

**HEALTHCARE IN THE NEIGHBOURHOOD:  
ROLE OF MOHALLA CLINICS IN PRIMARY  
HEALTHCARE SYSTEM IN DELHI**

*Dissertation submitted in the partial fulfilment of the requirements for the degree of*

**MASTER OF PHILOSOPHY**

**SONALI SMRITI BISWAS**



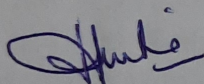
**Centre for the Study of Regional Development  
School of Social Sciences  
Jawaharlal Nehru University  
New Delhi  
India  
2021**

**RECOMMENDATION FORM FOR EVALUATION BY THE EXAMINER/S**

**CERTIFICATE**

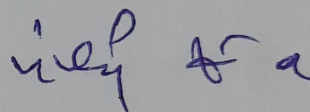
This is to certify that the dissertation titled **Healthcare in the Neighbourhood: Role of Mohalla Clinics in Primary Healthcare System in Delhi** submitted by Ms. **Sonali Smriti Biswas** in partial fulfillment of the requirements for award of degree of M.Phil. of Jawaharlal Nehru University, New Delhi, has not been previously submitted in part or in full for any other degree of this university or any other university/institution.

We recommend this dissertation be placed before the examiners for evaluation for the award of the degree of M.Phil.



Signature of Supervisor

Date: 5.3.21



Signature of Dean/Chairperson

Date: 8.3.21



Centre for the Study of Reg. Dev.  
School of Social Sciences  
Jawaharlal Nehru University  
New Delhi - 110067



Chairperson  
Centre for the Study of Reg. Dev.  
School of Social Sciences  
Jawaharlal Nehru University  
New Delhi - 110067

*Dedicated to all patients seeking affordable healthcare...*

*...for they rightly deserve it.*

## **Acknowledgement**

On this day of inexplicable ecstasy, I acknowledge my lifelong indebtedness to my supervisor, Prof. Sachidanand Sinha for believing in me and being a perpetual source of support, motivation and care throughout my journey. He has patiently guided me and helped me give this work its final shape. I shall remain grateful to Dr. Bikramaditya Choudhary for instilling the seed of interest in ‘Geography of Health’ in my mind, back during my M.A. days. This work has attained its present form with the help of indefatigable support from all the faculty members of the Centre for the Study of Regional Development (CSRD), especially, Dr. Sanjeev Sharma, Dr. Indrani Roychowdhury, Prof. K.S.James, Dr. Purva Yadav, Prof. Sucharita Sen who have always been approachable during every phase. I am also grateful to Prof. Rajib Dasgupta and Prof. Shanghamitra Acharya of the Centre of Social Medicine and Community Health (CSMCH) for their well-timed advice. I am highly obliged to Prof. Kunal Chakrabarti and Dr. Shubhra Chakrabarti for being a constant source of support and guidance. Dr. Sharmistha Mukherjee’s work and enriched discussions with her have been a constant guide during my work.

The office staff of CSRD have been amicable and supportive throughout the journey, and so have been the staff at the documentation units of CSRD and CSMCH and the staff at different units of Dr. B.R.Ambedkar Central Library. I shall remain highly indebted to Dr. Mahesh Chand for his well-timed support regarding Turnitin.

My colleagues have been enormously compassionate. Special mention may be made of Ranjan Karmakar, Hemant Kumar and Vijay Yadav for teaching me the nuances of collecting data from the field, especially on an issue as sensitive as health; Debapriya Karmakar for helping me with the details of the map work; Sahil Joon and Anjana Ratnu for being the shoulders to fall back on to; Akanchha Singh for being the anytime-go-to person and mutually working towards the deadlines; Raina Ghosh and Krishna Kumar for their expert advice during tea sessions; Gaurav Bhattacharya, Pintu Parui and the rest for helping me to sail through the tides of time.



Ashis Kumar Das has been a source of relentless motivation both through the consistent supply of photocopied material and boosting my morals; the warm greetings with the refreshing tea served by Latif Bhai and his colleagues have always cheered me up.

Advocate Naresh Yadav, MLA of Mehrauli Constituency has been especially helpful in assisting me in my work since its inception. The government officials of the AAMC Cell, Ministry of Health and Family Welfare, Govt. of NCT of Delhi, especially Dr. Shalley Kamra and Dr. Chandra have also been very co-operative in providing me with every document I needed access to. Despite the ongoing pandemic, I always had a continuous access to all documents and data that I needed to complete this work. Doctors at the clinics – Dr. Chaudhary and Dr. Pal have been very supportive despite their heavy burden of work and hectic schedule. The patients in the clinics have been a source of constant motivation. Their experiences of seeking healthcare have largely helped me conceptualize the structure of this work.

UGC's financial support has been a boon which helped to maintain the exchequer and devote all energy into this work without having to worry about any other aspect.

No amount of thanks can be enough to match the unfaltering support rendered by my mother, grandmother, Suvajit and the entire Sinha family – to whom I owe my existence – therefore I refrain myself from undertaking such a futile attempt.

While a lot of people's relentless efforts have gone into this product, yet all errors committed are owned by me and I extend my apologies for the same.

Thank you.

Sonali Smriti Biswas

# Contents

<i>Acknowledgement</i> .....	i-ii
<i>Contents</i> .....	iii-v
<i>List of Figures</i> .....	vii-viii
<i>List of Tables</i> .....	ix-x
<i>List of Abbreviations used</i> .....	xi-xiii
<b>Chapter 1: Introduction</b> .....	<b>01</b>
1.1 Introduction .....	01
1.2 Statement of the problem .....	07
1.3 Objectives.....	07
1.4 Research questions .....	08
1.5 Data Source and Methodology .....	08
1.6 Organization of Chapters .....	10
<b>Chapter 2: An Overview of Literature</b> .....	<b>11</b>
2.1 Introduction .....	11
2.2 Evolution of Medical Geography and Geography of Health .....	11
2.3 Role of Space and Place in Geography of Health: Concept of Accessibility .....	13
2.4 Factors Affecting Accessibility and Utilization of Healthcare .....	15
2.5 Universal Health Care .....	18
2.6 Challenges in Healthcare Infrastructure in India.....	21
2.7 Inception of the idea of Mohalla Clinics.....	24
2.8 Health care services in Mohalla Clinics.....	26
2.9 International appreciation and adoption of the concept in different states .....	29
2.10 Role during COVID-19 pandemic .....	29
2.11 Short falls within Mohalla Clinics .....	30
2.12 Research Gaps and Limitations.....	32
2.13 Conceptual Framework .....	33
2.14 Conclusion.....	35

<b>Chapter 3: Evolution and Structure of Healthcare System in India and Delhi .....</b>	<b>37</b>
3.1 Introduction .....	37
3.2 Defining Healthcare System .....	39
3.3 Defining Primary Healthcare .....	40
3.4 Importance of Primary Healthcare .....	42
3.5 Components of Primary Healthcare .....	42
3.6 Evolution of Healthcare System in India .....	44
3.6.1 Bhore Committee (1946) .....	45
3.6.2 Mudaliar Committee (1962) .....	47
3.6.3 Five-year plans (1951 – 2014) .....	48
3.6.4 National Health Policy (1983) .....	50
3.6.5 National Health Policy (2002) .....	52
3.6.6 National Rural Health Mission (2005) .....	54
3.6.7 Report of the High Level Expert Group (2011) .....	55
3.6.8 National Health Mission (2013) .....	58
3.6.9 National Health Policy (2017) .....	59
3.6.10 Ayushman Bharat (2018) .....	61
3.6.11 National Digital Health Mission (2020) .....	63
3.7 Structure of Healthcare System in India .....	64
3.8 Structure of Healthcare System in Delhi .....	69
3.9 Healthcare Infrastructure in Delhi .....	70
3.9.1 Primary and Secondary Healthcare Facilities .....	70
3.9.2 Tertiary Healthcare Facilities .....	74
3.10 Conclusion .....	76

<b>Chapter 4: Mohalla Clinics as Primary Health Centres in Delhi: Growth and Distribution .....</b>	<b>79</b>
4.1 Introduction .....	79
4.2 Trajectory of growth of Mohalla Clinics .....	80
4.3 Spatial Distribution .....	91
4.4 Impediments in the Initial Phase of the Project .....	93

4.5 Performance during 2015 - 2020.....	97
4.6 Role during COVID-19 Pandemic .....	101
4.7 Conclusion.....	107
<b>Chapter 5: Accessing Healthcare in the Neighbourhood: Primary Health Care Services at Mohalla Clinics .....</b>	<b>109</b>
5.1 Introduction .....	109
5.2 Sample Characteristics .....	110
5.3 Assessing Access to Mohalla Clinics.....	112
5.3.1 Availability .....	113
5.3.2 Accessibility .....	120
5.3.3 Accommodation.....	126
5.3.4 Affordability .....	136
5.3.5 Acceptability.....	141
5.3.6 Awareness.....	148
5.4 Network with other health care units: Development of a two-way referral system.....	155
5.5 Conclusion.....	156
<b>Chapter 6: Summary of Conclusions .....</b>	<b>157</b>
Bibliography .....	167-184
Appendices.....	185-210

## List of Figures

Figure 3.1: Responsibilities of Clinicians and Public Health Doctors: In Some Areas They Have Joint Responsibility. (After Ghai 1985) .....	43
Figure 4.1: The First Mohalla Clinic Established in Punjabi Relief Camp in West Delhi's Peeragarhi on 19 <sup>th</sup> July 2015.....	81
Figure 4.2: Foundation Stone at the first mohalla clinic, Punjabi relief camp, Peeragarhi, West Delhi. ....	84
Figure 4.3: A mohalla clinic in portable cabin newly inaugurated in Vasant Kunj, 11 <sup>th</sup> September 2019. ....	85
Figure 4.4: A building rented for establishment of a mohalla clinic, 6 <sup>th</sup> November 2019. ....	85
Figure 4.5: The absence of written timings outside a clinic in North West Delhi. ....	87
Figure 4.6: Advertisement inviting applications for AAMCs – rented premises and empanelment of doctors, The Indian Express, 5 <sup>th</sup> January 2020. ....	88
Figure 4.7: Advertisement for inauguration of Mohalla Clinic in Lado Sarai, 31 <sup>st</sup> July October 2019.....	90
Figure 4.8: Advertisement for inauguration of Mohalla Clinic in Masoodpur, Vasant Kunj, 15 <sup>th</sup> October 2019.....	90
Figure 4.9: Spatial distribution of Mohalla Clinics .....	92
Figure 4.10: OPD Consultations and Laboratory Investigations in Mohalla Clinics 2015-2020. ....	97
Figure 4.11: No. of OPD consultations and laboratory investigations in Mohalla Clinics 2018-19 .....	99
Figure 4.12: Age-wise distribution of patients seeking treatment in Mohalla Clinics 2018-19 .....	99
Figure 5.1: Females and elderly people coming to the clinic to seek treatment. ....	124
Figure 5.2: Water accumulated around the clinic. ....	132
Figure 5.3: Earthen pot beside the clinic act as breeding ground for mosquitoes. ....	133
Figure 5.4: Notice mentioning stipulated time for sample collection in the clinic in North West district. ....	135



Figure 5.5: The bed in the clinic in North West district where testectomy is performed. ....	144
Figure 5.6: The doctor in the clinic in North West district examining a child as her mother looks on. ....	146
Figure 5.7: Advertisement showing detail of the inauguration ceremony, The New Indian Express, 5 <sup>th</sup> January, 2020. ....	149
Figure 5.8: Chief Minister Arvind Kejriwal addressing the crowd at the inaugural ceremony in Peeragarhi on 5 <sup>th</sup> January, 2020. ....	150
Figure 5.9: The inner walls of the clinic in South West district adorned with posters showing methods of prevention of vector borne diseases. ....	151
Figure 5.10: The doctor in the clinic in North West district pointing to posters on the inner walls of the clinic which have been put up to create awareness about methods of health care. .	152

## List of Tables

Table 3.1: Percent distribution of households by the source of healthcare that household members generally use in the time of sickness, according to residence and the wealth index, India,2015-16.....	66
Table 3.2: Reason for not using public health care facilities, India 2015-16.....	68
Table 3.3: Primary/Secondary Healthcare Facilities in Districts of Delhi, 2009.....	71
Table 3.4: Distribution of Mother and Child Welfare Centres in Delhi, 2009.....	73
Table 3.5 Tertiary Healthcare Facilities in Districts of Delhi, 2009.....	74
Table 3.6: Reasons For Not Using Public Health Care Facilities in Delhi, 2015-16.....	76
Table 4.1: Common illnesses for which people seek treatment in Mohalla Clinics, 2018-19.....	100
Table 5.1: Sample Characteristics: Gender and Age Group.....	110
Table 5.2: Sample Characteristics: Religion of the Household.....	111
Table 5.3: Sample Characteristics: Social Groups.....	111
Table 5.4: District-wise distribution of mohalla clinics (till December 2020).....	113
Table 5.5: Perception Regarding Acquiring Primary Care Services Post Establishment of Mohalla Clinics.....	114
Table 5.6: Previous Place of Treatment.....	115
Table 5.7: Ailments for which people seek treatment in Mohalla Clinic.....	117
Table 5.8: Time-Distance of Previous Place of Treatment from Residence.....	121
Table 5.9: Time-Distance of Mohalla Clinics from Residence.....	122
Table 5.10: Transport Cost to the Previous Place of Treatment (per episode).....	122
Table 5.11: Person Accompanying the Patient to the Clinic.....	124
Table 5.12: Waiting Time to See the Doctor in Previous Place of Treatment.....	128

Table 5.13: Waiting Time to See the Doctor in Mohalla Clinic	129
Table 5.14: Level of Satisfaction Regarding Seating Arrangement Available in Mohalla Clinics	130
Table 5.15: Level of Satisfaction regarding Drinking Water Facilities Available in Mohalla Clinics	131
Table 5.16: Level of Satisfaction regarding Medicines Received in Mohalla Clinics	131
Table 5.17: Level of Satisfaction Regarding Diagnostic Tests Available in Mohalla Clinics	134
Table 5.18: Expenditure on Doctor's Fee in Place of Previous Treatment (per episode)	137
Table 5.19: Source of Payment of Medicines in Previous Place of Treatment	137
Table 5.20: Source of Procurement of Medicines in Previous Place of Treatment	138
Table 5.21: Place Where Diagnostic Tests Were Done	139
Table 5.22: Level of satisfaction regarding the behaviour of the doctor and the staff in the clinics	142
Table 5.23: Source of Awareness about Mohalla Clinics	152

## **List of Abbreviations Used**

AAMC	Aam Aadmi Mohalla Clinic
AAP	Aam Aadmi Party
AIIMS	All India Institute of Medical Sciences
ASHAs	Accredited Social Health Activists
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BJP	Bhartiya Janta Party
CDMO	Chief District Medical Officer
CHC	Community Health Centre
COVID	Corona Virus Disease
DAK	Delhi Aarogya Kosh
DAN	Delhi Aarogya Nidhi
DCB	Delhi Cantonment Board
DJB	Delhi Jal Board
DTC	Delhi Transport Corporation
DGHS	Directorate General of Health Services
GDP	Gross Domestic Product
GTB	Guru Teg Bahadur Hospital
HWCs	Health and Wellness Centres
IDSP	Integrated Disease Surveillance Programme

M & CW	Maternity and Child Welfare Centres
MCI	Medical Council of India
MDGs	Millennium Development Goals
MLA	Member of Legislative Assembly
MoHFW	Ministry of Health and Family Welfare
NCT	National Capital Territory
NDHB	National Digital Health Blueprint
NDHM	National Digital Health Mission
NGO	Non-governmental Organisation
NHM	National Health Mission
NHP	National Health Policy
NPP	National Population Policy
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OOP	Out-of-pocket
OPD	Out Patient Department
PHC	Primary Health Centre
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PWD	Public Works Department
RAT	Rapid Antigen Test
RSBY	Rashtriya Swasthya Bima Yojana



RT-PCR	Reverse Transcription Polymerase Chain Reaction
SDGs	Sustainable Development Goals
SECC	Socio-Economic Caste Census
TB	Tuberculosis
TRIPS	Trade Related Intellectual Property Rights
UFHC	Urban Family Welfare Centre
UHC	Universal Health Coverage
UHC	Urban Health Centre
UHP	Urban Health Post
UN	United Nations
UNDP	United Nations Development Fund
WHO	World Health Organisation

# Chapter 1: Introduction

## 1.1 Introduction

The word health comes from the ‘...old English word hal, meaning hale, whole, healed, sound in wind and limb’<sup>1</sup> which refers to the physical well-being of the people. In the constitution of the World Health Organisation (WHO) in 1946, an attempt was made to provide a comprehensive definition of health. In this constitution, health was defined as, ‘...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’<sup>2</sup> The concept of health as a fundamental human right for all people, irrespective of ‘...race, religion, political belief, economic or social condition’<sup>3</sup>, was propounded in this constitution, which came into force on 7<sup>th</sup> April, 1948. The novelty of this definition is that for the first time, emphasis was being laid upon ‘complete physical, mental and social well-being’ unlike the erstwhile narrow emphasis on ‘absence of disease or infirmity’. WHO outlined one of its principal agenda as ‘...attainment by all peoples of the highest possible level of health.’<sup>4</sup> This is the most popular and widely accepted definition of health. Last (1988), however, argued this to be a ‘poor operational definition’ and put forward his definition with measurable attributes. According to Last, health is, ‘... a

---

<sup>1</sup> J.M. Last. (1988). *Public Health and Human Ecology*, E. Norwalk, CT: Appleton & Lange.

<sup>2</sup> Constitution of the World Health Organisation (1946). *World Health Organisation*. p. 119. Accessed from [https://www.who.int/governance/eb/who\\_constitution\\_en.pdf](https://www.who.int/governance/eb/who_constitution_en.pdf) 18th August 2019 at 4:20pm.

<sup>3</sup> *ibid.* p. 119.

<sup>4</sup> *ibid.* p. 120.

state characterized by anatomic integrity; ability to perform personally valued family work and community roles; ability to deal with physical, biologic and social stress; a feeling of well-being; and freedom from the risk to untimely death.’<sup>5</sup> Nevertheless, the definition by WHO continues to be the most acceptable definition till now, mainly because it invoked rights based principle to health, which extends ‘...not only to timely and appropriate healthcare but also to the underlying determinants of health, for example access to health information, access to water and food, housing...’.<sup>6</sup>

According to this principle of health as a human right, all people, irrespective of background, are entitled to should be provided with healthcare services provided and/or organized by the state, irrespective of whichever background any person belongs to. Therefore, it is the duty of the state to provide health care services to all people, which is referred to as Universal Health Coverage (UHC). The World Health Organization defines UHC as, ‘...ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship’<sup>7</sup>. Health policies across the world as well as those in India have directed towards achieving universal health coverage but India is yet to attain this goal. ‘Achieving universal health care requires a significant amount of investment into the health technology

---

<sup>5</sup> Last. op.cit. p.6.

<sup>6</sup> Human Rights. *World Health Organisation*. Accessed from [https://www.who.int/topics/human\\_rights/en/](https://www.who.int/topics/human_rights/en/) on 14th September 2019, at 4:24 pm.

<sup>7</sup>Health Systems, *World Health Organisation*, Accessed from [https://www.who.int/healthsystems/universal\\_health\\_coverage/en/](https://www.who.int/healthsystems/universal_health_coverage/en/) on 22<sup>nd</sup> April 2019 at 6:30 pm.

infrastructure<sup>8</sup> but health care expenditure is extremely low in India (less than 1% of its Gross Domestic Product) which is a major reason for the inadequate health infrastructure in India. On the other hand, due to inadequate public healthcare facilities available, people are compelled to use private facilities. This results in high out-of-pocket expenditure which has multiple adverse consequences on the welfare of the people.

According to the World Health Organisation, a health system with strong primary health care at its core is a prerequisite for achievement of ‘universal health coverage and the health related SDGs<sup>9</sup> ...(and)... delivers better health outcomes, efficiency and improved quality of care compared to other models.’<sup>10</sup>. A health system has many components and its efficiency depends upon the integrated functioning of these components aimed towards achievement of better health care for all. ‘A well-functioning health system working in harmony is built on having trained and motivated health workers, a well maintained infrastructure and a reliable supply of medicines and technologies backed by adequate funding, strong health plans and evidence based policies’<sup>11</sup>.

---

<sup>8</sup> Kahol, K. & Balasubramaniam, P. Health Technology Infrastructure for Universal Health care. *Public Health Foundation of India*, p.1.

<sup>9</sup> SDGs: Sustainable Development Goals or Global Goals, 17 targets outlined by United Nations Development Programme in January 2016, after the success of Millenium Development Goals. These targets are to be achieved by 2030.

<sup>10</sup> World Health Organisation. Primary Health Care. Accessed from <https://www.who.int/primary-health/en/> on 17<sup>th</sup> April, 2019, at 10:45 am.

<sup>11</sup> World Health Organisation. Health systems. Accessed from <https://www.who.int/healthsystems/en/> on 17<sup>th</sup> April, 2019, 10:57 am.

The need for a strong primary health care delivery system in the public sector in India goes back to the Bhore committee report of 1946<sup>12</sup> and has been emphasized in the subsequent health policies. In 2011, the Planning Commission has outlined an ambitious target of achievement of universal health care in India by 2022. It also recognizes comprehensive primary healthcare services as high priority and recommends that 70% of health expenditure should be devoted to it. Strengthening of primary health care services will also reduce the burden on secondary and tertiary health care facilities. ‘Extensive and high quality primary care network...will reduce the need for secondary and tertiary care facilities’.<sup>13</sup> As a recent initiative towards universal health coverage in India, Ayushman Bharat or Healthy India – National Health Protection Mission was launched as a part of National Health Policy 2017. ‘This initiative has been designed on the lines as to meet SDG and its underlining commitment, which is “leave no one behind” ’.<sup>14</sup> As a part of this policy, ‘about 10 crore poor and vulnerable families (approximately 50 crore beneficiaries)’ will be guaranteed to receive a health insurance cover ‘upto 5 lakhs rupees per family per year for secondary and tertiary care hospitalization’.<sup>15</sup> Health expenditure support is also provided by respective state governments such as Swasthya Sathi in West Bengal, Delhi Aarogya Kosh (DAK) and Delhi Aarogya Nidhi (DAN) in Delhi to promote health care for all. Despite

---

<sup>12</sup> Report of the Health Survey and Development Committee – Vol. I. *The Manager of Publications*, Delhi, 1946.

