foul/seepage/ leakage/water logging
5. OPD timings
6. Waiting room/space for patients inside/outside the clinic
7. Sitting arrangement
8. Does the waiting room/space have benches/chairs for sitting
9. Does the doctors' consulting room have privacy (curtains/partition)
10. Is there more than one patient/person other than the patient during the time when doctor was examining the patient
11. Overcrowding in the clinic? Patient load in the clinic?
12. Process of getting treatment after entering clinic for new and old patients
13. Ratio (in terms of age, gender and class) of the patients attending clinic
14. Waiting time for each patients
15. Assessment of the patients- how the doctor is diagnosing the patients, asking questions or using stethoscope, thermometer
16. Time spent on each patient
17. Behaviour of the staff members
18. Availability of basic healthcare equipments (Stethoscope, Thermometer, Blood Pressure Apparatus, Adult Weighing Scale, Child/infant Weighing Scale, Electric/Non-electric Autoclave, Latex Gloves, Refrigerator)
19. Basic First-Aid Care
20. Type of services available
21. Diagnosis and Management of Communicable diseases/Non-communicable diseases
22. Quality of services available
23. Condition of the lab and tests available in the clinic
24. Waste Disposal and management system in the lab/clinic
25. Condition of medicine store
26. Availability of the medicines
27. Water and toilet facility at the clinic
28. Record maintenance at the clinic
29. Daily reporting in the clinic
30. Referral system to polyclinic
31. Any user fee charged for medicines and diagnostics?
32. All the prescribed medicines are available in the clinic or asked the patients to purchase from market

Endnote

[i] Definition of urban poor population: "A group of ten or more adjacent households whose housing structures are of visibly poor quality, and/or whose homes have been laid out in a non-conventional fashion without adherence to a ground plan" (Multiple Indicator Assessment of the Urban Poor, N.A., p.17). They live in challenging socioeconomic conditions that manifest multiple forms of deprivation, i.e. physical, material, social and political (Moreno and Warah, 2006, pp.vi-vii). UN-Habitat defines them as lacking one or more of the following characteristics:

Durable housing- If a house has a permanent structure which builds on a safe location that protects its inhabitants against extreme weather conditions like hot, cold, rain and humidity.

Adequate living area- If a house has enough space where not more than three members share a room

Access to safe water- If a household has access to sufficient amounts of improved and safe water which is available to the household members at an affordable price without making any excessive effort

Access to sanitation- If the members of a household have access to a proper excreta disposal system either in the form of a public or a private toilet which is shared by a reasonable number of people

Security of tenure- People have secure tenure when they have perceived protection against forced evictions

(Mckinney and Walters, N.A., p.17; UNHABITAT, N.A., p.7; Moreno and Warah, 2006, pp.vi-vii)