<sup>13</sup> T. Powell-Jackson, A. Acharya & A. Mills. (2013). An Assessment of the Quality of Primary Health Care in India. *Economic & Political Weekly*, Vol. 48 (19), Special Article, p. 53.

<sup>14</sup> Ayushman Bharat Yojna, National Health Portal, Ministry of Health and Family Welfare (MoHFW), Government of India, accessed from [https://www.nhp.gov.in/ayushman-bharat-yojana\\_pg](https://www.nhp.gov.in/ayushman-bharat-yojana_pg) on 27<sup>th</sup> June, 2019, 9:50pm.

<sup>15</sup> Ayushman Bharat – National Health Protection Mission, National Portal of India, Government of India, accessed from <https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission> on 27<sup>th</sup> June, 2019, 5:45 pm.



outlining of various policies aimed towards universal health coverage in India, health care system is inadequate to support the growing population of the country. Each health care unit in India is over burdened with patients and at the same time lacks infrastructure such as beds, doctors, nurses, medicines, diagnostic facilities among several others. This imbalance between the demand for health care and the ability of the health care system to deliver it forms the primary obstacle in the way of achievement of health for all. This inadequacy has been further exposed during the ongoing COVID-19 pandemic. While the hospitals are functioning beyond capacity to treat COVID-19 patients, non-COVID-19 patients are also unable to receive appropriate treatment. At this juncture it is important to explore possibilities to broaden the horizon of healthcare facilities available in the country.

The burden of patients on the tertiary care public hospitals in Delhi such as AIIMS (All India Institute of Medical Sciences) and Safdarjung is extremely high as they receive patients from across the country. High patient pressure and inadequate health infrastructure leads to poor delivery of health services in Delhi. Prior to the State Assembly Elections in 2015 the Aam Aadmi Party (AAP) declared that health and education would be of utmost priority to them and proposed to expand the healthcare infrastructure in Delhi as a part of the 70 point agenda in their election manifesto. According to this agenda, 900 (later modified to 1000, i.e. about 14 clinics per assembly constituency) new Primary Health Care Centres were to be established in Delhi with the chief aim to provide primary healthcare services to all communities within a few kilometres from their residence. Popularly known as ‘Aam Aadmi Mohalla Clinics’ (wherein ‘Mohalla’ refers to neighbourhood, i.e. clinics in the neighbourhood), they form a part of the three-tier health care delivery system in National Capital Territory of Delhi. Mohalla clinics were proposed with the virtuous

objective of delivering health care to all (aligned with the World Health Organization's principle of Universal Health Coverage which has been adopted as one of the SDGs for 2030) in the form of curative care for common illnesses, preventive services such as antenatal and postnatal care of pregnant women, supply of drugs, conducting laboratory tests, disseminating health information and education and creating awareness among people<sup>16</sup>. It was also proposed that at a later stage, these clinics would be networked with the polyclinics and government hospitals, where patients can seek specialized services on referral. With this motive, after several rounds of discussions, debates and detestation from the lieutenant governor's office, the first Mohalla Clinic was inaugurated at Peeragarhi Relief Camp (West Delhi) on 19<sup>th</sup> July 2015. After 8 months, in March 2016, AAP government started the pilot project of establishing 100 Mohalla Clinics which was to run for six months '...in order to develop the understanding for work flow and methods in management of the Mohalla clinics'.<sup>17</sup> Decentralized primary health care centres in Delhi, such as the one that has been proposed, is extremely important and cost-effective which will help health care to reach all people and protect them from seeking treatment from quacks. Lahariya (2016) opines that these Mohalla clinics can be '...a landmark in the health service delivery in India'<sup>18</sup>.

---

<sup>16</sup> Brief Write up on Aam Aadmi Mohalla Clinics. *Health and Family Welfare, Govt. of NCT of Delhi*. Accessed from [http://www.delhi.gov.in/wps/wcm/connect/doiit\\_health/Health/Home/Directorate+General+of+Health+Services/Aam+Aadmi+Mohalla+Clinics](http://www.delhi.gov.in/wps/wcm/connect/doiit_health/Health/Home/Directorate+General+of+Health+Services/Aam+Aadmi+Mohalla+Clinics) on 19<sup>th</sup> March 2019 at 10:31 am.

<sup>17</sup> P. Chatterjee. (2<sup>nd</sup> March 2016). Delhi Govt. Announces Pilot Project for Next 100 Mohalla Clinics. *The Indian Express*. Accessed from <https://indianexpress.com/article/cities/delhi/delhi-govt-announces-pilot-project-for-next-100-Mohalla-clinics/> on 28<sup>th</sup> March 2019, 10:24am.

<sup>18</sup> C. Lahariya. (January 2016). Delhi's Mohalla Clinics Maximising Potential. *Economic & Political Weekly*, Vol. 51 (4), 15-17.

## **1.2 Statement of the problem**

This study aims to understand the role played by the Mohalla clinics in providing and strengthening primary healthcare services in Delhi, especially the vulnerable sections of the society such as women, children and the elderly people. People face various impediments in access to and utilization of healthcare facilities which is one of the major obstacles in achieving health care for all. This study tries to find out in what ways Mohalla clinics as primary healthcare units have been able (and will be able, in the future) to enhance the accessibility and utilization of primary health care in Delhi. The role of these clinics during the COVID-19 pandemic has also been explored in this study.

## **1.3 Objectives**

The following objectives have been outlined for this study:

- To understand the healthcare delivery system in Delhi.
- To trace the trajectory and growth of Mohalla Clinics in Delhi.
- To study the role played by Mohalla clinics in achieving health care for all by increasing accessibility and utilization of primary healthcare services especially for the poor and vulnerable urban people – women, children and elderly.
- To study the nature of vertical and horizontal networks integrating the Mohalla clinics and other levels of healthcare system in Delhi.
- To study the role played by the Mohalla Clinics in healthcare delivery during the time of COVID-19 pandemic.

## **1.4 Research questions**

Based on the aforementioned objectives, the following research questions have emerged:

- What is the status of the available healthcare infrastructure in Delhi?
- What is the trajectory of growth of mohalla clinics and what are the impediments faced by them during their growth?
- Given the nature of infrastructure currently available at mohalla clinics, could it be considered as an effective institutional arrangement in providing Universal Health Care in Delhi?
- How are the mohalla clinics creating an efficient healthcare delivery system by establishing referral network with other levels of healthcare units in Delhi?
- How efficient can these clinics become in handling the COVID-19 pandemic or similar such health challenges in future?

## **1.5 Data Sources and Methodology**

To understand the overall structure and condition of healthcare system in Delhi, secondary data has been used from Department of Health and Family Welfare, Government of NCT of Delhi, National Family and Health Survey – 4 (2015-16), District Level Household and Facilities Survey – 3 (2007-08) and Census of India 2011.

To trace the trajectory of establishment and growth of mohalla clinics, official documents have been studied from Directorate of Health Services Delhi. Media reports and newspaper articles have been studied from newspapers and online news material from

February 2015 to December 2020. These help us to understand the discourse which has been going on regarding the clinics, their role and performance. Information has also been incorporated from the interviews with the stakeholders – the doctors and staff working in the clinics, MLAs and inaugural function speeches (5<sup>th</sup> January 2020).

A primary survey has been conducted in two selected locations in Delhi during 2019-2020. Semi-structured interviews and detailed discussions have been carried out with the patients to understand their perception about primary healthcare system in Delhi and healthcare in mohalla clinics. The primary survey has helped us to assess how far mohalla clinics have been successful in delivering healthcare to all by enhancing accessibility and utilization. Focus has also been given on how these clinics have established referral networks with other levels of healthcare system in Delhi and helped in dealing with the COVID-19 pandemic. Expert interviews have been carried out with doctors and staff employed in the clinics, the MLAs and officials of Directorate of Health Services Delhi to understand the functioning of these clinics, the problems faced by them and their future prospects. Participant observation has been carried out done in the selected clinics to get an overview of the functioning of the clinics. Photographs have been used to study the physical infrastructure and conditions outside and within the clinics.

IBM SPSS Statistics 20 has been used to compile the sample data collected in the field. Mixed methods including both descriptive statistics and qualitative tools have been used to understand the accessibility and utilization of healthcare services in the mohalla clinics. Maps have been prepared using Google Earth Pro and Arc Map 10.2.2 softwares.



## **1.6 Organization of Chapters**

This study has been divided into six chapters, the outline of which has been provided here. The first chapter introduces the background of the study, includes critical literature, objectives, research questions, data source and methodology, organization of chapters. Chapter two provides an overview of the relevant literature that have helped to arrive at the research problem and organize the background of the study. This is followed by the research gaps in the existing knowledge regarding the topic, the limitations of the present study and the conceptual framework adopted for the study. The third chapter sets the background for the study. It aims to trace the development of health system in India with special emphasis on the position that primary health care has occupied in these polices. This chapter is divided into three parts: the first section deals with the significance of primary healthcare within the health system, the second section deals with the evolution of healthcare system in India with special reference to primary healthcare and evaluates its present status and the third section deals with the structure and status of the existing healthcare system in Delhi. The fourth chapter traces the development of mohalla clinics, their spatial distribution, problems faced by them during their evolution, how they have dealt these problems and the role they have been playing during the COVID-19 pandemic. The objective of the fifth chapter is to understand the role of the mohalla clinics in providing and enhancing the accessibility and utilization of primary health care services among people in Delhi, to understand the linkages created by them with other levels of healthcare system and their contribution in improvement of the overall healthcare system in Delhi. The sixth chapter gives a summary of conclusions which includes the future prospects of the mohalla clinics and the way ahead.

## **Chapter 2: An Overview of Literature**

### **2.1 Introduction**

This chapter presents an overview of literature and discusses the themes and conceptual framework that has been developed for the present study. The literature discussing the role of Geography in the study of healthcare has been studied first. The second theme includes the concept of accessibility wherein it is discussed how space and place influence the accessibility and utilization of healthcare services. The third theme is based on the other factors that influence accessibility and utilization of healthcare. The fourth theme is based on Universal Health Care or Healthcare for All. This is in line with the WHO's principle and SDGs related to Health for All. The need for a strong primary healthcare system to achieve UHC has been emphasized herein. The fifth theme deals with the healthcare infrastructure in Delhi and discusses the inadequacies. This leads to the next theme regarding the inception of the idea of mohalla clinics. The seventh theme deals with the healthcare services available in the mohalla clinics, followed by the international appreciation and replication of the idea in different regions outside NCT of Delhi. The ninth theme deals with the shortfalls within the mohalla clinics and discusses how these clinics can help in increasing the efficacy of the existing healthcare system in Delhi.

### **2.2 Evolution of Medical Geography and Geography of Health**

During the 17<sup>th</sup> Century and the early phases of the 18<sup>th</sup> Century, Geographers' focus was mainly on the influence of the physical elements on human health,

including climate, topography, soil and biotic organisms. It was only in the later part of the 18<sup>th</sup> Century and early 19<sup>th</sup> Century that the study of the influence of cultural elements on the health of people gained importance. One of the first definitions of medical geography was given by Finke (1795) who defined it as, ‘...the description country after country of its position, soil, air, lightning, foodstuffs, mode of living, customs and habits of the people, in so far as all these factors have a bearing on health and disease and on local therapeutics’.<sup>1</sup> Zeiss (1932) defined medical geography as, ‘...the branch of geography which attempts to study and explain the effects of geographical space, earth, and its vital forms, on man, animal, and plant’.<sup>2</sup> Zeiss’ definition aimed at the study of how geographical factors affected man, animals and plant. The need to develop a definition for medical geography was recognized in the Report to the Commission on Medical Geography of the International Geographical Union (1952), and it was defined as, ‘...the study of the distribution of manifested and potential diseases over the earth’s surface...’.<sup>3</sup> The narrowness of this definition was acknowledged and later in 1976 International Geographical Union adopted a broader perspective of ‘Geography of Health and Health Care’ in contrast to the term of ‘Medical Geography’.

Kearns (1993) has suggested ‘...two inter-related streams...within the medicine/health/geography nexus: medical geography and the geography of health’.<sup>4</sup> Pacione (1986) also recognizes two broad components of medical geography: ‘...the first concerning

---

<sup>1</sup> J.M. May. (1978). Report to the Commission on Medical Geography of the international Geographical Union 1952. *Social Science and Medicine*. Vol. 12 (D), p. 211.

<sup>2</sup> *ibid.* p. 211.

<sup>3</sup> *ibid.* p. 211.

<sup>4</sup> R.A. Kearns. (1993). Place and Health: Towards a Reformed Medical Geography. *Professional Geographer*, Vol. 45 (2), 139-147.

the epidemiology and ecology of disease, and the second addressing the location and utilization of health services'.<sup>5</sup> It is concerned with, '...the availability and accessibility of health care facilities, including patient travel patterns, inequalities in health care provision, modeling future demand for facilities, and the relationship between need and socio-economic and cultural factors'.<sup>6</sup> Geography of Health or Health Geography is a broad term indicating, '...the application of geographical information, perspectives, and methods to the study of health, disease, and healthcare. It explores the patterns, causes, and spread of disease, environmental hazards, environmental mediators of health behaviours, and the planning and provision of health services.'<sup>7</sup>

### **2.3 Role of Space and Place in Geography of Health: Concept of Accessibility**

Geographers have concentrated in the 'justice oriented critique of ill-health and health service delivery systems' and have raised questions of 'who gets what, where and why – with respect to illness and appropriate care'<sup>8</sup>. Therefore, place plays an important role in the field of Geography of Health. There are important correlations between any phenomenon in place and health because, 'what occurs in a place (in terms of the relations between people and elements of their environment) has profound importance to health'<sup>9</sup>. Therefore place is not considered merely as location but as different attributes affecting health. Geography of Health has been defined by Kearns (1993) as '...the dynamic

---

<sup>5</sup> M. Pacione. (1986). (Ed), *Medical Geography: Progress and Prospect*. Wolfeboro: Croom Helm.

<sup>6</sup> *ibid.*

<sup>7</sup> 'Health Geography', Department of Geography, University at Buffalo, accessed on 10<sup>th</sup> September 2019 at 11:10am, <http://www.buffalo.edu/cas/geography/research/health-geography.html>

<sup>8</sup> Kearns (1993). *op.cit.* p. 139.

<sup>9</sup> *ibid.* p. 141.

relationship between health and place and the impacts of both health services and the health of population groups on the vitality of places'<sup>10</sup>. There has been an emphasis of the role of space and place behind the occurrence of any health-related phenomenon in health geography studies. Anthamatten and Hazen (2016) have emphasized the role of place in the study of geography of health, '...the geography of health is distinct, however, in its emphasis on place, grounding geographers in spatial questions: where does something occur and why is that significant?''<sup>11</sup> They further add that '... geographers focus on the importance of variations across space, with an emphasis on concepts such as location, direction, and place'.<sup>12</sup> Andrews (2018) opines '...place plays a central role in a variety of processes that impact on health and health care'<sup>13</sup>. In geography of health, attempts are made to understand the causes of and find answers or solutions to health issues in the context of space and place. As the background characteristics of people vary across space, their health also varies, which is the primary focus of health geographers.

Space and place play an important role in the availability, accessibility and utilization of health care services. Access to health care refers to the ease with which an individual can obtain the necessary medical services but the access is conditioned on the availability or supply of the services. 'Supply of service is the prerequisite for its accessibility. Unless services are "available", there can be no consideration of the factors, geographical or otherwise, that differentially influence the access of individuals or groups to

---

<sup>10</sup> *ibid.* p. 145.

<sup>11</sup> P. Anthamatten, P. & H. Hazen. (2016). *An Introduction to the Geography of Health*, India: Routledge (special Indian edition) p.2.

<sup>12</sup> *ibid.* p.2.

<sup>13</sup> J.A. Gavin (2018). Health and Place. In T. Brown et. al. (Eds.) *Health Geographies: a critical introduction* (39-56). New Jersey: Wiley Blackwell, p. 44.

needed services'<sup>14</sup>. Meade and Earickson (2000) have outlined four sets of variables which govern access to health care. 'Access to health care is a product of four sets of variables: the availability of services, the possession of the means of access (money or insurance, transportation), the non-discriminatory attitudes of healthcare providers, and the failure of the ill themselves to cope with their situation, such as their ability to recognize symptoms, communicate with health professionals, and navigate the health care system (Lee, Wolch, & Walsh, 1998)<sup>15</sup>. In similar lines, Penchansky and Thomas (1981) identified five factors that affect the realization of health care and access to health care: availability (the adequate supply of health care infrastructure), accessibility (depends on the spatial and geographical location of health care providers and their uses, whereby travel costs and time are taken into account), accommodation (describes the organizational structures of health care service such as appointment system, opening hours), affordability (the need for patients to have financial means to use the available health care) and acceptability (relationship between user's attitude towards the providers and vice-versa). Saurman (2016) further modified this model to include the factor of awareness in determining healthcare access. The role of awareness in access to healthcare services has also been outlined by Russel (2013) and Levesque et. al. (2013).

## **2.4 Factors affecting Accessibility and Utilization of Healthcare**

Donabedian (1984) has outlined two main groups of factors responsible for access to health care: socio-organizational and geographic. The significance of geographic

---

<sup>14</sup> A. E. Joseph & D. R. Phillips. (1984). *Accessibility & Utilization: Geographical perspectives on health care delivery*, New York: Harper & Row, p. 52.

<sup>15</sup> M.S. Meade & R.J. Earickson. (2000). *Medical Geography*, New York: The Guilford Press, p. 381.

factor ‘physical proximity’ or distance in access to health care has received substantial importance in health literature. Physical proximity plays a decisive role in accessibility and utilization of health care services (Mayer, 1983; Powell, 1995). Similar to other activities, accessibility to healthcare services follows a distance-decay curve which means that association between any two places diminishes as distance increases. Shannon, Bashshur and Metzner (1969) describe distance as a factor in accessibility and utilization of health care. The concept has been further illustrated by Shannon, Skinner and Bashshur (1973) wherein the accessibility to health care facilities in relation to the distance and time taken to travel. Hunter, Shannon and Sambrook (1986) have used data compiled by Edward Jarvis in U.S. to study the concept of distance decay around mental hospital (popularly known as the Jarvis’s law). Meade and Earickson (2000) opine that as the distance between the patient and the location of healthcare service increases, their accessibility and utilization decreases.

However, while assessing the accessibility to health care services, distance should be studied in relation to other variables because narrow focus on distance can overshadow the influence of other factors. Therefore, overemphasis on the role of distance in access to health care should be avoided. There are other non-spatial factors which often play a deterministic role in access to health care. In the opinion of Choudhary (2014), ‘Access to, and utilization of, health care are determined primarily by social relations, and access to the knowledge available’<sup>16</sup>. ‘Health care, like many public services, is not equally available to all individuals. This is because it is not a “pure” public good (Cox and Reynolds

---

<sup>16</sup> B. K. Choudhary. (2014). Health, illness and disease. *Economic and Political Weekly*, Vol. XLIX. (45). p.64.

1974)<sup>17</sup>. Non-spatial determinants of access to health care include age, gender, socio-economic class, income, type of place of residence, educational attainment, ethnicity, religion, caste, awareness, exposure to mass media and so on. It should be mentioned that all these factors are highly inter-related and their effect cannot be studied in isolation. Mechanic (1928) identified ‘seven general areas of medical care in which barriers to access develop: excessive cost, insufficient supply, poor distribution, inadequate scope, ineffective co-ordination, psychological and socio-cultural impediments to effective use, inadequate organizational arrangement and poor use of technology.’<sup>18</sup> Fuchs (1974) divided the problem of access to health care into two broad categories: special and general. Special problems are those problems of access faced by particular backward or marginalized group of population while the general problems include access to quality health care. However, in a developing country like India, what Fuchs defined as special problem seems to be the general problem.

Daniels (1975) argues that access to health care should be available to anyone in medical need and non-medical characteristics of individuals such as gender, race, geographical location or their ability to pay should not be decisive factors in accessing health care. Joseph and Phillips (1984) argue that accessibility and utilization are two sides of the same coin and distinguishes between potential accessibility and revealed accessibility. Potential accessibility is influenced by characteristics of the society and the healthcare system, whereas revealed accessibility refers to the actual utilization of healthcare services.

---

<sup>17</sup> Joseph & Phillips. op.cit. p. 52.

<sup>18</sup> D. Mechanic. (1928). Towards a coherent and co-ordinated health care policy: Issues for the development of policy options. In Charles E. Lewis, Rashi Fein and David Mechanic (Eds.), *Right to Health: The Problem of Access to Primary Medical Care* (33-40). New York: John Wiley & Sons. p. 33.



Eyles and Woods (1983), Phillips (1981) and Joseph and Phillips (1984) assert that accessibility and utilization of healthcare services depends not only upon the location of the healthcare facilities but also by other characteristics of the patients such as age, gender, class, income, religion, marital status. These factors act as constraints to accessibility and result in differential utilization of healthcare services. Baru et.al. (2010) state that large inequities in health and access to healthcare services continue to persist in India and have widened across states, between rural and urban areas, and within the communities. They identify three forms of inequities - historical inequities, socio-economic inequities in the availability, utilization and affordability of healthcare services.

## **2.5 Universal Health Care**

While several barriers come in the way to access to healthcare services, health for all has been widely advocated as a basic right for all people. The concept of UHC is based on the principle of health as a basic right for all. Article 25.1 of the 1948 Universal Declaration of Human Rights states, ‘Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services.’<sup>19</sup> In 1966, member states of the International Covenant on Economic, Social and Cultural Rights recognized ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.<sup>20</sup>

---

<sup>19</sup> United Nations, The Universal Declaration of Human Rights 1948. Accessed from <http://www.un.org/en/documents/udhr/index.shtml>

<sup>20</sup> International Covenant on Economic, Social and Cultural Rights. General Assembly Resolution 2200A (XXI), 16 December 1966.

Since a variety of factors can affect the access and utilization of health care services, it is important to provide access to all population, irrespective of their background characteristics. In January 2016, United Nations Development Fund (UNDP) outlined 17 goals for countries to be achieved by 2030. These goals, also known as Sustainable Development Goals (SDGs) or Global Goals, among others, focus on health care for all. The concept of Universal Health Care, however, is not a new one and has been a part of health policies of different countries since a long time. Universal health coverage ensures that all people, irrespective of any background to which the person belongs, should be entitled to access to basic health care services. The crux is that in this process no person should be exposed to financial hardship and that the government should undertake adequate steps to protect the individuals. UHC was defined by the High Level Expert Group (HLEG) on UHC as:

Ensuring equitable access for all citizens resident in any part of the country, regardless of income, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as public health services addressing wider determinants of health delivered to individuals and populations with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services (Planning Commission, 2011).<sup>21</sup>

It is important to outline the steps which will be beneficial for achievement of universal health care. According to World Health Organisation, a health system with strong primary health care at its core is a prerequisite for achievement of ‘universal health coverage

---

<sup>21</sup> Planning Commission, 2011, cited in S. Nandraj & D. Nambiar (2018). Kerala’s Early Experience: Moving Towards Universal Health Coverage. In Purendra Prasad and Amar Jesani (Eds.), *Equity and Access: Health Care Studies in India* (323-337). India: Oxford University Press. pp. 323-4.

and the health related SDGs<sup>22</sup>.....(and)... delivers better health outcomes, efficiency and improved quality of care compared to other models.’<sup>23</sup>

In 2011, the Planning Commission has outlined an ambitious target of achievement of universal health care in India by 2022 ahead of the target of SDGs. As a recent initiative towards universal health coverage in India, Ayushman Bharat or Healthy India – National Health Protection Mission was launched as a part of National Health Policy 2017. ‘This initiative has been designed on the lines as to meet SDG and its underlining commitment, which is “leave no one behind”’<sup>24</sup>. As a part of this policy, ‘about 10 crore poor and vulnerable families (approximately 50 crore beneficiaries)’ will be guaranteed to receive a health insurance cover ‘upto 5 lakhs rupees per family per year for secondary and tertiary care hospitalization’<sup>25</sup>. In several countries of the world, health has been declared as a human right because it is an important component for the development of the nation. The scenario is somewhat different in India owing to the fact that wide regional and other disparities are seen across the country.

---

<sup>22</sup> SDGs: Sustainable Development Goals or Global Goals, 17 targets outlined by United Nations Development Programme in January 2016, after the success of Millenium Development Goals. These targets are to be achieved by 2030.

<sup>23</sup> World Health Organisation, Primary Health Care, Accessed <https://www.who.int/primary-health/en/> on 17<sup>th</sup> April, 2019, at 10:45 am.

<sup>24</sup> Ayushman Bharat Yojna, National Health Portal, Ministry of Health and Family Welfare (MoHFW), Government of India, accessed on 27<sup>th</sup> June, 2019, 9:50pm, [https://www.nhp.gov.in/ayushman-bharat-yojana\\_pg](https://www.nhp.gov.in/ayushman-bharat-yojana_pg)

<sup>25</sup> Ayushman Bharat – National Health Protection Mission, National Portal of India, Government of India, accessed on 27<sup>th</sup> June, 2019, 5:45 pm, <https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission>

The need for a strong healthcare delivery system with efficient primary healthcare facilities is important for the achievement of UHC. The importance of strong primary healthcare facilities in the public sector in India goes back to the Bhore committee report of 1946<sup>26</sup> and has been emphasized through various health policies in the following years. The need for primary health care units accessible to all sections of population within short distance has always been acknowledged at the global level (the Alma-Ata declaration, 1978) and also accepted in India's National Health Policy (1983 and 2002). Rais (2004) suggests that the Third world countries like India need a model of health care wherein human resources and health infrastructure are distributed in relation to the population of the regions, focusing on special regions such as rural, backward, tribal, mountainous and endemic areas. Therefore, decentralized planning or planning at the micro-level is necessary to address the localized issues of health care access.

## **2.6 Challenges in Healthcare Infrastructure in India**

In the absence of adequate quality health care services in the public sector, people have to depend on the private sector for health care. Private health care facilities provide specialized health care and the time required to seek treatment is comparatively lower than the public sector health facilities. However, the people have to bear a high burden of high out-of-pocket (OOP) expenditure since the private health care facilities are mostly profit-oriented ventures. All sections of the society do not afford high OOP, as a result of which a large number of people in the lower economic and social strata are unable to access and utilize health care services even when the need arises. According to Duggal

---

<sup>26</sup> Report of the Health Survey and Development Committee, op.cit.

(2018), ‘Out-of-pocket spending on health care as a mode of financing is both regressive and iniquitous’.<sup>27</sup> Even when quality public health facility is available, it might have a huge opportunity cost for the poor people as they often lose their day’s wage waiting in the queue to seek treatment. On the other end of the spectrum, the people in the higher rung of the society possess enough resources to seek highly specialized and expensive treatment. This exacerbates the gap between the health of the two sections of population. It is argued that had there existed good quality and adequate public health facilities, the need for emergence and sprawl of private health care facilities would not have risen at all. Prasad (2018) claims, ‘The paucity of basic care is prompting a proliferation of high cost medicare in the form of super-speciality, hospital-based medical care, which pushes affordable basic care even further out of reach, contributing to a sharpening of health inequalities’.<sup>28</sup>

Kumar and Gupta (2012) have emphasized that the existing healthcare infrastructure in India is inadequate and ‘...needs radical reforms to deal with new emerging challenges’<sup>29</sup>. India is facing a dual challenge: one from the private players in the form of expensive and hence inaccessible medical care, and other from the government sector in the form of lack of infrastructure. Kumar and Gupta (2012) also recommend that there should be a regular monitoring of the policies, ‘The government must also review its health policy at regular intervals, possibly every two years to assess the impact of different schemes and

---

<sup>27</sup> R. Duggal. (2018). A financing strategy for Universal Access to Health Care: Maharashtra Model. In P. Prasad & A. Jesani (Eds), *Equity and Access: Health Care Studies in India*, (339-359). India: Oxford University Press. p. 340.

<sup>28</sup> P. Prasad & A. Jesani. (2018). (Eds.) *Equity and Access: Health Care Studies in India*, India: Oxford University Press. p.1.

<sup>29</sup> A. Kumar & S. Gupta. (2012). Health Infrastructure in India: Critical Analysis of Policy Gaps in the Indian Health care Delivery. *Vivekananda International Foundation*, Occasional Paper. p.3.

programmes which are run by it... (and)... identify the areas which are lagging behind in health care services, and special focus must be provided for such areas'<sup>30</sup>. In similar lines, Lakshmi and Sahoo (2013) in a study on health infrastructure in Andhra Pradesh categorically mention that, 'Only building good health infrastructure does not yield good health outcomes. It largely depends on the operational efficiency, implementation, maintenance of health infrastructure, and the efficient utilization of the available infrastructure in the state'<sup>31</sup>. The health system should be organized in a way conducive for the people to use it for their own wellbeing. Banerji (1996) argues that interplay of two sets of socio-cultural and political factors are responsible for the shape of public healthcare practice in India. There is a strong urban and curative bias in the health care services in India.

Powell-Jackson, Acharya and Mills (2013) have used data from District Level Household Survey-3 to assess the quality of primary health care in India and concluded that the mean level of care suggests that there is ample scope for improvement in the health services in India if quality services are to be achieved. Shivani Garg has described the challenges that India is facing in the form of competition from private sector, inadequacy of infrastructure among others. She emphasizes the importance of primary health care and states that, 'Primary health care needs to be recognized as a public good which is non-excludable and non-rival consumption'<sup>32</sup>. Kahol and Balasubramaniam emphasise that in order to achieve universal health care, a substantial amount of investment should be made in

---

<sup>30</sup> *ibid.*

<sup>31</sup> T. Subba Lakshmi and Dukhabandhu Sahoo, 'Health Infrastructure and Health Indicators: The Case of Andhra Pradesh, India', *IOSR Journal Of Humanities and Social Science*, Vol. 6, No. 6, 2013), p.28

<sup>32</sup> Shivani Garg, 'Health care Policy in India: Challenges and Remedies', p.6

health technology infrastructure. Investment in all types of health infrastructure is important. Haggerty and others opine that strong primary health care system will definitely improve health of the people but it requires a huge amount of investment into health services. These are also some of the challenges that India faces and these pose as hindrances towards achievement of universal health care. Sinha and Mukherjee (2004) have pointed out the glaring gaps in healthcare infrastructure in Delhi and emphasise the need to strengthen the public sector healthcare facilities which can focus on the preventive aspects of healthcare, hitherto neglected by the private sector.

## **2.7 Inception of the idea of Mohalla Clinics**

With the aim to strengthen primary health care in India and provide health care to all population within short distance from the residence, especially the urban poor and vulnerable people, proposal for establishment of Mohalla clinics was initiated by AAP prior to the State Assembly elections of February 2015. Duggal (2018) argues that, 'Health care cannot be planned at the central or state level but has to be decentralized at an appropriate community level'<sup>33</sup> and Mohalla Clinics are aimed in this direction.

In the AAP Manifesto 2015 it has been categorically mentioned that health and education would receive paramount importance and that there would be increased budgetary allocations in the health sector, establishment of 900 primary health care units (later modified to 1000) in Delhi and increase in the per capita bed availability among many others. This model of healthcare delivery, which received widespread appraisal from different parts of the globe, has incited interest among scholars and researchers from various

---

<sup>33</sup> Duggal. op.cit. p. 356-357.

fields to study, comment and successfully outline the strengths and weaknesses which are so prominent in the system.

Lahariya (2017) envisions that the Mohalla 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’<sup>34</sup>. Basu and Barria (2018) have scrutinised in their essay the health policy reforms in Delhi that have been adopted by AAP against the backdrop of increasing private health care delivery systems. They have concluded that Mohalla clinics will be a good alternative to private health care system which is expensive and often charge exorbitant rates from patients which create a heavy toll on their pockets. It will also be helpful for people who have newly shifted to Delhi or who do not have access to large super-speciality hospitals to seek medical aid. Lahariya (2017) argues that the Mohalla clinics ‘have the potential to decongest hospitals and reduce expenditure in health services’<sup>35</sup>. It is the common tendency of people to visit the secondary and tertiary care hospitals even with common illnesses which could be treated at primary health care units. Lahariya (2016) suggests that unless the primary health care system is strengthened to treat common illnesses, tertiary care hospitals like All India Institute of Medical Sciences (AIIMS) will always remain overcrowded and will never be able to treat patients who need specialized care. The Chief Minister of Delhi also commented during the establishment of the first clinic that, ‘...the clinics will be able to cure 95 per cent of the patients and will reduce the rush at hospitals such as AIIMS,

---

<sup>34</sup> C. Lahariya. (2017). Mohalla Clinics of Delhi, India: Could these become platform to strengthen primary health care? *Journal of Family Medicine and Primary Care*, Vol. 6 (1), p. 1.

<sup>35</sup> C. Lahariya. (27<sup>th</sup> May 2017). Decongest hospitals with Mohalla clinics. *Deccan Herald*, Bengaluru. Accessed from <https://www.deccanherald.com/content/613762/decongest-hospitals-Mohalla-clinics.html> on 20<sup>th</sup> March 2019, 5:40pm.



Safdarjung and GTB Hospital among others, which can cater to patients with serious ailments<sup>36</sup>. He enumerates the advantages that the Mohalla clinics will have, including increased accessibility, reduction in costs, budget friendly intervention, provisioning of referral services and so on. Sah et al. (2019) also opines that these clinics will help in substantial reduction of patient pressure on tertiary care hospitals. ‘Easy access to health service in local and underdeveloped areas is encouraging people to get treatment done at the early stage of the illness, which is leading to reduction in burden on other alternative facilities such as government hospitals and private clinics’<sup>37</sup>.

The cost of establishing these clinics is quite low compared to government dispensaries. Moreover, Delhi perhaps can provide the most appropriate location for the implementation of this project due to its multiple advantages including high budgetary allocation. The AAP Manifesto 2020 indicated towards UHC and categorically mentions that it aims to provide ‘affordable, accessible and advanced healthcare facilities’<sup>38</sup> to all people of Delhi through Mohalla clinics and hospitals.

## **2.8 Healthcare services in Mohalla Clinics**

Sah et al. (2019) argues that Mohalla Clinics have been instrumental in enhancing geographical access to healthcare to people in Delhi, especially the deprived

---

<sup>36</sup> Unknown author. (20<sup>th</sup> July 2015). Delhi Gets First “Aam Aadmi Clinic”, CM Kejriwal Says 1000 More in Line. *The New Indian Express*, Delhi. Accessed from <https://indianexpress.com/article/cities/delhi/delhi-gets-first-aam-aadmi-clinic-cm-kejriwal-says-1000-more-in-line/> on 16<sup>th</sup> February, 7:26pm.

<sup>37</sup> T. Sah, R. Kaushik, N. Bailwal & N. Tep. (2019). Mohalla Clinics in Delhi: A Preliminary Assessment of their Functioning and Coverage. *Indian Journal of Human Development*, Vol. 13(2), 206.

<sup>38</sup> Ten Guarantees, AAP, Delhi Vidhan Sabha 2020 Manifesto, p. 3, accessed from <https://aamaadmiparty.org/manifesto2020/> on 1<sup>st</sup> March 2020, 11:05pm.

sections of the population. Lahariya (2016) says that, ‘These clinics should not be seen as ends in themselves but as a new beginning in the journey to find workable solutions to improve health care in India’<sup>39</sup> and emphasizes the need for multi-faceted health care services that should be provided through the Mohalla clinics. ‘The facilities should go beyond curative services and also cover a range of population health services, including vaccination, screening for non-communicable diseases, prevention and control of seasonal diseases as part of the assured package’<sup>40</sup>. Without the inclusion of these services, the clinics cannot become platform to strengthen primary health care. The same has also been recognized in the Delhi Citizen’s Handbook (2016) where it is stated that, ‘Mohalla Clinics have the potential to move beyond being sub-centres with primarily curative functions and become Mohalla – specific wellness centres targeting the specific health needs of different neighbourhoods and taking into account preventive public health measures at a local level’<sup>41</sup>. However, although these clinics share certain similarities with the functions of an urban sub-centre, yet they should not be equated with the sub-centres primarily because functions of a sub-centre vary across places (Sah et al., 2019).

These clinics are significant from public health point of view. Rai and Komal (2017) are of the opinion that these clinics will be extremely helpful in the early detection and control of diseases. The online database of patients can be helpful in research as well as monitoring the patients. They conducted survey in selected Mohalla clinics of West, East and North West Delhi through which they have concluded that patients are happy with this

---

<sup>39</sup> C. Lahariya (2016)., op.cit.

<sup>40</sup> C. Lahariya (2019). Op.cit.

<sup>41</sup> N. Hazarika, N. Srinivasan, & T. Sharma. (2016) Mohalla Clinics: Will they address the health needs of Aam Aadmi in Delhi? Delhi Citizens Handbook 2016. *Centre for Civil Society*, p. 131.

initiative as they have been able to save out-of-pocket expenditure by avoiding private consultations, diagnostic tests and have reduced opportunity costs as these clinics are located close to their place of residence as they do not have to miss their work or wait in long queues. Delhi Citizen's Handbook (2017) has also documented satisfaction among patients visiting Mohalla clinics in selected locations compared to public hospitals. The waiting time is lower in Mohalla clinics and since they are located within their locality, the patients save time, travel costs and their day's work. Kearns (1993) asserts that 'by regularly visiting the communities themselves, health care professionals are closer to patients' living conditions and are therefore better placed to counsel on issues of health and welfare'<sup>42</sup>. Since the doctors visit the clinics within the neighbourhood, they are aware of the conditions in which the patients live – this helps in better interaction and treatment of patients. In a recent study on mohalla clinics by Agarwal, Bhattacharya and Lahariya (2020), based on a sample of 493 ever-married women across 25 localities, it has been concluded that these clinics have been successful in making primary care accessible, equitable and affordable for vulnerable section of the population in the underserved areas. Two regression models found that proximity to households, waiting time at clinics, interaction time with the doctor, perceived performance of doctor, and effectiveness of treatment influenced the decision on a return visit for care seeking. The authors conclude that this model of government primary healthcare can be replicated in urban settings to increase access. It is therefore argued that 'supply-side financing strategy like the one being implemented through Mohalla Clinics is more rational than the demand-side financing strategy of insurance in countries like India where a large

---

<sup>42</sup> Kearns. Op.cit.

chunk of the population in both rural and urban areas is still unable to avail proper health care service<sup>43</sup>

## **2.9 International appreciation and adoption of the concept beyond Delhi**

This model has received widespread recognition both nationally as well as beyond the national borders. Kofi Annan, the former Secretary General of the United Nations appreciated and commented that ‘the initiative was “consistent with the Universal Health Coverage (UHC) goal” of the World Health Organisation<sup>44</sup>. Appraisal was also received from former Secretary General of the United Nations Ban Ki-moon and former Norwegian Prime Minister Gro Harlem Brundtland during their visit to a health facility (Peeragarhi in West Delhi) built under this project in September 2018<sup>45</sup>. Pune and Greater Hyderabad Municipal Corporation also promised to adopt this model of health care delivery.

## **2.10 Role during COVID-19 pandemic**

Since the initial days of the pandemic in the early months of 2020, there have been debates and discussions regarding the huge impact the healthcare infrastructure in India is about to face due to the pandemic. Public health experts have argued that besides the secondary and tertiary care hospitals, the resources from the primary healthcare units also

---

<sup>43</sup> T. Sah, R. Kaushik, N. Bailwal & N. Tep. Op.cit. pp. 195–210.

<sup>44</sup>Unknown author. (28<sup>th</sup> January, 2017). Kofi Annan Praises Mohalla Clinics. *The Hindu* accessed from <https://www.thehindu.com/news/cities/Delhi/KofiAnnanpraisesMohallaclinics/article17105541.ece> on 18<sup>th</sup> March 2019, 11:35pm.

<sup>45</sup> Unknown author. (7<sup>th</sup> September, 2018). AAP’s Mohalla Clinic project in Delhi draws praise from Ban Ki-moon. *Business Standard*. Accessed from [https://www.business-standard.com/article/current-affairs/aap-s-Mohalla-clinic-project-in-delhi-draws-praise-from-ban-ki-moon-118090700602\\_1.html](https://www.business-standard.com/article/current-affairs/aap-s-Mohalla-clinic-project-in-delhi-draws-praise-from-ban-ki-moon-118090700602_1.html) on 20th March 2019, 11:44am.

have to be pooled in to mitigate the pandemic. In this context, the potential of the mohalla clinics in dealing with the COVID-19 pandemic has often been discussed. Lahariya (2020) argues that these clinics have been a support system during the time of the pandemic in two ways – by treating non-COVID patients when other healthcare facilities were out of reach and by doubling as testing centres. These clinics could be used as centres for early detection of COVID cases, treating and isolation and also as awareness creating centres especially in the underserved areas of the capital (Bailwal et al. 2020). However, Bailwal et al. (2020) also argue that the maximum potential of these clinics have not been utilized during the pandemic. They have shown ‘...how a well-developed network of primary healthcare can play a decisive role in curbing the COVID pandemic, as is evident from the examples of Kerala and Himachal Pradesh. We also show that Delhi has completely ignored its network of mohalla clinics in checking the pandemic’<sup>46</sup>. These clinics could also be used for a more efficient contact tracing mechanism (Bailwal et al. 2020).

### **2.11 Short falls within Mohalla Clinics**

There are gaps which demand special attention for proper decentralization and strengthening of these primary health care units in Delhi. Despite the existence of the cabins for the clinics, several units do not have doctors for treating patients. On the other hand, in some other clinics, the doctors are extremely dissatisfied and are continuing to work only under compulsion. The doctors and staff in the clinics often complain about the lack of

---

<sup>46</sup> Bailwal, N., Kaushik, R. & Sah, T. (2020). Importance of Primary Healthcare in Delhi in the Times of COVID-19. *Indian Journal of Human Development*, Vol.14 (3), 533

infrastructure and poor remuneration<sup>47</sup>. Studies revealed that some clinics lack basic services of providing medicines to patients or conducting diagnostic tests. There is need for immediate interventions in these areas for which the first step is identification of the glitches.

Lahariya's (2017) statement regarding the future plan of action is absolutely pertinent in saying that 'A roadmap-cum-operational plan with timelines, budget and role and responsibility assigned among stakeholders has to be developed, in consultation with key stakeholder, and approved by highest level of authorities in urban civic bodies. This would be absolutely needed to achieve the clinics' success, sustainability and desired accountability'<sup>48</sup>.

However, the overwhelming target of 1000 clinics is yet to be achieved. At present there are about 485 Mohalla Clinics in Delhi (Ministry of Health and Family Welfare, Govt. of NCT of Delhi). More significant than missed target are the deplorable conditions in which the existing clinics function especially with respect to lack of proper infrastructure, unavailability of medicines and diagnostic tests (NDTV, 29<sup>th</sup> August 2018). Several newspapers and television channels have conducted surveys in some of the clinics and have reported the appalling conditions of these clinics. Some of the clinics are even non-functioning and are in dilapidated condition. Researchers and scholars from various disciplines have also conducted studies on the performance and working of Mohalla clinics and have found some of them to be functioning under unacceptably poor conditions. The establishment of Mohalla clinics was conceived with high ambition and benevolent motive

---

<sup>47</sup> Unknown author. (3<sup>rd</sup> August, 2018). Delhi Mohalla Clinics Have Patients Raving About it, But Doctors Have a Sad Tale to Tell. *CNN-News 18*. Accessed from <https://www.news18.com/news/india/delhi-Mohalla-clinics-have-patients-raving-about-it-but-doctors-have-a-sad-tale-to-tell-1832939.html> on 15<sup>th</sup> March 2019, 9:10 am.

<sup>48</sup> Lahariya (2019). Op.cit.

but neither could the promised target be fulfilled yet nor do the few existing clinics function to full capacity. Interviews have also revealed that the staff who are appointed in the clinics (the doctor, the laboratory assistant) are also not contented with the remuneration that they receive, their working conditions, the available infrastructure, medicines and so on.

## **2.12 Research Gaps and Limitations**

Mohalla Clinic is a relatively new project launched by the Delhi Government in 2015. In the absence of adequate data available in the public domain related to these clinics, studies are usually based on few clinics visited by the scholars, which may be seen to present a biased picture. Limited research works have taken place on the aspects of accessibility and utilization of healthcare services in mohalla clinics. Most of the works are focused on patients visiting the clinics and the population around the clinics has not been taken into consideration. This study, besides including the patients seeking healthcare in the clinics have also included the population in the residential areas around the clinics. This study therefore attempts to include phases of the growth of these clinics and the present role played by them in enhancing the efficacy of the primary healthcare system in Delhi by focusing on aspects of accessibility and utilization. This will be helpful in policy implications for expanding this project within and beyond the borders of Delhi.

It should be mentioned that very limited data is available in the public domain regarding the utilization of healthcare services in Mohalla Clinics. In the absence disaggregated data, it is difficult to portray the picture of Delhi as a whole. The data that could be collected from Mohalla Clinic Project Cell was too aggregate to study the spatial variations or differential utilization of the existing services by different sections of the population. The delay in receipt of approval from the competent authority to carry out this

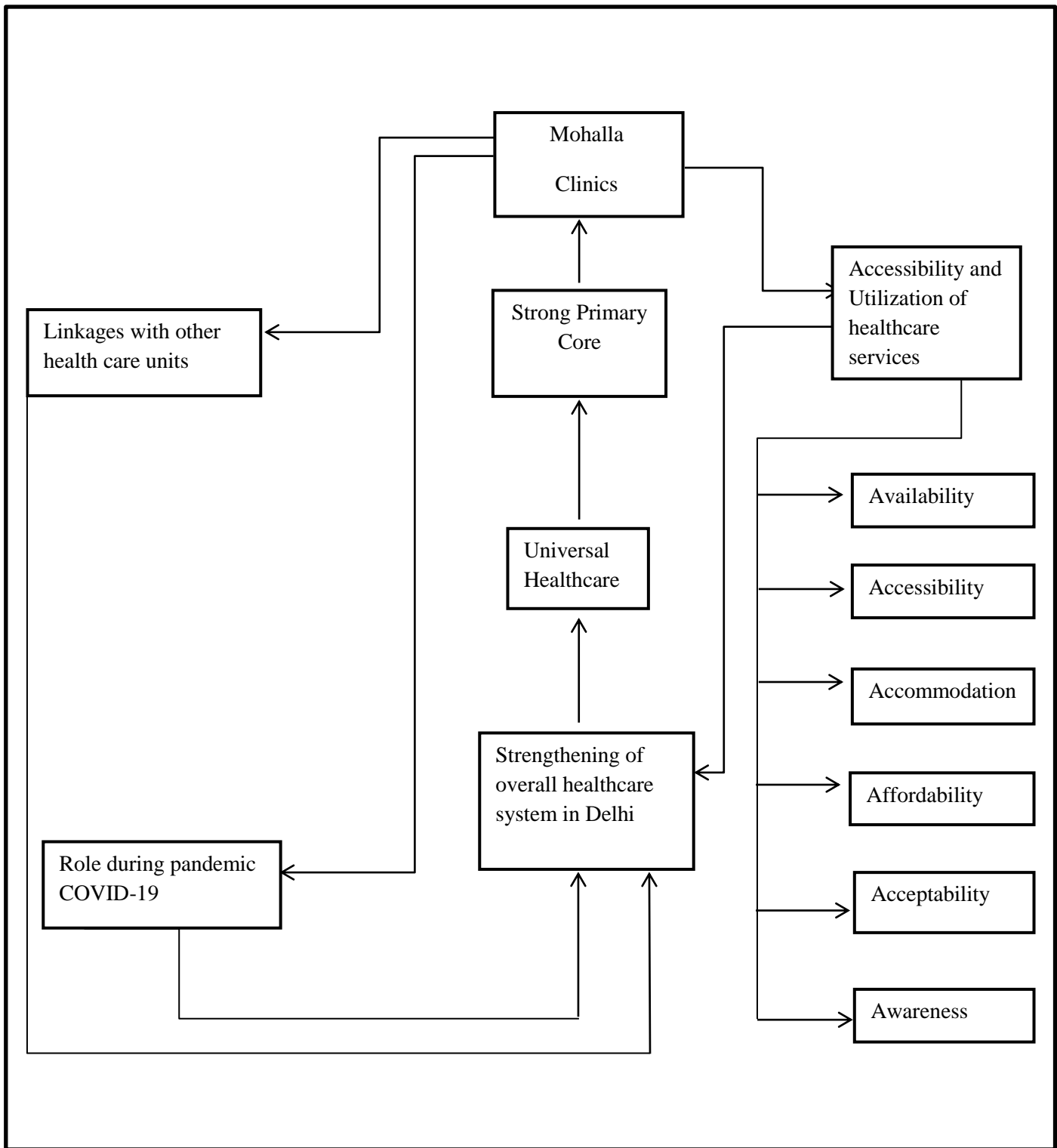
project had led to inadvertent deferral of initiation of data collection from the field. Further, the COVID-19 situation had been an impediment in the way in the process of data collection.

### **2.13 Conceptual Framework**

Based on the above literature, the following framework has been outlined based on which the present study has been carried out.

Aligned with the principle of Health for All, health policies in India aim towards Universal Health Care – provisioning affordable and accessible healthcare at all levels for every section of the population. It has been emphasized that a healthcare system with a strong primary core is necessary for achieving UHC. While development of all three levels of healthcare is an important step towards UHC, development of primary healthcare facilities deserve special attention. As a move towards strengthening primary healthcare services in Delhi, the idea of establishment of Mohalla Clinics was proposed in 2015, prior to the Delhi Assembly elections. Despite various impediments in the early phase of the project, till December 2020, 485 clinics have been established across Delhi. In this study, three broad objectives pertaining to the functioning of mohalla clinics have been studied and it has been assessed whether and in what ways these clinics are strengthening the overall healthcare system in Delhi and aiding in achieving UHC.





*Figure 2.1: Methodological Framework of the Study (Modified after Penchansky and Thomas 1981; Saurman 2016)*

The model of healthcare access by Penchansky and Thomas (1981) which has been later modified by Saurman (2016) has been adopted with some further modifications to study the accessibility and utilization of primary healthcare services through these clinics. The parameters that have been taken into consideration to study access to healthcare are: availability, accessibility, accommodation, affordability, acceptability and awareness. The referral network created with other levels of healthcare units in Delhi and the role played by these clinics during COVID-19 pandemic have also been studied. All these functions taken together lead to the strengthening of the overall healthcare system in Delhi and aid in achieving UHC, through a strong primary healthcare system.

## **2.14 Conclusion**

This chapter summarizes the various themes of literature that has helped in the development of the conceptual framework of the study and outlines the gaps in the existing literature. The themes include role of Geography in the study of healthcare, role of space and place in the accessibility and utilization of healthcare services, factors that influence accessibility and utilization of healthcare, Universal Health Care or Healthcare for All, healthcare infrastructure in Delhi, the idea of mohalla clinics, healthcare services available in the mohalla clinics, international appreciation and replication of the idea in different regions outside NCT of Delhi, shortfalls within the mohalla clinics and how these clinics can help in increasing the efficacy of the existing healthcare system in Delhi. While the present work tries to address the research gaps, yet it is subject to certain limitations. Finally it discusses the conceptual framework of the present study.

## **Chapter 3: Evolution and Structure of Healthcare System in India and Delhi**

### **3.1 Introduction**

In the foregoing chapters the relevant literature has been reviewed and the objectives and research questions for this study have been framed. The present chapter forms the background chapter of the study and aims to trace the development of healthcare system in India with special emphasis on the position that primary healthcare has occupied in the health policies. This chapter is divided into three parts: the first section deals with the significance of primary healthcare within the health system, the second section deals with the evolution of healthcare system in India with special reference to primary healthcare and evaluates its present status and the third section deals with the structure and status of the existing healthcare system in Delhi.

Health and healthcare systems have occupied significant position both in the 2015 target of Millennium Development Goals (MDGs) and 2030 target of Sustainable Development Goals (SDGs) wherein affordable and accessible health care services for all have been recognized as a crucial element of sustainable development of nations. The World Health Organization (WHO) defines health for all or Universal Health Coverage (UHC) as, ‘...all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health

promotion to prevention, treatment, rehabilitation, and palliative care'.<sup>1</sup> A healthcare system is responsible for providing an array of health services to the people without having them to undergo financial hardships. According to the WHO, about half of the world population fails to receive the health services they require while about a hundred million of them have to sustain poverty each year due to out-of-pocket expenditure on health. Therefore, provision of health care services at all levels at free of cost or lowest possible cost is important to achieve health for all. Although primary health care is recognized as an efficient and effective way to achieve universal health care, primary, secondary and tertiary health care services are intricately linked and none can function in isolation. Therefore, the development of all three components of the health system in tandem is prerequisite for achievement of complete well-being of the people.

Since primary health care is the first point of contact with the health system, it is an effective tool for providing health care to all. The importance of primary health care in universal health care was first emphasized in the Alma Ata Declaration in 1978 and reinstated in Astana Declaration in 2018. Primary healthcare is an umbrella term which encompasses '...not only individual and family health needs, but also the broader issue of public health...'.<sup>2</sup> The Asian Charter for Health Development (1978) formulated by the WHO South-East Asia Region also affirms the need to strengthen primary health care services among other objectives.

---

<sup>1</sup> World Health Organisation, 'Universal Health Coverage', accessed from [https://www.who.int/health-topics/universal-health-coverage#tab=tab\\_1](https://www.who.int/health-topics/universal-health-coverage#tab=tab_1) on 18<sup>th</sup> November 2019, 9:19pm.

<sup>2</sup> World Health Organisation. Primary Health Care. Accessed from [https://www.who.int/health-topics/primary-health-care#tab=tab\\_1](https://www.who.int/health-topics/primary-health-care#tab=tab_1) on 18<sup>th</sup> November 2019, 9:45pm.

### 3.2 Defining Healthcare System

The World Health Report (2000) on 'Health Systems: Improving Performance' defines a health system '...to include all the activities whose primary purpose is to promote, restore or maintain health'.<sup>3</sup> It must be noted that health system not only refers to the organized spectrum of health services but also includes all efforts which directly influences health. Broadly it can be defined as,

Health systems are defined as comprising all the organisations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health.<sup>4</sup>

The indirect factors which have the potential to improve health such as education and socio-economic structure, however, are not included in the domain of healthcare system. A health system is the collective responsibility of multitude of factors working in tandem. The WHO states that, '...a well-functioning health system working in harmony is built on having trained and motivated health workers, a well-maintained infrastructure, and a reliable supply of medicines and technologies, backed by adequate funding, strong health plans and evidence-based policies'.<sup>5</sup> An efficient health system is necessary for complete well-being of the population. While improving health is the primary objective of a health system, 'responding to people's expectations and providing financial

---

<sup>3</sup> World Health Organisation (2000). Why do Health Systems Matter? Health Systems: Improving Performance. p.5

<sup>4</sup> *ibid.* p. 11

<sup>5</sup> World Health Organisation, *Health Systems*, accessed on 22<sup>nd</sup> November 2019 at 3:45pm from <https://www.who.int/healthsystems/en/>

protection against the costs of ill-health'<sup>6</sup> are also among its objectives. The knowledge and behaviour of the people are important components of the healthcare system since people are the 'central actors in their own health.'<sup>7</sup> Hsiao (2003) conceptualized health system as 'a set of relationships in which the structural components (means) and their interactions are associated and connected to the goals the system desires to achieve (ends)'.<sup>8</sup>

### 3.3 Defining Primary Healthcare

The Alma Ata Conference of 1978 defined Primary Healthcare as, '...essential health care, which should be easily accessible to all people in the community'.<sup>9</sup> Social justice and right to health were clearly enunciated in the Alma Ata Conference and it mobilized a 'Primary Health Care Movement'<sup>10</sup>. Primary care is the entry point to the healthcare system and is inter-linked to the other components of the system. Primary care is '...a system of care that provides accessible and acceptable care for patients; ensures the equitable distribution of health resources, integrates and coordinates curative, palliative, preventive, and health promotion services; rationally controls secondary technology and drugs; and increases cost-effectiveness of services...'<sup>11</sup> Donaldson et al. (1996) defines

---

<sup>6</sup> World Health Organisation. (2000). Op.cit. p.8.

<sup>7</sup> Priya, Ritu. (2018). State, Community and Primary Health Care: Empowering or disempowering discourses? In Purendra Prasad and Amar Jesani (Eds.) *Equity and Access: Health Care Studies in India* (25-49). India: Oxford University Press. p. 43.

<sup>8</sup> Hsiao, W.C. (2003). What is a Health System? Why Should We Care. Working Paper Series, Department of Health Policy and Management, *HSPH*.

<sup>9</sup> O.P.Ghai. (1985). *Management of Primary Health Care*. New Delhi: Interprint. p.2.

<sup>10</sup> World Health Organisation (2008). Primary Health Care – Now More Than Ever. World Health Report. p. 6.

<sup>11</sup> World Health Organization, A Charter for General Practice/Family Medicine in Europe. Regional Office for Europe. Geneva: World Health Organization, working draft, 1994. Cited in Barbara Starfield. (1998). *Primary Care: Balancing Health Needs, Services and Technology*, New York: Oxford University Press, p. 25.

primary care as, ‘...the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.’<sup>12</sup> Integrated primary care implies it should be comprehensive, coordinated and continuous<sup>13</sup>, wherein people can utilize a combination of health services for a health problem at any age, and over a long period of time. According to World Health Report (2008), ‘Primary care provides a place to which people can bring a wide range of health problems – it is not acceptable that in low income countries primary care would only deal with a few “priority diseases”.’<sup>14</sup> Primary health care is important for the total well-being of man. Primary health care should be central to the health care delivery system with secondary and tertiary care services to support it. Ritu Priya (2018) emphasizes that, ‘A primary care approach requires the design of health systems development to incorporate (i) centrality of primary level care, (ii) use of appropriate technology at primary, secondary and tertiary levels of care and (iii) recognition of the determinants of health other than medical care’.<sup>15</sup> Primary care includes disease prevention, early detection, diagnosis and treatment, maternal and child health care, emergency care, rehabilitative and palliative care, referral services, health promotion and awareness creation besides.<sup>16, 17, 18</sup>

---

<sup>12</sup> M. Donaldson, K. Yordy, K. Lohr, N. Vanselow (Eds). *Primary Care: America’s Health in a New Era. Institute of Medicine*. Washington, DC: National Academy Press, 1996. Cited in Barbara Starfield (1998). *Primary Care: Balancing Health Needs, Services and Technology*. New York: Oxford University Press, p. 23.

<sup>13</sup> Ibid. p. 23.

<sup>14</sup> World Health Organization, World Health Report (2008). Cited in K. Srinath Reddy (2019). *Make Health in India: Reaching a Billion Plus*, Hyderabad: Orient BlackSwan. p. 48.

<sup>15</sup> Ritu Priya, op.cit. p. 25.

<sup>16</sup> World Health Organization (2008), op.cit. p. 11.

<sup>17</sup> Alberta Medical Association, op.cit.

### 3.4 Importance of Primary Healthcare

Health systems need to respond in an improved manner to the challenges of the changing world and Primary Healthcare can do that (WHO, 2008). The health system has undergone overall improvement as suggested by the health indicators over time. However, inequalities in health loom large wherein some communities lag behind others in terms of health indicators. Therefore it is imperative that the health condition of every individual should improve. Enhancement of primary healthcare services is crucial in improving the overall health system directed towards health for all. The importance of primary care lies in the fact that it is the first point of entry into the health system and this point of entry should be easily accessible to any person who thinks has a health problem and needs care. Starfield, et al. (2005) argues that stronger primary healthcare systems have helped in lesser mortality, equitable distribution of health in population and better health outcomes<sup>19</sup>.

### 3.5 Components of Primary Healthcare

The fundamental premise of primary healthcare rests on the principle that ‘all people, everywhere, deserve the right care, right in their community’.<sup>20</sup> Primary health care is a broad term which is a people-centred approach and includes physical, mental as well as social well-being.<sup>21</sup> Primary healthcare includes an array of services from health promotion, disease prevention and treatment to rehabilitation and palliative care. Ghai (1985) opines

---

<sup>18</sup> B. Starfield. (1998). *Primary Care: Balancing Health Needs, Services and Technology*, New York: Oxford University Press.

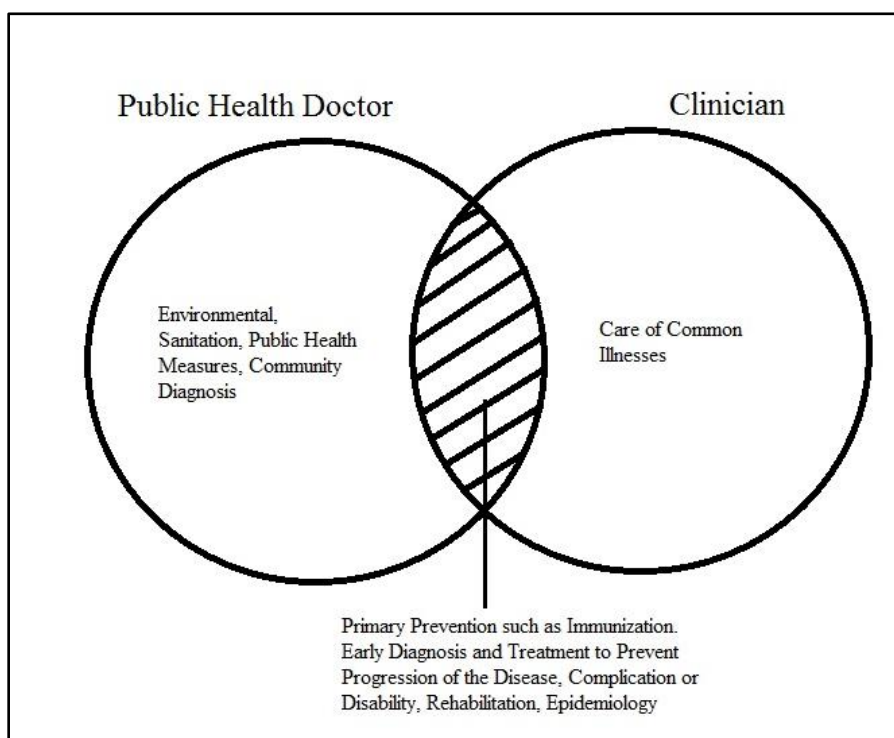
<sup>19</sup> B. Starfield, L. Shi & J. Macinko. (2005). Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*, Vol. 83 (3), 457–502.

<sup>20</sup> World Health Organisation, *Primary Health Care*, accessed on 18th November 2019 at 9:45 pm from

<sup>21</sup> World Health Organisation, *Primary Health Care*, accessed on 18th November 2019 at 9:45 pm from



that an important component of primary health care is the control of communicable diseases in the community which is two-fold: protection of individuals from the ill-effects of communicable diseases and minimization of spread of infection to others.<sup>22</sup> Primary health care provides care in the community and through the community which extends its scope beyond individual needs to address the broader issue of public health. Therefore, promotion of primary health care includes the joint responsibility of clinicians and public health doctors which has been illustrated by Ghai (1985):



**Figure 3.1: Responsibilities of Clinicians and Public Health Doctors: In Some Areas They Have Joint Responsibility. (Ghai 1985, p.6)**

Ritu Priya (2018) recognizes three versions of primary health care: (i) Selective Primary Health Care which includes affordable essential health services; (ii)

<sup>22</sup> O.P.Ghai, *Management of Primary Health Care*, Interprint, New Delhi, India, 1985, p.136

Comprehensive Primary Health Care which places primary level care at the centre of health care system and secondary and tertiary care services to support it and (iii) Comprehensive Primary Health Care which includes local knowledge and community participation supported by institutional primary, secondary and tertiary health care services.<sup>23</sup> The World Health Report 2008 organizes the PHC reforms in four groups that are necessary to achieve health for all. Since Indian health system has drawn largely from the Western model of medical services, curative healthcare has received more emphasis than care (Deodhar, 1982).<sup>24</sup> Preventive and promotive healthcare demands attention and substantial resources should be directed in this direction within the primary health care services.

### **3.6 Evolution of Healthcare System in India**

India strongly believed in the traditional healing practices such as Yoga and Ayurveda on which people depended for cure entirely at least till the advent of modern medical system in India. In the latter part of the eighteenth century, the British introduced modern medicine in Indian who still continued to have faith in the traditional healing practices followed by the 'vaid, hakims, and specialist or mid-wives – healers who lived amidst them in villages and towns'<sup>25</sup>. 'The social, cultural, economic and political changes that followed the introduction of British rule in India dealt an almost fatal blow to the practice of the Indian systems of medicine'<sup>26</sup>. Between 1889 and 1894, only 0.15 percent of

---

<sup>23</sup> Ritu Priya, op.cit. p. 39.

<sup>24</sup> N. S. Deodhar. (March 1982). Primary Health Care in India. *Journal of Public Health Policy*. Vol. 3 (1), p. 87.

<sup>25</sup> K. S. Rao. (2017). *Do We Care? India's Health System*. India: Oxford University Press. p. 8.

<sup>26</sup> D. Banerji. (1974). Social and Cultural Foundations of Health Services Systems. *Economic and Political Weekly*, Vol. 9 (32/34), Special Number, p. 1334.

revenue was spent on health compared to 4 percent on education (Rao, 2017). Health never occurred on the priority list of the British till a large section of their troops became affected by several diseases. It was then that they intervened in the area of public health and several hospitals and health care units were established. Drawing upon the fact that environmental sanitation and disease are directly linked, sanitary commissions were appointed in the provinces of Madras, Bombay and Calcutta between 1863 and 1869 to take care of the public health needs. Improved quality of water and sanitation and better housing helped in improving the health indicators. The importance of public health was reduced when the post of Sanitation Commissioner was merged with the post of Director General (DG) of the Indian Medical Service in 1914. The Medical Council of India (MCI) was established in 1933. In 1940 the post of DG Medical Services was changed to DG Health Services and the post of public health commissioner was abolished. According to the Bhore Committee report (1946), during the time of Independence, British India had 17654 medical graduates, 29870 licentiates, 7000 nurses, 750 health visitors, 5000 midwives, 75 pharmacists and about 1000 dentists.

### ***3.6.1 Bhore Committee (1946)***

The Health Survey and Development Committee was appointed by the Government of India in October 1943 to review the health status of the country and recommend measures to improve it. This committee presented its report in 1946 under the chairmanship of Sir Joseph Bhore which is why this report is well known by the name Bhore Committee Report. Taking account of the then prevalent situation in India, the committee recommended free healthcare for all. The epidemiological approach adopted by the committee in studying the health issues in India deserves appreciation. The committee

collated extensive data on health infrastructure, nutritional status of the people, laid special emphasis on the health of the mother and child and also on the study of morbidity related issues. The committee also recognized the role of socio-economic factors in the ill health of the people. The overall significance of the environment (in the broadest meaning of the term) can hardly be exaggerated and the committee had efficiently mentioned that. It also recommended that raising the dietary standards of the people is an important determining factor to ensure proper health among the people of the country. Bhore committee had shown enough farsightedness to promote universal healthcare way back in the pre-independence years. This policy is an important agenda even in the present day health policies of the country. The committee was aware of the lack of resources for the implementation of the policy; however, it never failed to recognize its importance. Despite these achievements, several drawbacks of the committee may be outlined. The major flaw of the committee was that it did not adopt the 'Health as a Right' approach (Bajpai and Saraya, 2018). Another failure was that the committee had undermined the indigenous system of medicine and had promoted the adoption of the western system of medicines. The committee was also biased in saying that there should be only one category of doctors who will be highly trained. This is a major failure since only a certain section of the population could afford their children to send to the higher level education institutions for training. The Bhore committee was essentially an extension of the colonial system of healthcare wherein the 'white *sahib*' was replaced by the 'brown *sahib*'.<sup>27</sup> The Malthusian approach adopted by the committee in understanding the population problem was a structural problem of the committee. It recognized the

---

<sup>27</sup> V. Bajpai & A. Saraya. (2018). *Health Beyond Medicine: Some Reflections on the Politics and Sociology of Health in India*. New Delhi: Aakar Publication. p.19.

population as the part of the problem and as a result recommended policies in that direction. However, more important and effective way to deal with the problem would be to outline policies that aim at the amelioration of the socio-economic and political condition of the people. Therefore, Bhore committee recommendation was a mixed bag of positive and negative aspects. Despite the failures, the importance of this committee is immense and it continues to influence the present day policy frameworks in the country. That the country has failed even to fulfill the short term goals that had been outlined by the committee is a warning bell to the policy makers that it is high time that more resources should be directed in this field and proper implementation of the plans must be ensured.

The first Primary Health Centre was established in October 1952 as a part of the Community Development Programme (CDP). Its aim was to provide integrated preventive, promotive and curative services to the people, which was a landmark in the development of health services in India. This may be regarded as the first step towards implementation of the Bhore Committee recommendations (Bajpai and Saraya, 2018).

### ***3.6.2 Mudaliar Committee (1962)***

In 1959, the Health Survey and Planning Committee, popularly known as Mudaliar Committee, headed by Dr. A.L. Mudaliar, was appointed. The main task of this committee was to evaluate the performance in health sector during the first two Five-Year Plans and suggest recommendations for the future. This committee noted that deaths due to communicable diseases had declined but overall health care system was far from satisfactory. Not only was there a shortage in number of PHCs but also the quality of services provided therein was below average. Private practice by the doctors was rampant and more emphasis

was laid on curative services. It suggested that the PHCs already established should be strengthened before further expansion. Strengthening of sub-divisional and district hospitals was also advised. It was stressed that a PHC should not be made to cater to more than 40000 population and that they should be equipped to provide curative, preventive and promotive services. The committee also recommended that an All India Health Service should be created to replace the erstwhile Indian Medical service.

### ***3.6.3 Five-year plans (1951 – 2014)***

The public health policies in India have been formulated through various Five-Year Plans starting from 1951. However, these plans have often been accused of being ‘high on rhetoric but have not been able to deliver on the ground’<sup>28</sup> especially in case of the health sector. The Bhore Committee had recommended an increase in the funds allocated to health care expenditure of the total GDP to at least 15%. This was far from implementation. The First Five-Year Plan (1951-56) emphasized on construction of hospitals and dispensaries, provision for medical education and training and prevention of diseases. In the year 1953, a nation-wide family planning programme was launched. Second Five-Year Plan (1956-61) emphasized on the expansion of the existing health facilities so as to make the facilities accessible to more people. The Indian Medical Council and the Central Health Education Bureau were established in the year 1956. The Third Plan (1961-66) emphasized on the control of communicable diseases and also on expansion of health services in the rural areas. In the Fourth Plan (1969-74) an emphasis was laid on strengthening of the primary health care facilities which were not only supposed to deliver preventive and curative

---

<sup>28</sup> Ibid. p.51.

services but also take over the onus of controlling communicable diseases. The sub-divisional and district hospitals were strengthened to serve as referral centres for Primary Health Centres. During the Fifth Plan (1974-79), the policy of 'Health for All by 2000 AD' enunciated in the Alma Ata Declaration of 1978 was adopted, which was an important move in the arena of public health. However, all throughout, the expenditure on public health remained lower than 4%. A joint report by ICSSR and ICMR report recommended that investments in health should increase to about 6% of GDP by the year 2000. The Sixth Plan (1980-85) which was highly influenced by Alma Ata Declaration (1978) and ICSSR-ICMR report (1980) categorically stated that the inequality in health across population was inbuilt in the structure of the health care system in India with over emphasis on hospitals, specialization, super-specialization and curative care. Only the affluent class could utilize these services and the rural people and poor were deprived. This plan aimed to focus on provisioning of health services to the rural areas, encouraged community participation and integration of inter-related programmes. However, by the Seventh Plan (1985-90), the emphasis had shifted to 'development of specialized care and training in super-specialities...in public and the private sectors' (Planning Commission, 1985). Eventually during the subsequent Ninth (1997-2002), Tenth (2002-07) and Eleventh (2007-12) Plans, the focus shifted from 'Health for All' as suggested by Bhore Committee to 'Health for the Underprivileged' (Bajpai and Saraya, 2018). It was declared on the Independence Day speech in 2011 by the Prime Minister of India that health would be given the highest priority in the Twelfth Five Year Plan which would become operational in 2012.<sup>29</sup> In the Twelfth Plan (2012-17) it was declared that public health services should be emphasized, expenditure

---

<sup>29</sup> Planning Commission of India (2011). *High Level Expert Group Report on Universal Health Coverage for India*, New Delhi, p. 1.

on health should be increased. This plan outlined an inclusive agenda for health directed towards universal health coverage. This was the last five year plan by the Planning Commission as it was dissolved in August 2014 and was superseded by the NITI Aayog.

### **3.6.4 *National Health Policy (1983)***

The first Health policy in India was introduced in 1983 which recognizes that emphasis on ‘specialized curative care’ has led to poor development of important aspects of preventive, promotive, rehabilitative and public healthcare (National health Policy, 1983).<sup>30</sup> Also, the available curative care facilities are highly skewed towards urban centres in its distribution. This compels the people residing in faraway locations to come to the urban centres for seeking treatment which otherwise could have been possible through a stronger primary health care system at the community level. Due to the lack of a well-established referral system, the specialized urban centres face congestion and duplication of efforts. This policy document outlined a 20-point programme aimed to develop a comprehensive primary healthcare policy based on the actual needs of the population, at an affordable cost, which would accentuate the achievement of universal healthcare. The primary healthcare should be a decentralized system with efficient referral facilities and close co-ordination of the secondary and tertiary level care institutions. This policy highly advocated the participation of the community in the primary level by transfer of knowledge and skill from the community to the health volunteers chosen by them. An efficient referral system would reduce the congestion and burden over the tertiary care hospitals and they in turn could direct their resources to focus on specialized curative care. This policy also recommended the

---

<sup>30</sup> Government of India. (2017). National Health Policy. *Ministry of Health and Family Welfare*, New Delhi, p.2.



establishment of a chain of sanitary-cum-epidemiological stations across the country, preferably between the primary and secondary levels of care or integrated with the primary health centres to tackle the problems of disease breakouts and local environmental problems. Similar set up was also recommended in the urban areas where the municipal and local authorities would perform the function of tackling 'local preventable public health problems'.<sup>31</sup> Healthcare institutions should be related to the population and other factors that affect health care accessibility and utilization. The focus should be on providing better care in the existing facilities. Referral system should be strengthened to reduce patient pressure at higher levels of healthcare system hierarchy. This policy outlined three steps to reduce governmental expenditure: by encouraging private practice, increased investment by non-governmental organizations and offering support to voluntary agencies in the field of health. While this policy recognized the need to improve specialist centres with a well-integrated referral system, it also enunciated the need to establish and strengthen primary healthcare centres. Establishment of private clinics within the governmental set up was encouraged in order to reduce the burden on governmental expenditure. In this manner, free health care could be provided to those who need it while the affluent section could utilize health care from private clinics on payment. Though this set up would enhance accessibility and utilization of health care services, it would also lead to inequality in health care. At the same time, this policy also aimed at reducing regional disparities as well as disparities based on disabilities, age or gender. Development of indigenous medicines, which was locally acceptable, was proposed to be extended and integrated with modern system of medicines. Besides these, measures were suggested to take care of other factors affecting health of

---

<sup>31</sup> Government of India. (1983). National Health Policy. *Ministry of Health and Family Welfare*, New Delhi, p.7.

population: nutrition, prevention of food adulteration, maintenance of the quality of drugs, water supply and sanitation, environmental protection, immunization programme, maternal and child health services, school health programme and occupational health services.<sup>32</sup> This policy also recognized the importance of easily comprehensible health education to all people and indirect factors affecting health such as universal education. A well-coordinated information system along with developed medical industry and medical research would help in overall improvement of health of population. This policy aimed to provide health for all by the year 2000 by strengthening primary health care system. However, it was later realized that the financial support and public health administrative capacity required for this ambitious and holistic goal was inadequate.

### ***3.6.5 National Health Policy (2002)***

A need was again felt to outline a health policy for the country in 2002. This policy was outlined after two years of adoption of Millennium Development Goals (MDGs). The main objective of this policy was to achieve ‘acceptable standard of good health’<sup>33</sup> and equitable health care access in the country. While the National Health Policy 1983 was successful in improving overall health in some aspects, there were some pockets where public health met with limited success and needed immediate and focused attention. Significant epidemiological transition occurred in the form of emergence of lifestyle diseases. Therefore policies have to be directed towards coping up with them. NHP 2002 aimed to review the prevailing health situation in the country and outline measures for

---

<sup>32</sup> Ibid. pp.9-12.

<sup>33</sup> Government of India. (2002). National Health Policy. *Ministry of Health and Family Welfare*, New Delhi, p. 22.

improvement of the same through realistic goals. The foremost requirement was the increase of public health expenditure by the states and contribution by the central government in augmenting public health investments. Statistics revealed wide regional and rural-urban disparities which were often overlooked at the aggregate level. Socio-economic inequalities were extended to health sector especially for the vulnerable section of the society including women, children and the socially disadvantaged sections of the society. NHP 2002 aimed to reduce inequities so that all sections of the population had equitable access to public health care services. Many people preferred not to use public health services despite incurring out-of-pocket payment on using private health care services. This was due to the dismal condition of inadequate public health facilities available in the country. The integration of indigenous health practices with the modern medicine was re-emphasized in order to overcome the shortage of medical personnel. The syllabus of education of health care had to be revamped so as to train the graduates to be ready to fulfill the health care needs right after the completion of their degree. Experts in public health and family medicine were required especially due to the inadequate availability of health services to discharge the responsibilities pertaining to public health. NHP 2002 also tries to address health security of population in the post-TRIPS era since it is apprehended that globalization will lead to high costs of drugs which will eventually lead to high overall health costs. Since private health facilities overpower public health facilities in urban areas, there is an increasing need to strengthen public health facilities in urban areas especially in the face of growing urbanization. In addition to these, NHP 2002 would also address policies related to mental health, health education, information and communication, health research, an efficient disease surveillance mechanism, medical ethics, maintenance of food and drugs standards,

environmental and occupational health. Health of women and other vulnerable sections of the society should be prioritized because their poor health standards affect the society adversely. It is necessary to impart education regarding preventive and promotive health care. With adoption of liberalization, globalization and privatization of the economy in the 1990s, there was an imperative need to extend privatization to the health care sector as well, beyond private practitioners. NHP 2002 also recognized the importance of indirect factors contributing to health such as proper nutrition, safe drinking water, sanitation, clean environment and primary education, especially for the girls. Together with National Population Policy 2000, NHP 2002 aims to improve overall health conditions of population by focusing on communicable diseases, universal immunization, reproductive health services and infrastructural needs. Health sector expenditure was recommended to be increased to 6% of GDP with 2% being dedicated to public health investment by the year 2010. Similar proposal was outlined for state governments as well where they were supposed to increase investment in health sector to 7% by 2005 and 8% by 2010. To reduce inequity in health care access and utilization, emphasis was laid on enhancement of primary healthcare services aimed at preventive and early stage curative care.

### ***3.6.6 National Rural Health Mission (2005)***

The National Rural Health Mission (NRHM) was launched on 12<sup>th</sup> April 2005 as an initiative to revamp the state of health in India. NRHM was launched with the objective to provide universal access to ‘equitable, affordable, and quality healthcare’<sup>34</sup> but was mainly directed to meet the maternal and child health care needs. This mission outlined several

---

<sup>34</sup> Swedish Agency for Growth Policy Analysis (2013). India’s Health Care System: Overview and Quality Improvements. Sweden, p. 7.

objectives including accessibility to integrated comprehensive primary health care, universal access to public services including food and nutrition, hygiene and sanitation facilities, revival of local health traditions and mainstreaming of AYUSH and others. This mission was mainly focused on maternal and child health problems and infectious diseases while non-communicable diseases, mental health were largely ignored, thinking these to be majorly urban problems. Contrary to the spirit of comprehensive primary health care, many health issues were neglected purposely. Therefore, this mission continued to remain as a selective approach to health care.

### ***3.6.7 Report of the High Level Expert Group (2011)***

Universal Health Coverage encompasses a broad meaning and is ‘...beyond “insurance” by providing an “assurance” of health care for multiple needs and includes health beyond health care, going beyond a mere illness response’.<sup>35</sup> This report provides a framework for designing the Universal Health Coverage system. UHC as defined by the HLEG is as follows: ‘Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services’.<sup>36</sup> This definition is broad and incorporates different aspects of health assurance: health care, health

---

<sup>35</sup> Planning Commission of India (2011). Op.cit. p. 2.

<sup>36</sup> Ibid. p. 3.

coverage and health protection.<sup>37</sup> UHC is considered as a mechanism of guaranteeing balanced development, ‘where the economic growth of a nation is accompanied by an increase in the health and well-being of all persons’.<sup>38</sup> The following ten principles guided the formulation of the recommendations for introducing a system of UHC in India: ‘(i) universality; (ii) equity; (iii) non-exclusion and non-discrimination; (iv) comprehensive care that is rational and of good quality; (v) financial protection; (vi) protection of patients’ rights that guarantee appropriateness of care, patient choice, portability and continuity of care; (vii) consolidated and strengthened public health provisioning; (viii) accountability and transparency; (ix) community participation; and (x) putting health in people’s hands.’<sup>39</sup> This report recognizes health as a human right which is a prerequisite for achieving UHC and is directed towards providing health security to all individuals. ‘The HLEG affirmed that UHC should address health in all of its dimensions and emphasize prevention and primary health care, which are ignored, neglected or even undermined by the usual systems of health insurance.’<sup>40</sup> This policy recognized the significance of addressing the social determinants of health to achieve a regional balance in health care. Therefore, it is the responsibility of the state to improve the factors which affect health such as nutrition, water and sanitation, clean environment and so on. An effective approach towards UHC should be gender sensitive. The recommendations in this policy are based on experiences from India as well as other developed and developing countries across the world. This policy recommended that all

---

<sup>37</sup> Reddy (2019). op.cit. p. 62.

<sup>38</sup> Planning Commission of India (2011). p. 41.

<sup>39</sup> Ibid. p. 3.

<sup>40</sup> Reddy (2019). p. 61.

people should be entitled to ‘essential primary, secondary and tertiary health care services’<sup>41</sup> through public as well as private health care providers.

It was apprehended that following these policy terms, India would achieve greater equity in health and disparities would be reduced. An integrated primary health approach would also reduce the disease burden in the country. This policy recognized six critical areas which should be developed within the health system to achieve UHC: (i) Health financing and financial protection (ii) Health service norms (iii) Human resources for health (iv) Community participation and citizen engagement (v) Access to medicines, vaccines and technology (vi) Management and institutional reforms.<sup>42</sup> This policy recommended that the Government should increase public expenditures on health from present rate of 1.2% of GDP to at least 2.5% by the end of the 12th plan (i.e. 2017) and to at least 3% of GDP by the year 2022. This would help in significant reduction of OOP expenditure and ensure a more equitable health care accessibility and utilization. The High Level Expert Group (HLEG) was of the opinion that ‘user fee of any kind militated against the version of UHC’.<sup>43</sup> It was also stated that 70% of all health care expenditures should be directed towards primary health care such as general health information and promotion, curative care services at the primary level, risk factors screening and cost effective treatment. India faces major challenges in delivery of primary health care including lack of adequate health workforce, lack of connectivity with the health system and poor public health care system which demands immediate attention. Therefore it is imperative to

---

<sup>41</sup> Planning Commission of India (2011), p. 4.

<sup>42</sup> Ibid. p. 7.

<sup>43</sup> K.S. Reddy & M.R. Mathur (2018). Universal Health Coverage: How viable? In Purendra Prasad and Amar Jesani (Eds.) *Equity and Access: Health Care Studies in India* (305-322). India: Oxford University Press. p. 311.

develop a National Health Package which offers essential health care services at different strata of the health care delivery system. Strengthening of primary health care services was highly recommended in this policy. This would require adequate health care personnel trained to provide services at the community level especially among the marginalized section. Significant investment should also be directed towards establishment of training institutions for these health personnel. Role of community in enhancement of health can hardly be exaggerated. This policy envisages a decentralized health care system and ensures participation of the community by cultivating their local knowledge. Effective and affordable access to medicines, vaccines and appropriate technologies and an efficient management system is crucial for health security which has also been enunciated in this policy. This policy called for a ‘greater political commitment to UHC’<sup>44</sup> and more attention to the social determinants of health and non-health sectors which have a bearing on health care.

### ***3.6.8 National Health Mission (2013)***

The existing NRHM was modified to incorporate an urban component and was relabelled as National Health Mission (NHM) in 2013. The objective was to strengthen the existing health system features. The objectives included introduction of village level community health workers ASHAs (Accredited Social Health Activists), strengthening of primary health care infrastructure from sub centres to community health centres, decentralization of health care planning up to the district level, involvement of the local community in health care delivery system, strengthening of health management information

---

<sup>44</sup> Planning Commission of India (2011). Op.cit. p. 39.



system among others. NHM was partially successful as can be seen in terms of increased institutional deliveries and reduced maternal mortality. Though both NRHM and NHM had little scope in fulfilling the demands of UHC, these definitely provided scope for provisioning comprehensive primary health care.

### ***3.6.9 National Health Policy (2017)***

NHP 2017 came after two years of adoption of Sustainable Development Goals (SDGs). Therefore, these policies not only reflected the health experiences and aspirations of India, but were also ‘... shaped partly by the global commitments made through the endorsements of MDGs and SDGs at different time periods’.<sup>45</sup> The primary objective of NHP 2017 is to ‘...inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions – investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross-sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance.’<sup>46</sup> In similar lines with the earlier NHPs of 1983 and 2002, NHP 2002 also aimed at providing universal health care through promotive and preventive approach without anyone facing financial burden for the same. This policy was based on 10 key principles: (i) professionalism, integrity and ethics (ii) equity (iii) affordability (iv) universality (v) patient centered and quality of care (vi) accountability (vii) inclusive partnerships (viii) pluralism (ix) decentralization and (x) dynamism and

---

<sup>45</sup> Reddy (2019). Op.cit. p. 82.

<sup>46</sup> Government of India (2017). Op.cit. p. 1.

adaptiveness.<sup>47</sup> This policy aimed to improve provisioning of quality preventive, promotive, curative, palliative and rehabilitative services through the public health sector. It outlined three broad pathways to achieve universal health coverage: strengthening of primary health care services, improving accessibility and utilization of secondary and tertiary health care services and reducing out-of-pocket expenses. It recognized the need to reinforce the trust in public health care system and align the private sector with public health goals. It outlined specific objectives to be achieved by 2025. Besides health status goals, it also envisaged goals related to sanitation and hygiene, reduced substance abuse and safe drinking water. This policy recommended the health expenditure by government to be increased from the existing 1.15% to 2.5% as a percentage of GDP by 2025 and the state spending on health sector to greater than 8% of their budget by 2020. Enhancement of primary and secondary health facilities with respect to numbers as well as quality should be ensured. Establishment of an efficient health management information system and monitoring of health statistics was important to understand the present health status of the population. NHP 2017 proposed raising public health expenditure to 2.5% of the GDP. It also promoted inter-sectoral coordination at centre and state levels to optimize health outcomes. It also recommended incorporation of health education within the curriculum, promotion of hygiene and safe health practices within school environment as a part of primary health care. In similar lines with the erstwhile NHPs, preventive and promotive care was recognized as significant avenues of achieving health for all. Unlike previous policies, specific and targeted objectives were outlined for preventive and promotive approaches besides curative care. This policy recommended some shifts in organization of public health care services such as

---

<sup>47</sup> Ibid. pp. 1-2.

from selective care to comprehensive primary health care with a strong referral system. Comprehensive primary health care would include palliative care, geriatric health care and rehabilitative care services. Public health facilities would remain the focus of the entire health care delivery system. While free public health services were recommended, aid could also be taken from non-government sector to meet the immediate health needs. To meet the growing demands of urban health, National Urban Health Mission (NUHM) was required to be expanded to include entire urban population within the following five years. It also recommended special provisions for tribal and socially vulnerable groups. Every individual would possess a health card and have access to primary health care services anywhere in the country. The policy recommends that health centres should be established on the basis of geographical norms besides population norms. The existing sub-centres and Primary Health Centres should be upgraded to provide comprehensive primary health care services. Other measures mentioned within this policy included: control of communicable and non-communicable diseases, universal immunization, interventions to control malnutrition and micro-nutrient deficiencies, mental health programmes, food and drug safety, health research and monitoring of health status. Reddy (2019) critiques NHP 2017 and argues that the right based approach to health is missing in this policy framework, in the absence of which the commitments made in this policy can remain unfulfilled.

#### **3.6.10 *Ayushman Bharat (2018)***

In line with the recommendations of NHP 2017, Ayushman Bharat was launched in 2018 with the aim of achieving Universal Health Coverage. It aims to address healthcare holistically, which includes prevention, promotion and ambulatory care at all three levels – primary, secondary and tertiary. It focuses on ‘comprehensive need-based health care

service’ and ‘adopts a continuum of care approach, comprising of two inter-related components, which are -

- Health and Wellness Centres (HWCs)
- Pradhan Mantri Jan Arogya Yojana (PM-JAY)<sup>48</sup>.

Following NHP 2017, in February 2018, the Government of India announced the creation of 150000 Health and Wellness Centres (HWCs) by converting the existing Sub Health Centres and Primary Health Centres. These centres would provide Comprehensive Primary Health Care (CPHC) in closer to the homes of people. They cover a wide range of services – maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services. These centres are expected to facilitate access, universality and equity close to the community.

PM-JAY, on the other hand, was launched on 23rd September, 2018. It is the largest government-funded health insurance scheme which provides ‘health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization to over 10.74 crores poor and vulnerable families (approximately 50 crore beneficiaries) that form the bottom 40% of the Indian population. The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas respectively<sup>49</sup>. It also includes ‘families that were covered in RSBY but are not present in the SECC 2011 database’<sup>50</sup>.

---

<sup>48</sup> Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, National Health Authority, *Ministry of Health and Family Welfare*, Government of India, accessed on 11<sup>th</sup> October 2020, 1:25 am, from <https://pmjay.gov.in/about/pmjay>

<sup>49</sup> Ibid.

<sup>50</sup> Ibid.

### **3.6.11 National Digital Health Mission (2020)**

The National Digital Health Mission (NDHM), launched on 15<sup>th</sup> August 2020, is aligned with the NHP 2017 and SDGs related to the health sector. It is based on the National Digital Health Blueprint (NDHB) prepared by the Ministry of Health and Family Welfare (MoHFW). It aims to develop the necessary infrastructure to facilitate healthcare through digitized platform. Its vision is. ‘To create a national digital health ecosystem that supports universal health coverage in an efficient, accessible, inclusive, affordable, timely and safe manner, that provides a wide-range of data, information and infrastructure services, duly leveraging open, interoperable, standards-based digital systems, and ensures the security, confidentiality and privacy of health-related personal information’<sup>51</sup>. The main objective is to digitized healthcare to all through a unique health ID (UHID), digitized health records, Health Facility Registry, an updated repository of all doctors available in the nation with their detail information, e-Pharmacy and telemedicine. Citizens will have the option to update all health records, consultation and treatment information which can be accessed from anywhere. It aims to provide support to the existing health systems in a ‘citizen-centric’ approach and to strengthen the existing health information system, all the while providing security of the private data of the citizens and ensure quality of healthcare provided while enhancing the effectiveness of governance at all levels. NDHM rests on the principles that it is wellness centric and wellness drive. It is inclusive in nature as it tries to incorporate the sections of population who are digitally illiterate, reside in remote, tribal and hilly areas and provide health facilities through telemedicine.

---

<sup>51</sup> National Digital Health Mission, National Health Authority, *Ministry of Health and Family Welfare*, Government of India, accessed from <https://ndhm.gov.in/home/ndhm> on 10<sup>th</sup> October 2020, 7:27pm.

The significance of digitized healthcare, especially in the face of the ongoing pandemic can hardly be exaggerated. While physical visits to the doctors' clinics or hospitals are being avoided, both the doctors and the patients are depending heavily upon telemedicine services to carry out the treatment processes.

### **3.7 Structure of Healthcare System in India**

Health comes under the State List of the Indian Constitution which makes the provision of healthcare the responsibility of the state government. The healthcare system in India is a three-tier pyramidal structure – the lowest rung is the primary healthcare units, middle rung is the secondary healthcare units and the top most rung comprises the tertiary care units. In the rural areas, the primary level comprises the sub-centres and primary healthcare centres, the middle rung comprise the community health centres and the top most rung comprises the district hospitals and medical colleges. In the urban areas, the scenario is slightly different with dispensaries and polyclinics in the primary level, multi-speciality hospitals in the secondary level and super-speciality hospitals in the tertiary level. In addition to these, there are private hospitals, nursing homes, private practitioners, non-profit organizations who provide healthcare such as NGOs and charitable units, Railway hospitals, Army hospitals and so on. In the urban areas there is high concentration of hospitals and medical colleges which offer specialized services, but a well-organized primary healthcare system is often absent in urban areas (Mukherjee, 1997)<sup>52</sup>. Therefore, for primary healthcare services, people either through the public hospitals or depend on private practitioners.

---

<sup>52</sup> S. Mukherjee (1997). Aspects of Distribution, Accessibility and Utilization of Health Care Facilities in Urban Delhi. Unpublished thesis. New Delhi: Jawaharlal Nehru University. p. 41

Public and private health care providers co-exist within the health care system in India. The inadequacy of public health care services is clearly reflected in the predominant utilization of private health care services. According to NSSO report 2014, about 72% and 79% spells of treatment took place in private sector in rural and urban areas respectively<sup>53</sup>. In the case of in-patient treatments too, private institutions dominated both the rural (58%) as well as urban areas (68%)<sup>54</sup>. It may be mentioned here that private sector includes private doctors, nursing homes, private hospitals, charitable institutions<sup>55</sup>. This growth of the private health care sector has been dominant in India since the onset of globalization-privatisation-liberalisation era in the 1990s. Dependence on private health care institutions also leads to a heavy out-of-pocket expenditure. According to NFHS-4, the private health sector is the primary source of health care for 56 percent and 49 percent of urban and rural households respectively. On the other hand, the public health sector is the main source of health care for 42 percent and 46 percent of households in urban areas and rural areas respectively. The following table shows the percent distribution of households by the source of health care that household members generally use in the time of sickness, according to residence and the wealth index, India, 2015-16.

---

<sup>53</sup> NSSO, Health in India, 2014, p. i.

<sup>54</sup> NSSO, Health in India, 2014, p. ii.

<sup>55</sup> NSSO, Health in India, 2014, p. 32

**Table 3.1: Percent distribution of households by the source of healthcare that household members generally use in the time of sickness, according to residence and the wealth index, India, 2015-16**

Source	Residence		Wealth Index					Total
	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	
<b>Public Health Sector</b>	42	46.4	45.7	51.1	50.6	45.7	31.5	44.9
Government/Municipal Hospital	28.5	16.1	12.7	18.3	23.5	26.4	21.2	20.4
Government Dispensary	2.3	1.4	1.1	1.6	1.8	2	2.1	1.7
UHC/UHP/UFWC	1.7	1	1	1.3	1.6	1.5	0.9	1.3
CHC/rural hospital/block PHC	5.4	14	16.9	15.1	11.5	7.6	3.9	11
PHC/additional PHC	3.1	12	11.7	12.6	10.6	7	2.6	8.9
Sub centre	0.3	1.5	1.9	1.7	1.1	0.7	0.2	1.1
Vaidya/Hakim/Homoeopath (AYUSH)	0.2	0.2	0.2	0.1	0.1	0.2	0.2	0.2
Other public health sector	0.3	0.2	0.2	0.2	0.3	0.3	0.4	0.3
NGO or trust hospital/clinic	0.4	0.2	0.1	0.2	0.2	0.4	0.5	0.3
<b>Private health sector</b>	56.1	49	48.1	43.7	46.1	52.3	66.8	51.4
Private hospital	25.3	15.1	8.4	11.4	16.5	22.9	34	18.7
Private doctor/clinic	28.6	29.5	34	28.3	25.9	26.7	31.1	29.2
Private paramedic	0.5	1.2	1.8	1.1	0.9	0.6	0.5	1
Vaidya/Hakim/Homoeopath (AYUSH)	0.2	0.3	0.4	0.2	0.2	0.2	0.3	0.3
Traditional healer	0.1	0.6	1.1	0.5	0.3	0.1	0.1	0.4
Pharmacy/drugstore	0.7	1	1.6	1	0.8	0.5	0.4	0.9
Other private health sector	0.7	1.2	0.8	1.1	1.5	1.1	0.5	1
<b>Other source</b>	1.5	4.5	6.1	5	3.1	1.7	1.2	3.4
Shop	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.1
Home treatment	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.1
Other	1.2	4.2	5.7	4.7	2.9	1.5	0.9	3.1
<b>Total</b>	100	100	100	100	100	100	100	100
Data source: NFHS 2015-16								

Though public health facilities are most commonly used in rural areas, percentage of people who use government dispensaries in rural areas is as less as 1.4 percent. Only 1.5 percent seek treatment in SC while less than 15 percent of them go to PHC or CHC for treatment. In case of urban areas, people visiting SC, PHC and CHC are 0.3, 3.1 and 5.4



respectively, 2.3 percent seek treatment in the government dispensaries while more than 28 percent visit the government hospitals. 49 percent of rural population use private health care facilities. While it is lower than 56 percent of urban population using it, the figure still remains higher than 46 percent of rural population using public health care facilities. More than 48 percent of people from lowest quintile seek treatment at private facilities while 34 percent of them seek treatment from private doctors and clinics. It is a well-known fact that the money required to seek treatment at private health care facilities is often high. Despite having to incur high costs of treatment, why the poor people prefer private treatment is the question. The answer is to be found in the shortcomings of the public health care facilities. According to NFHS-4, about 55 percent of households in India do not avail public health care facilities though these facilities offer no cost treatment. The most commonly reported reason for not using government health facilities at the national level is the poor quality of care (reported by 48% of households that do not generally use government facilities). The second most commonly reported reason is that no government facility is available nearby (45%), followed by the long waiting time at government facilities (41%)<sup>56</sup>. The opportunity costs which the people have to bear in order to avail public health care facilities are higher – in terms of distance to be covered to avail the facility, the long waiting time for which people often have to forgo a day's work and wages. The following figure shows the reasons why people do not prefer public health care facilities.

---

<sup>56</sup> Government of India, National Family and Health Survey 4 – India Report, 2016, Ministry of Health and Family Welfare, p. 347.

<b>Table 3.2: Reason for not using public health care facilities, India 2015-16</b>	
<b>Reason for not using public health care facilities</b>	<b>Percentage of people not using public health care facilities</b>
Poor quality of care available	48.1
No nearby facilities available	44.6
Waiting time is too long	40.9
Facility timing is not convenient	26.4
Health personnel is often absent	14.8
Data source: NFHS-4.	

The public health care system in India functions through a network of sub-centres, primary health centres, community health centres and district hospitals, each of which function beyond their capacities. On an average, a sub centre in India serves 8372 population (in place of 5000 in plain area), a primary health centre serves 49193 population (in place of 30000), a community health centre serves 128356 population (in place of 120000) and a district hospital serves 1444633 population. The condition in Delhi is worse, where each sub centre serves about 16881 population and each primary health centre serves about 75992 population<sup>57</sup>. The burden of patients on the tertiary care hospitals in Delhi such as AIIMS and Safdarjung is also high. The healthcare structure in Delhi has been discussed in the following section.

---

<sup>57</sup> District Level Household and Facility Survey 2007-08, *Ministry of Health and Family Welfare*, Government of India, 2010, p. 214.

### 3.8 Structure of Healthcare System in Delhi

National Capital Territory of Delhi is primarily an urban agglomeration with 97.5% of its 167.53 lakh population residing in urban areas<sup>58</sup>. A large number of daily commuters and people coming to Delhi for treatment are added to this already existing high population. The delivery of health care services in Delhi may be categorized into three broad groups: (i) Public (ii) Private (iii) Charitable or Voluntary Organizations and others. The agencies which provide health care services in the public sector are:

- (a) Central Government Health Scheme
- (b) Delhi Administration
- (c) Municipal Corporation of Delhi (MCD)
- (d) New Delhi Municipal Corporation (NDMC)
- (e) Delhi Cantonment
- (f) Railways
- (g) Statutory Bodies
- (h) Voluntary/Charitable<sup>59</sup>

In addition to these public health care facilities, there is a vast network of private hospitals, nursing homes, dispensaries and private practitioners who provide health care in Delhi. Besides the aforementioned agencies, few other agencies which provide health care services in Delhi are:

- (a) D.E.S.U. (Delhi Electric Supply Unit) Dispensaries
- (b) D.T.C. (Delhi Transport Corporation) Dispensaries
- (c) Delhi Water Supply Sewage Disposal Undertaking Dispensaries
- (d) Reserve Bank of India Dispensaries
- (e) State Bank of India Dispensaries<sup>60</sup>

---

<sup>58</sup> Compiled from Census of India, 2011.

<sup>59</sup> Mukherjee, op.cit. p. 71.

Department of Health & Family Welfare, Govt. of NCT<sup>61</sup> of Delhi is entrusted with the task of looking after the delivery of health care and health related matter in Delhi. Various directorates, hospitals, departments and autonomous bodies function under the Department of Health and Family Welfare, Government of NCT of Delhi and together work towards delivery of health care services in Delhi. Due to the existence of a variety of health care providers in Delhi, there happens to be duplication in the services provided.

### **3.9 Healthcare Infrastructure in Delhi**

The first criterion required for accessibility and utilization of healthcare services is the availability of the facility. In order to understand the aspects of accessibility and utilization of healthcare services in Delhi, it is important to understand the condition of the services available at all three levels – primary, secondary and tertiary. There are various facilities provided by a number of agencies at each level which have been discussed under two broad categories: primary/secondary and tertiary. Since many of the functions in certain healthcare facilities transcend the boundaries of primary and secondary care and cannot be designated as purely primary or secondary, they have been made into a single group.

#### **3.9.1 *Primary and Secondary Healthcare Facilities***

Primary and Secondary healthcare services include Primary Health Centres (9), Maternity and Child Welfare Centres (34), Urban Family Welfare Centre (5) and School and Mobile clinics (4), Dispensaries (666), Polyclinics (16), Unani/Homoeopathy/Ayurvedic clinics (9), TB clinics (11). The distribution has been illustrated in the following table.

---

<sup>60</sup> Mukherjee. Op.cit. p. 72.

<sup>61</sup> National Capital Territory of Delhi.



The bulk of M & CW centres are run by MCD, followed by NDMC and others. The highest number of M & CW centres is located in North West and South districts, followed by West district; while South West has only 1 M & CW centre. PHCs are run by DHS and MCD. South district has 4 and North West has 3 PHCs. North, North East, East, Central and New Delhi do not have any PHCs. Urban Family Welfare Centres are run by NDMC, DHS and the Delhi government. There is one UFWC each in North East, East, South, West and New Delhi. The remaining districts do not have UFWC. School and mobile clinics are run by MCD and the Delhi government. There are 2 clinics in East and one each in North and North West districts. There are 666 dispensaries in Delhi which provide secondary healthcare facilities. The highest number of dispensaries under Directorate of Health Services is highest (225), followed by the state government (125), the Municipal Corporation of Delhi (103), central government (82) and 43 under New Delhi Municipal Corporation. The highest number of dispensaries is in the North West district (131) and the lowest is in New Delhi (8). Polyclinics also provide secondary level healthcare facilities. There are a total of 16 polyclinics in Delhi – 13 under MCD and 1 each under NDMC, Delhi Cantonment Board and central government. North West and Central districts have 4 polyclinics each while East district has 3. There are 11 tuberculosis (TB) clinics in Delhi, all under the MCD. South West district and New Delhi districts do not have any TB clinic. There are 9 Unani, Homoeopathy and Ayurvedic clinics. These show very sparse distribution across Delhi. North, North East, South West and West districts do not have any of these clinics.

On an average there are 21 primary and secondary healthcare facilities available in Delhi. However, the distribution across the districts is not uniform. The Central

district has 88 healthcare facilities per 100000 population which is the highest. The lowest is in North East (15), followed by South West (17), West (17) and South (17). Although the total number of healthcare facilities is almost equal in Central and South districts, yet the availability per 100000 population is lower in South district since the total population is higher than that in Central district. Although the total number of facilities available is highest in North West district (142), yet the availability per 100000 population is quite low.

Since the Mother and Child Welfare centres provide care specifically to women of the reproductive age (15-49 years) and children (0-14 years), the number of mother and child welfare centres have not been considered to calculate the availability of primary and secondary healthcare facilities per 1000000 population.

<b>Table 3.4: Distribution of Mother and Child Welfare Centres in Delhi, 2009</b>					
<b>Districts</b>	<b>M &amp; CW</b>	<b>Female (15-49 Years)</b>	<b>Children (0-14 Years)</b>	<b>Total Females and Children (2011)</b>	<b>M &amp; CW per 100000 Population</b>
<b>North West</b>	8	982334	1029563	2011897	4
<b>North</b>	3	244047	236449	480496	6
<b>North East</b>	4	606788	683931	1290719	3
<b>East</b>	3	472108	438414	910522	3
<b>New Delhi</b>	2	39897	31247	71144	28
<b>Central</b>	3	161373	141072	302445	10
<b>West</b>	5	685566	653056	1338622	4
<b>South West</b>	1	628775	597987	1226762	1
<b>South</b>	5	744506	753600	1498106	3
<b>Delhi</b>	34	4565394	4565319	9130713	4
Data compiled from: Health and Family Welfare, Govt. of NCT of Delhi					

Availability of mother and child welfare centres has been calculated according to the total number of children and women in the reproductive age. It is observed that the

highest availability of M & CW per 1000000 population is found in New Delhi district (28), since population is lower, availability is high despite low actual numbers. The lowest availability is in South west district (1), followed by North East (3), East (3) and South (3) districts. Highest number pf M & CW are found in North West district (8).

### 3.9.2 Tertiary Healthcare Facilities

Tertiary care hospitals are run by central government, state government, MCDs, Railways, statutory bodies and others.

Districts	Population (2011)	Agencies												Tertiary Healthcare Services per 100000 population
		Delhi Government	MCD	DHS	NDMC	Railway	DCB	Private	ESI	AYUSH	Central Government	Others	Total	
North	180044	1	2	0	0	0	0	3	0	0	0	1	7	2
North West	736253	8	4	0	0	0	0	8	1	0	0	0	21	2
North East	406125	5	2	0	0	0	0	0	0	0	0	2	9	1
East	358937	4	0	0	0	0	0	7	1	0	0	0	12	2
South	574133	2	2	1	2	0	0	20	0	1	1	5	34	2
South West	494439	4	0	0	0	0	3	2	0	0	1	0	10	0.4
West	533221	6	1	0	0	0	0	13	1	0	0	1	22	1
Central	119639	7	2	3	0	2	0	3	0	1	1	0	19	3
New Delhi	33208	0	0	0	0	0	0	2	0	0	0	0	2	9
<b>Total</b>	<b>3435999</b>	<b>37</b>	<b>13</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>58</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>9</b>	<b>136</b>	<b>2</b>

Data compiled from: Health and Family Welfare, Govt. of NCT of Delhi



In aggregate, there are 136 hospitals in Delhi under various organisations. It may be noted that 37 hospitals are under the control of the state government, followed by 13 under the Municipal Corporation of Delhi. The Central Government has only 3 hospitals in South, South West and Central districts. Two railway hospitals are located in the Central district. Private hospitals make up for the bulk of hospitals in Delhi – 58 spread across all districts. South district has the highest number of hospitals (34) and also account for the highest number of private hospitals (20). The Central district, on the other hand, has the lowest – 2 private hospitals only. North East district does not have any private hospital facility and New Delhi does not have any hospital under the state government. The data for number of hospitals available per 100000 population in each district reveals that on an average there are 2 tertiary healthcare facilities per 100000 population in Delhi. The condition is worst in case of South West district where there is less than 1 tertiary care facility per 100000 population. North East and West districts have only 1 facility per 100000 population, while North, North West, East and South districts have 2 facilities per 100000 population. South district has the highest total number of facilities (34) but has only 2 tertiary care facilities available per 100000 population. Similarly, North district has only 7 facilities in total, but since the population is lower compared to South district, the number of facilities available per 100000 population is the same as South district.

Although a broad spectrum of public health care facilities exist in Delhi, according to NFHS-4 data, these are not accessed and utilized by more than 42 percent of people, despite their no cost services. Several factors are responsible for non-utilization of public healthcare services in Delhi. The following table shows the reasons why people in Delhi do not prefer to use public health care services.

<b>Table 3.6: Reasons For Not Using Public Health Care Facilities in Delhi, 2015-16</b>	
<b>Reasons for not using public healthcare facilities</b>	<b>Percentage of population not using public healthcare facilities</b>
Waiting time is too long	67.1
No nearby facilities available	44.4
Poor quality of care available	34.1
Facility timing is not convenient	33.4
Health personnel is often absent	13.3
Source: NFHS 4.	

The two most prominent reasons why people in Delhi do not prefer to use public healthcare facilities are because the waiting time to see the doctor is too long (67.1%), followed by lack of healthcare facilities close to the residence (44.4%). Other reasons include poor quality of care available and inconvenient timings (about 34% each) and absenteeism of health personnel (13.3%). Therefore, a model of healthcare in the public sector needs to be provided which are bereft of these shortcomings – so that people can seek quality healthcare, within short distances, with low patient pressure and without having to pay any user fee.

### **3.10 Conclusion**

This chapter gives a broad overview of the development of healthcare policies in India – especially pertaining to primary healthcare services. The importance of primary healthcare has been mentioned since the Bhore Committee report of 1946 and has been reaffirmed in the subsequent health policies that have been outlined. The chapter also

illustrates the availability of healthcare facilities at different levels in Delhi. Since the facilities are not uniformly distributed in accordance with the population, the availability and accessibility is also adversely affected which in turn affects the utilization of healthcare services. Also, the public healthcare facilities which are available are not easily accessible and patient-friendly due reasons such as long waiting time, unavailability of healthcare facilities in short distance and poor quality of healthcare services. People therefore refrain from using public healthcare facilities and depend on private facilities for treatment for which they have to bear the costs themselves. It is therefore imperative that the existing healthcare facilities in Delhi have to be revamped – especially the primary healthcare system because of two reasons. In the first place, primary healthcare units are the first points of contact and can be effective in preventive care facilities and secondly, a public healthcare system with a strong primary core is essential to achieve UHC – providing affordable healthcare to all, irrespective of the background characteristics. Therefore, provisioning of healthcare facilities at the primary level deserves special attention as they have a higher reach among the population. In the subsequent chapters strengthening of the primary healthcare system according to such a model of healthcare provisioning shall be discussed in light of the recent healthcare policy of the AAP pertaining to the establishment of Mohalla Clinics in Delhi.

## **Chapter 4: Mohalla Clinics as Primary Health Centres in Delhi: Growth and Distribution**

### **4.1 Introduction**

As discussed in chapter 3, a strong primary health care system is essential for achieving health for all. This has been reaffirmed in various policies that have been outlined in India starting from the Bhore Committee Report of 1946. However, the distribution of healthcare facilities at the primary level in accordance with the population is not adequate to serve the high population in Delhi as discussed in the previous chapter. Therefore, it is imperative to improve the primary healthcare network in Delhi. This chapter traces the development of the primary healthcare units in the form of mohalla clinics, their spatial distribution, impediments faced by them during their initial phase of establishment, how they have dealt these problems and the role they have been playing during the pandemic. Data have been collected from Government documents, newspapers, news reports, inaugural ceremony speech in Pitampura (5<sup>th</sup> January 2020), websites of DGHS, Delhi State Health Mission, interviews of patients and doctors and other stakeholders such as MLAs and Government Officials.

India draws heavily on the western model of health care system which has resulted in more emphasis on curative services than preventive and promotive ones. In reality, the primary healthcare units can efficiently work towards preventive services and treat minor diseases so that the need to use secondary or tertiary care services might be

avoided. India, however, is far from achieving this. The demand for health care services outnumbers their supply especially in the public sector with shortfall of doctors, nurses, hospital beds and so on. The tertiary care hospitals in Delhi are thronged by people from faraway places for specialized treatment. At the same time the doctors also have to deal with basic and minor diseases which hinder specialized treatment and can be treated in other smaller health care units. Therefore, strengthening of primary health care system is also necessary for the reason that it will help to reduce patient burden on tertiary care hospitals. A wide network of primary healthcare facilities will also be effective in mitigating the ongoing pandemic. Sah et al. (2019) argues that ‘...since primary health care is out of the purview of health insurance schemes in developing countries, its provision should be made through supply-side financing, irrespective of the income strata that people belong to’<sup>1</sup> and mohalla clinic is one such initiative.

## **4.2 Growth of Mohalla Clinics**

Prior to the Delhi State Assembly elections in 2015, the Aam Aadmi Party (AAP) declared in their election manifesto a 70-point plan to revamp Delhi through a ‘government that is transparent, participative and interactive’<sup>2</sup>. Among 70 points that were proposed, three were dedicated to improvement of the health care system. These included budgetary expansion in health care sector, expansion of health care infrastructure and provisioning of quality drugs at affordable prices. AAP proposed to establish 900 (later modified to 1000) primary health centres and provide 30000 beds in hospitals of Delhi out

---

<sup>1</sup> T. Sah, R. Kaushik, N. Bailwal & N. Tep. (2019). Op. cit. p. 207.

<sup>2</sup> Aam Aadmi Party 70 Point Action Plan: Delhi Assembly Election 2015. *Aam Aadmi Party*. Accessed from [https://aamaadmiparty.org/wp-content/uploads/2017/10/AAP-Manifesto-2015\\_70-Pt-Action-Plan.compressed.pdf](https://aamaadmiparty.org/wp-content/uploads/2017/10/AAP-Manifesto-2015_70-Pt-Action-Plan.compressed.pdf) on 1<sup>st</sup> March 2020, 11:05pm.

of which 4000 would be dedicated to maternity care (AAP Election Manifesto 2015). On 10<sup>th</sup> February AAP won the State Election 2015 with an overwhelming majority of 67 seats out of 70. Soon after AAP assumed power in office, the project for establishing primary health care centres was undertaken. The establishment of 1000 primary health centres implied that every assembly constituency in Delhi would have more than 14 clinics and each district would have 91 clinics. On 19<sup>th</sup> July 2015, the first primary health centre of its kind was launched as a pilot project at the Punjabi relief camp in West Delhi's Peeragarhi.



*Figure 4.1: The First Mohalla Clinic Established in Punjabi Relief Camp in West Delhi's Peeragarhi on 19<sup>th</sup> July 2015. Photograph by Author During Field Visit, February 2020.*

These clinics were one of the flagship projects of the party and were named Aam Aadmi Mohalla Clinics (AAMCs). In Hindi, Mohalla refers to locality. Therefore,

these are clinics within the locality which are established to enhance the accessibility to primary health care services. 'Health care cannot be planned at the central or state level but has to be decentralized at an appropriate community level'<sup>3</sup> and mohalla clinics are a mechanism for decentralization of primary health care services in Delhi. The Government of Delhi recognized several areas which have poor access to primary health care facilities such as 'JJ (Jhuggi Jhopri) Clusters, slums, unauthorized colonies, densely populated areas and rural areas'<sup>4</sup>. These clinics are meant to serve these under-served areas and 'are centred around the aam aadmi of the country'<sup>5</sup>. In order to improve the availability of health services, there has been 'a paradigm shift' in restructuring of health care services through which a 'four tier health care delivery system' has been created:

- i. 'Aam Aadmi Mohalla Clinic - for primary health care.
- ii. Multi-Speciality Poly Clinic - for secondary health care in the form of OPD consultation by specialist doctors including diagnostics.
- iii. Multi-Speciality Hospital - for IPD care (earlier called Secondary Level Hospital)
- iv. Super-Speciality Hospital - (earlier called Tertiary Level Hospital)<sup>6</sup>.

The main objective of this model is to deal with the rising health care needs of the population efficiently. As Mohalla Clinics are being established as primary health care units, the effect will be two-fold: easy access to primary health care units will help more people to

---

<sup>3</sup> Duggal. op. cit. p. 356-7.

<sup>4</sup> Brief Write up on Aam Aadmi Mohalla Clinic, op. cit.

<sup>5</sup> Chawla. Op.cit.

<sup>6</sup> Brief Write up on Aam Aadmi Mohalla Clinic, op. cit.

seek treatment which will eventually help in achieving health for all; basic illnesses can be treated at primary level which will help to reduce the pressure on secondary and tertiary care units. Each clinic would serve 10000 to 15000 population and the government has claimed that there will be one clinic every 1 square kilometre<sup>7</sup>. It is with the hope that people do not have to walk more than 10 to 15 minutes from their residence to reach a clinic<sup>8</sup>. The Government has outlined the following objectives with which these clinics are being established:

- i. 'Basic curative care for common illnesses such as fever, diarrhoea, skin problems, respiratory problems, first aid for burns and injuries, dressing and management of minor wounds and referral services.
- ii. Diagnostic tests to be carried out by the empanelled laboratory for the clinic.
- iii. Provision of all essential drugs free of cost.
- iv. Preventive care services including antenatal and postnatal care of pregnant women, assessment of nutritional status and counselling and preventive and promotive component of National/State Health Programmes.
- v. Disseminating of health information, education and creating awareness.'<sup>9</sup>

The primary duty of these clinics therefore is to provide curative services for common illnesses because people suffering from these diseases through government hospitals which eventually leads to crowding and lowers the efficiency of treatment there. Since these clinics are located within the locality, the advantages are manifold. The patients do not have to travel long distances to government dispensaries or hospitals, they can save both time and

---

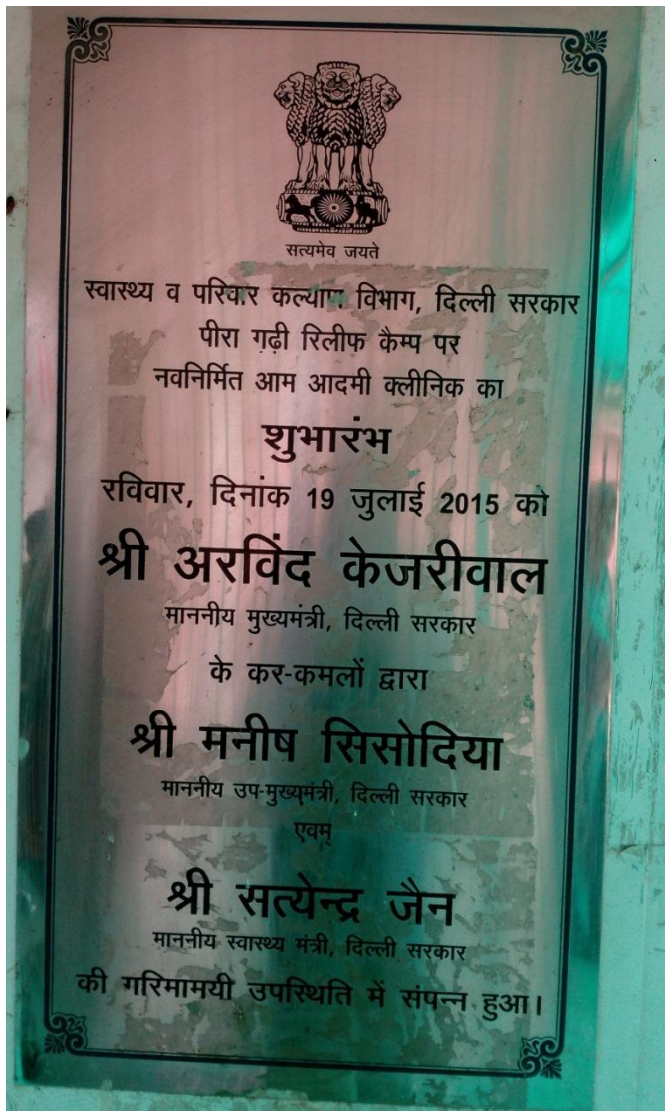
<sup>7</sup> Unknown Author. (20<sup>th</sup> October 2019). Arvind Kejriwal spells out healthcare target: One mohalla clinic per square km. *The New Indian Express*. Accessed from <https://indianexpress.com/article/cities/delhi/arvind-kejriwal-spells-out-healthcare-target-one-mohalla-clinic-per-square-km-6078179/> on 31<sup>st</sup> October 2019, 8:31pm.

<sup>8</sup> Director General of Health Services, Notice for hiring of premises for Aam Aadmi Mohalla Clinic, p. 2.

<sup>9</sup> Brief Write up on Aam Aadmi Mohalla Clinic. Op. cit.



money which they would have otherwise spent on travel, they do not have to wait in long queues and undertake lengthy and complicated paperwork, nor have they to miss their work and forego wages. These clinics provide 212 different types of diagnostic tests which are performed free of cost at the empanelled laboratories. There are about 78 types of essential medicines and injections and essential dressing material available in these clinics. These clinics would also serve as referral units to other government health care facilities creating a network of health services availability.



*Figure 4.2: Foundation Stone at the first Mohalla clinic, Punjabi relief camp, Peeragarhi, West Delhi. Photograph by author during field visit, February 2020.*

मोहल्ला क्लीनिक  
वसंत कुंज



*Figure 4.3: A Mohalla clinic in portable cabin newly inaugurated in Vasant Kunj, 11<sup>th</sup> September 2019.*

*Figure 4.4: A building rented in Mehrauli Assembly Constituency for setting up a Mohalla clinic, 6<sup>th</sup> November, 2019.*



These clinics function mainly in porta-cabins or portable cabins which are defined as ‘Pre-Engineered Insulated Box Type Re-located Structures which are to be manufactured and installed through PWD’<sup>10</sup>. It is claimed by the government that each clinic can be built at a cost of 20 lakh rupees which is 1/25<sup>th</sup> of the cost required for establishment of a government dispensary (The Indian Express, 20<sup>th</sup> July 2015). However, due to lack of availability of land for establishment of these clinics in porta-cabins, the government has also started some of these clinics in rented premises. Initially these clinics were supposed to function for six days a week starting from 8 am in the morning to 2 pm in the afternoon. However, due to high patient pressure (where daily footfall was above 150)<sup>11</sup> in some locations, 33 clinics have been made to operate in double shifts from 7 am to 7 pm with two different sets of doctors and staff while the rest continue to operate in single shifts from 8 am to 2 pm. Double shift clinics are helpful for the patients who can attend work in the morning and visit the doctor in the evening without having to bear high opportunity cost of missing their work or foregoing wages. The school or college students have also benefitted from these clinics.

---

<sup>10</sup> Brief Write up on Aam Aadmi Mohalla Clinic. Op. cit.

<sup>11</sup> Ghosh, S. (10<sup>th</sup> August 2019). 36 Mohalla clinics to start working on 12-hour shifts. *The New Indian Express*. New Delhi. Accessed from: <https://www.newindianexpress.com/cities/delhi/2019/aug/10/36-mohalla-clinics-to-start-working-on-12-hour-shifts-2016924.html> on 18th August 2019, 8:36pm.



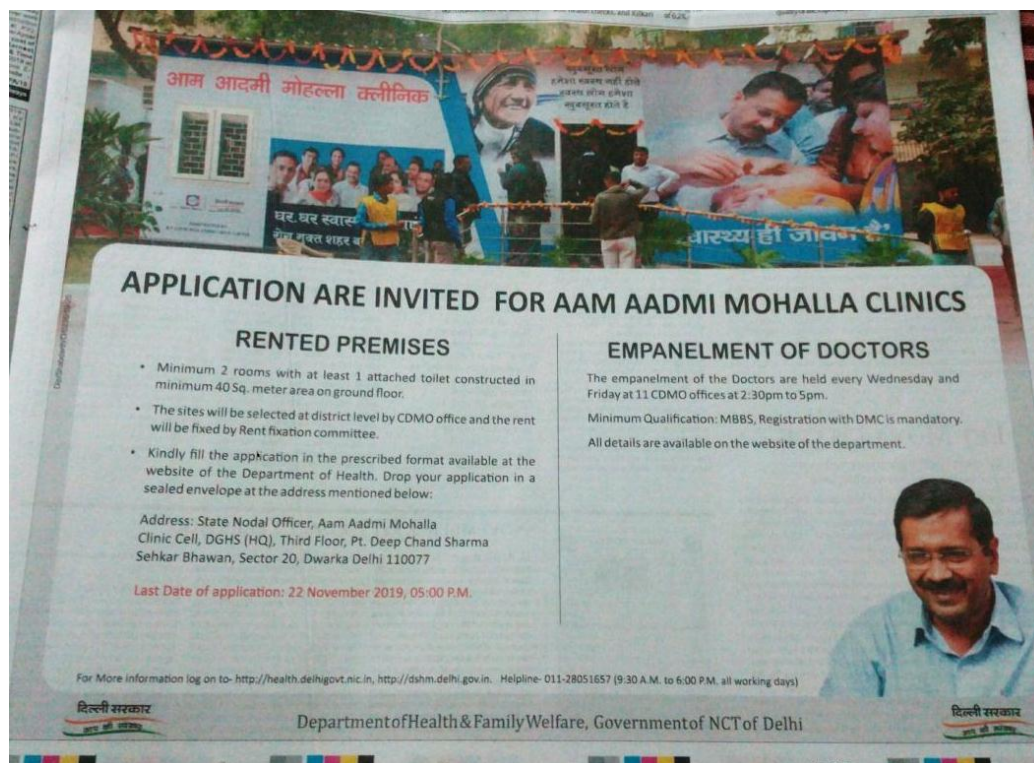
*Figure 4.5: The absence of written timings outside a clinic in North West Delhi. Photography by author during field visit, February 2020.*

Doctors are empanelled by the Directorate General of Health Services (DGHS) every Wednesday at Delhi Government Dispensary Building for East District and Chief District Medical Officer (CDMO) Office for the remaining ten districts. Doctor working at mohalla clinic would receive as remuneration ‘Rs. 40 per patient registered with minimum assured guarantee of 75 patients per day to be calculated on monthly basis’<sup>12</sup>. It was also mentioned that training on public health and various health programmes shall be mandatory for all empanelled doctors at AAMCs for smooth functioning and provisioning of health care services.

---

<sup>12</sup> Directorate General of Health Services, Notice for empanelment of Doctors for Aam Aadmi Mohalla Clinic, Government of NCT of Delhi, p. 1.





**Figure 4.6: Advertisement inviting applications for AAMCs – rented premises and empanelment of doctors, The Indian Express, 9<sup>th</sup> November 2019.**

The 212 types of laboratory tests which can be carried out at each mohalla clinic free of cost, have been outsourced to private diagnostic centres which carry out the tests on the samples collected at mohalla clinics and give the reports. A person is designated to collect samples from each clinic at a specific time and submit at the diagnostic centre. Each clinic usually has a time earmarked for collection of blood and urine samples, in the absence of which people keep coming to the clinic the whole day for tests and it becomes difficult to carry out OPD treatments. Though a patient does not require any document for OPD consultation, however, for carrying out any diagnostic test producing AADHAR card is mandatory. In the absence of AADHAR card, often many patients are unable to get their tests done in the mohalla clinics. It is alleged by a doctor of mohalla clinic in West Delhi

that patients sometimes become aggressive for getting tests done. They insist and often force the doctor to prescribe tests. According to this doctor, a patient is prescribed tests only when the doctor feels the needs for the same, otherwise there is no point wasting the government resources. The clinics have mentioned the stipulated time for sample collection. Despite this, the patients continue to come to the clinics at any point of the day and demand for tests to be conducted. The reports are usually ready within the third day of the test. Patients often do not collect the test reports and the clinic staff contact them through phone calls and request them to come and collect their report.

In October 2018, the Directorate General of Health Services issued a notice calling for applicants for the 200 posts of pharmacists, mohalla clinic assistant (ANM) and multitask worker each<sup>13</sup>. The pharmacist would be entitled to Rs. 12 as remuneration per patient, with minimum guarantee of 75 patients. The clinic assistant would be entitled to Rs. 10 as remuneration per patient, with minimum guarantee of 75 patients and an additional remuneration of Rs 30/- per ANC checkup, Rs. 10 for each blood sample drawn by him/her and Rs. 10/- for each inject/immunization done by him/her at AAMC. The multitask worker would be entitled to remuneration of Rs. 8 per registered patient and Rs. 10 for each wound dressing if done by him/her with a minimum assured guarantee of 75 patients per day to be

---

<sup>13</sup> Directorate General of Health Services, Information regarding empanelment of staff for Aam Aadmi Mohalla Clinics, Government of NCT of Delhi, p. 1.

calculated on monthly basis<sup>14</sup>. The examination for these posts was conducted after a lapse of close to a year – on 25<sup>th</sup> August 2019<sup>15</sup>.



Figure 4.7: Advertisement for inauguration of Mohalla Clinic in Lado Sarai, 31<sup>st</sup> July October 2019

Figure 4.8: Advertisement for inauguration of Mohalla Clinic in Masoodpur, Vasant Kunj, 15<sup>th</sup> October 2019



<sup>14</sup> Directorate General of Health Services, Information regarding empanelment of staff for Aam Aadmi Mohalla Clinics, Government of NCT of Delhi, p. 1.

<sup>15</sup> Directorate General of Health Services, Notice No. F.45/AAMC Proj/152/DHS/AAMC Proj/2019/15347-8, dated 20<sup>th</sup> August 2019, Government of NCT of Delhi.

The mohalla clinics function as two way referral services: the cases which are beyond the treatment of mohalla clinics are referred to government dispensaries or government hospitals, the tests such as X-ray and ultra sound which are unavailable at mohalla clinics are referred government dispensaries and hospitals. On the other hand, the patients who are seeking treatment at government hospitals often have to wait for long for diagnostic tests. Sometimes the doctors refer them to mohalla clinics where they can get their tests done quickly and get their reports soon. The introduction of the mohalla clinics has strengthened the referral network within the government health care units in Delhi.

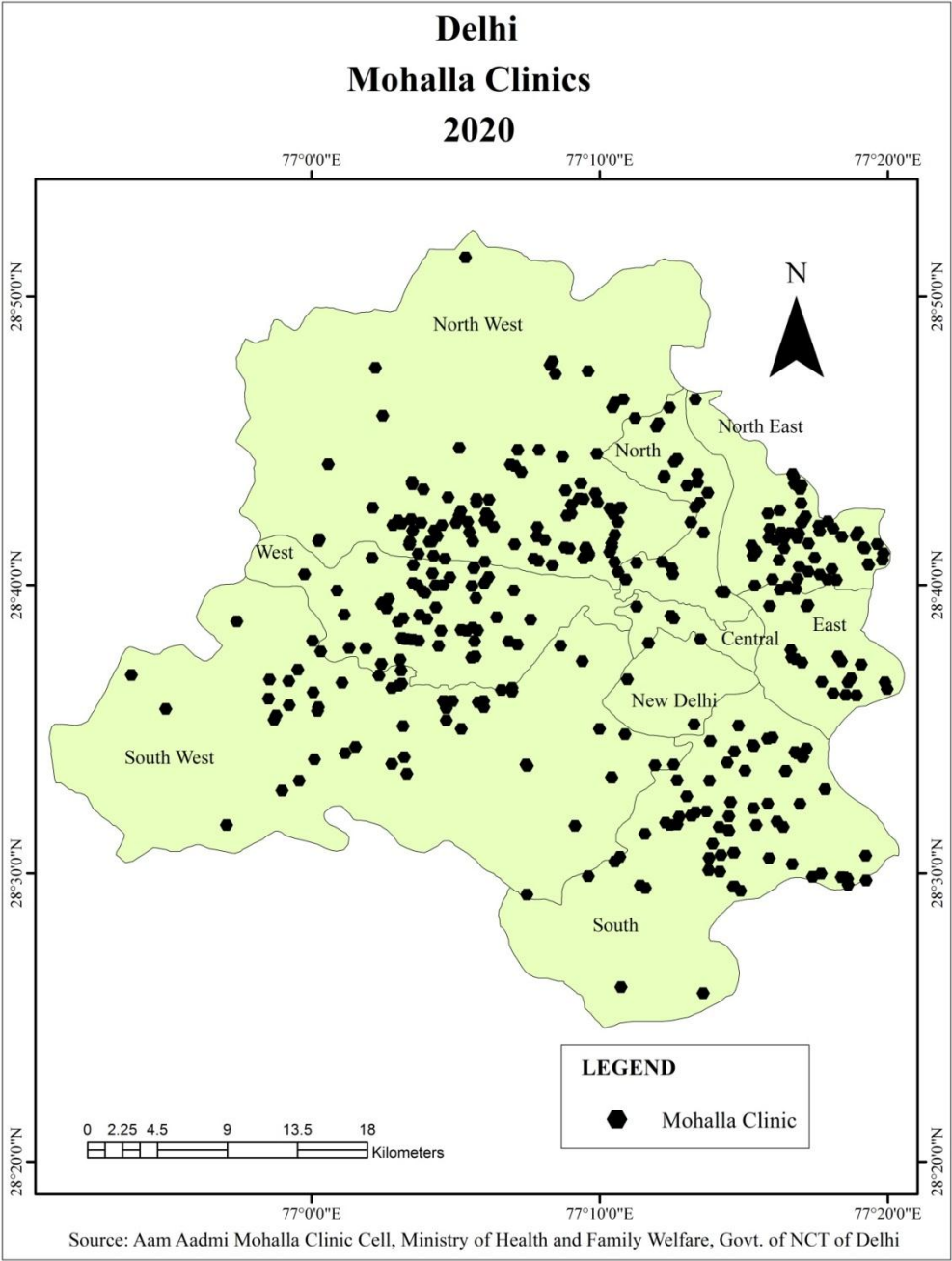
Mohalla clinics have been an important project by the AAP government since 2015 and its importance has been reinforced time and again which is prominent in the AAP election manifestoes. The establishment of these clinics in strategic times has successfully maneuvered the sentiments of the people.

### **4.3 Spatial Distribution**

In 2015, AAP had announced the establishment of 1000 primary health care centres in the form of mohalla clinics which meant about 14 to 15 clinics in every assembly constituency. However in the initial years after coming to power in state legislature of Delhi, only few clinics could be established due to the deadlock between the government and the lieutenant governor. Later the proposal was accepted but the project faced another hurdle in the form of lack of availability of suitable land for setting up these clinics. Till 15<sup>th</sup> April 2019, there were only 189 functional mohalla clinics. At the end of 2019, it was announced that for every one kilometre there will be a clinic. At the time of this announcement there



were about 301 clinics only. On 5<sup>th</sup> January 2020, an additional 150 clinics were inaugurated, which added up to 451. Till December 2020, there are 485 clinics in total. The spatial distribution of these clinics is not uniform across Delhi. While some constituencies and districts had a higher density of clinics, some had very few.



*Figure 4.9: Spatial distribution of Mohalla Clinics*

#### 4.4 Impediments in the Initial Phase of the Project

The ambitious project of mohalla clinics had to face several impediments since the initial phase of the project. The project was delayed as the Lt. Governor's office and the AAP government were not in agreement over the clearance of the Mohalla Clinics project. AAP government received approval from Lt. Governor's office in September 2017, only after which full-fledged work over this project could begin. Therefore the December 2016 deadline (as promised by the Government) of establishing 1000 clinics could not be fulfilled. The Delhi Cabinet got autonomous decision-making power after the verdict by the Supreme Court on 4<sup>th</sup> July 2018. Until then, the Delhi Cabinet had to take the approval from the Lt. Governor for all its decisions (The Indian Express, 29<sup>th</sup> October 2019). As a result of which all programmes received a setback. The day the first clinic was established in Peeragarhi, the BJP also accused the Delhi government of political nepotism when they named their clinics as 'Aam Aadmi Mohalla Clinics' and claimed that they had violated political and electoral code<sup>16</sup>. As the model code of conduct came into force prior to the Lok Sabha elections to be held in May 2019, the Chief Electoral Officer (CEO) instructed that photos of CM Arvind Kejriwal and rest of the political executives had to be removed or covered up on Delhi government websites as well as infrastructure like the mohalla clinics.

---

<sup>16</sup> Unknown Author. (19<sup>th</sup> July 2015). Naming Clinics as 'Aam Aadmi' Political Nepotism: BJP. NDTV. Accessed from <https://www.ndtv.com/delhi-news/naming-clinics-as-aam-aadmi-political-nepotism-bjp-783076> on 26<sup>th</sup> July, 2015, 7:39pm.

It must also be mentioned here that the words ‘Aam Aadmi’ had been covered up prior to the municipal elections in 2017 so as not to benefit the AAP<sup>17</sup>.

Once these hurdles were overcome, a new problem of that of land availability and acquisition cropped up. AAP government had selected spaces for establishment of these clinics, but faced problems in acquiring land for mohalla clinics as several agencies which own land in Delhi were not ready to give it for this project. As the government was facing difficulty in acquiring land, it went on to establish clinics in rented premises. The government had selected 450 suitable sites for establishing mohalla clinics. However, the DDA and MCDs refused to give permission for the same. The Delhi government alleged that DDA refused to hand over sites for setting up mohalla clinics, saying it is not permissible under the master plan for NCT and that the government would have to wait till 2021 for the next plan<sup>18</sup>. Therefore the AAP government decided to set up clinics at rented premises for which it rolled out advertisements to acquire space from any private owners. The first advertisement which was rolled out for hiring premises (on lease) for mohalla clinics mentioned the following criterion for any premise to be suitable for hire:

State Health Society (D) invites expression of interest from interested parties for hiring of premises on ground floor for opening of Aam Aadmi Mohalla Clinics. The location should be easily approachable. The Aam Aadmi Mohalla Clinic will be set up in minimum 50-60 sq. meter built up area, in a plot of

---

<sup>17</sup> Unknown Author. (12<sup>th</sup> March 2019). Mohalla clinics to remove CM’s photos. The Hindu. New Delhi. Accessed from <https://www.thehindu.com/news/cities/Delhi/mohalla-clinics-to-remove-cms-photos/article26505419.ece> on 16<sup>th</sup> March, 2019, 9:59pm.

<sup>18</sup> Unknown Author. (2<sup>nd</sup> February 2019). DDA creating hurdles for mohalla clinics: Delhi government to HC. The Times of India. Accessed from <https://timesofindia.indiatimes.com/city/delhi/dda-creating-hurdles-for-mohalla-clinics-delhi-govt-to-hc/articleshowprint/67800511.cms> on 26<sup>th</sup> February 2019, 10:09pm

about 100-150 sq.meter. There should be minimum two (2) rooms with two (2) toilets. Rent will be decided as per norms and no case rent will be more than 20000/- per month<sup>19</sup>.

Besides these, the property should have continuous water supply for drinking and utility services and electricity with a separate meter connection. The premise should also be easily accessible for wheel-chairs and stretchers. Since the property will be on lease, the owner will continue to bear property taxes, municipal taxes, maintenance costs including civil, electrical, mechanical, plumbing. The owner also has to undertake annual repairs and maintenance work such as painting, white wash and electricity and so on<sup>20</sup>.

Till October 2019, 300 clinics had been operational as against 1000 proposed. Therefore on 18<sup>th</sup> October 2019, the Directorate General of Health Services issued another notice for hiring of premises for mohalla clinics. This time, some of the criteria for hiring had been relaxed as stated below:

State Health Society (D) invites expression of interest from interested parties for hiring of premises on ground floor for opening of Aam Aadmi Mohalla Clinics. The location should be easily approachable. The Aam Adami Mohalla Clinic will be set up in minimum 40 sq. meter built up area atleast one Toilet. Rent will be decided as per norms and no case rent will be more than 30000/- per month<sup>21</sup>.

---

<sup>19</sup> Directorate General of Health Services, Notice for hiring of premises for Aam Aadmi Mohalla Clinic, July 2019, p. 1.

<sup>20</sup> Directorate General of Health Services, Notice for hiring of premises for Aam Aadmi Mohalla Clinic, July 2019, p. 2.

<sup>21</sup> Directorate General of Health Services, Notice for hiring of premises for Aam Aadmi Mohalla Clinic, 18<sup>th</sup> October 2019, p. 1.

In order to expedite the process of establishment of the clinics, more suitable land was required within short period of time. Therefore the Government was ready to negotiate both in terms of minimum requirements as well as the rent. The change in criteria was approved by ‘Cabinet vide decision 2748 dated 18-09-2019’<sup>22</sup>. While the built up area required for a clinic was 50-60 square metres in the previous notice, it was reduced to 40 square metres in the following notice. There was no mention of the dimensions of the plot on which the room for rent was available, as against 100-150 square metres stated in the previous notice. Also, earlier the necessary provision was that of two toilets, which was now reduced to one. On the other hand, the maximum rent payable for hiring premises was increased to Rs. 30000/- from Rs. 20000/- monthly. By relaxing the space requirement, the Government opened up opportunities for more people to apply for renting premises. Also, the proposed increase in maximum rent would be attractive for the people which will also help the Government to acquire more spaces on rent soon. It was also mentioned that the applications which were received after the previous notice and were rejected due to inability to meet the previously prescribed requirements, will be reassessed according to the new criteria with the fresh applications which will be received now. The last date for sending applications against this notice was extended till 22<sup>th</sup> November 2019<sup>23</sup> (which was 11<sup>th</sup> November 2019 earlier).

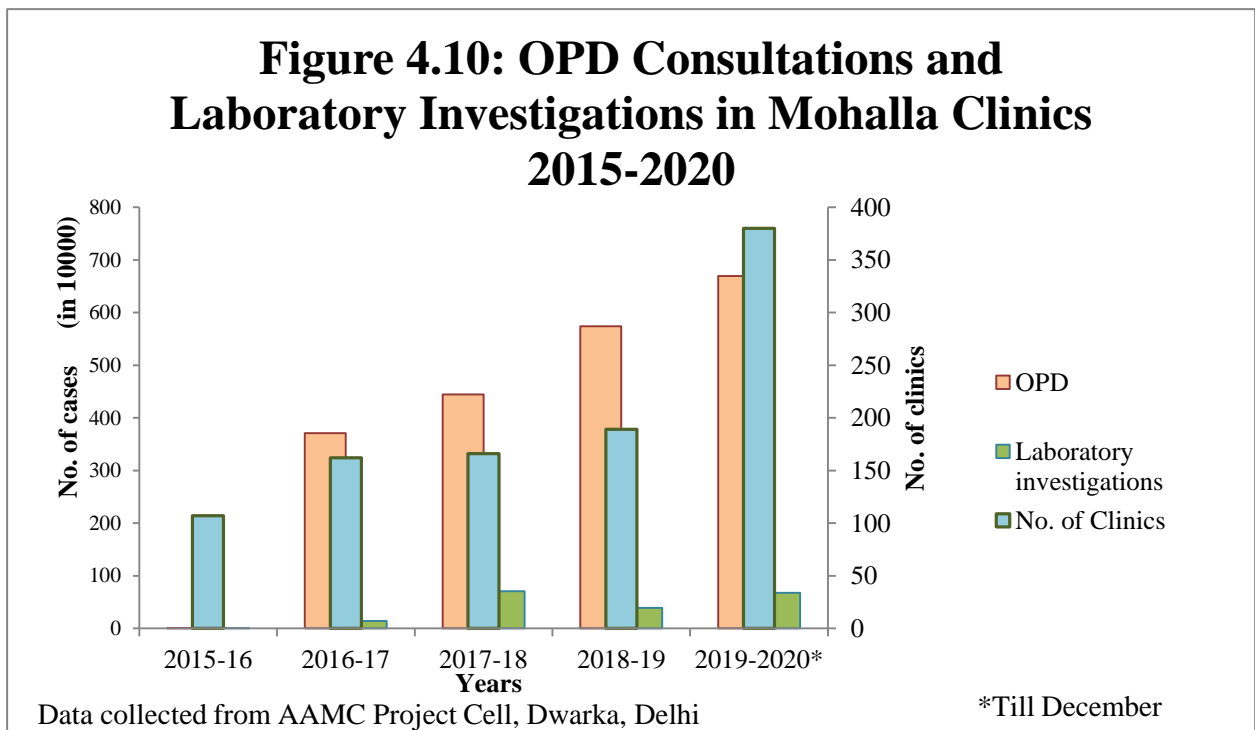
---

<sup>22</sup> Directorate General of Health Services, Notice for hiring of premises for Aam Aadmi Mohalla Clinic, 18<sup>th</sup> October 2019, p. 2.

<sup>23</sup> Directorate General of Health Services, Amended Notice for hiring of premises for Aam Aadmi Mohalla Clinic, November 2019, p. 1.

#### 4.5 Performance during 2015 - 2020

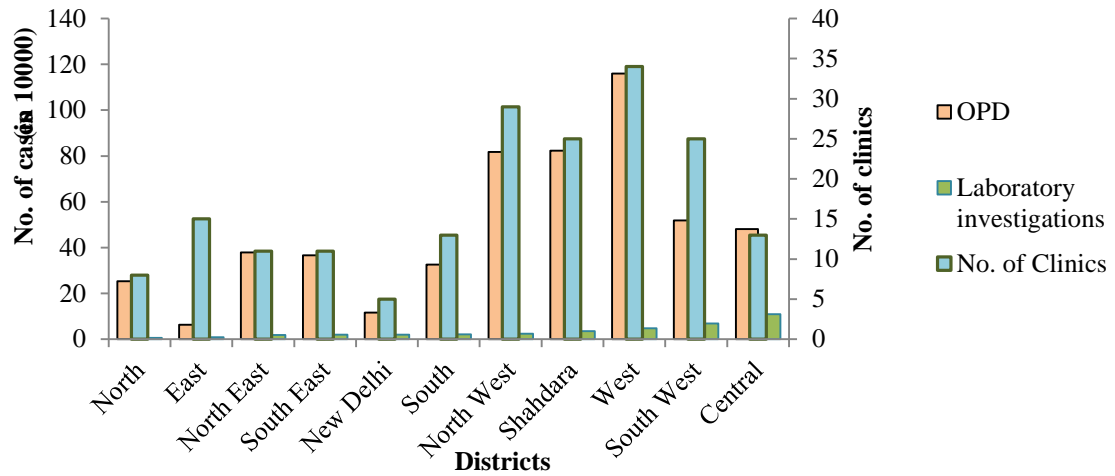
In the following section the performance of mohalla clinics over the years has been discussed based on data collected from secondary sources – mainly government reports, Health Department website and government documents. These clinics serve as primary care centres and have two main functions: doctor consultation and diagnostic tests. The following figure shows the total number of cases treated in these clinics and the total number of diagnostic tests performed from its inception in 2015 to 2020 (data is included till December 2019). In the first year of establishment, from July 2015 to March 2016, there were a total 107 clinics out of which the first 100 were included in the pilot project. The number of patients treated during this period was 6616 while the total number of diagnostic tests that had been performed was 3588. In the period 2016-17, the number of clinics increased to 162. The total number of patients treated during this period was 3709139 while 141108 diagnostic tests were performed. During 2017-18, the clinics increased to 167 which treated 4443351 patients and



performed 707872 tests. During 2018-19, the number of clinics increased to 189 which treated 5739547 patients and performed 390664 diagnostic tests. During the period starting from April 2019 to December 2019, the number of clinics had increased to 380. The total number of patients treated was 6692908 and the total number of tests performed was 676000.

In the following section, the performance of these clinics during 2018-19 has been shown as this is the latest data available. The following table shows the district wise number of patients who have sought treatment in mohalla clinics during the year 2018-19 and the total number of diagnostic tests (blood and urine samples) that have been performed in these clinics. It is observed that in total 5307310 people have been treated in these clinics and 379461 diagnostic tests have been performed during the year 2018-19. Lowest number of patients who have sought treatment is in East district (63731) where there were 15 clinics. It is followed by New Delhi district (116867) although the number of clinics is lowest here (5). Highest number of people have sought treatment in these clinics in West district (1160495) where there is highest number of clinics (34). North West and Shahadra districts also have high number of patients seeking treatment (817595 and 823870 respectively) wherein the number of clinics was 29 and 25 respectively. Laboratory investigations, on the other hand, is lowest in North district (5402), followed by East (9135). Highest is observed in Central district (109943). In total, 379461 diagnostic tests have been performed during 2018-19. These have been illustrated in the following figure.

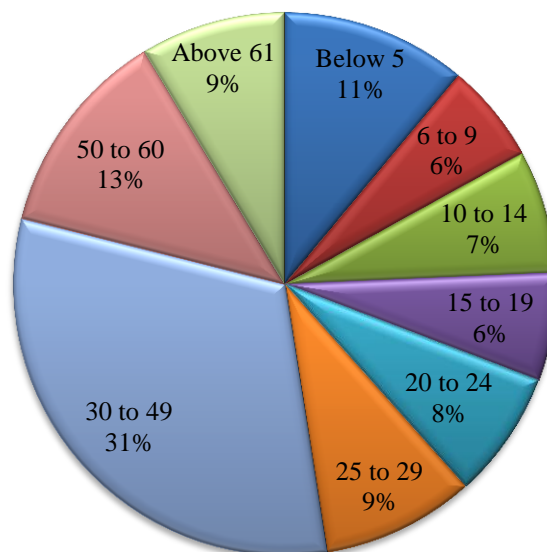
**Figure 4.11: No. of OPD consultations and laboratory investigations in Mohalla Clinics 2018-19**



Data Source: Annual Report 2018-19, DGHS

The following figure shows the age wise distribution of patients seeking treatment in mohalla clinics.

**Figure 4.12: Age-wise distribution of patients seeking treatment in Mohalla Clinics 2018-19**



Data collected from AAMC Project Cell, Dwarka, Delhi



These clinics are specifically meant to treat illnesses at the primary level. Most people usually seek treatment for common illnesses such as seasonal cough, cold and backache, followed by weakness, viral fever, respiratory infections and common cold. Less than 1% patients who seek treatment have complaints of boils and abnormal and pelvic pain. The following table shows the distribution of patients classified according to the types of illnesses.

<b>Table 4.1: Common illnesses for which people seek treatment in Mohalla Clinics, 2018-19</b>		
<b>Diagnosis</b>	<b>No. of Patients</b>	<b>Percentage of patients</b>
Cough	1296053	14.93
Backache	1239742	14.28
Generalized Weakness	803150	9.25
Viral Fever	767153	8.84
Acute Upper Respiratory Infections	747403	8.61
Acute Nasopharyngitis (Common Cold)	562216	6.48
Type-2 Diabetes Mellitus	560301	6.45
Fever of Unknown Origin	421610	4.86
Gastroenteritis	305998	3.52
Skin Problems	293761	3.38
Essential (Primary) Hypertension	257397	2.96
Hypothyroidism	241325	2.78
Anaemia	232360	2.68
Arthritis	215507	2.48
Diarrhoea Gastroenteritis	197553	2.28
Gastritis and Duodenitis	193251	2.23
Allergic Contact Dermatitis	180294	2.08
Headache	68029	0.78
Boils	57530	0.66
Abdominal and Pelvic Pain	41299	0.48
<b>Total</b>	<b>8681932</b>	<b>100.00</b>
Data Source: AAMC Project Cell, Dwarka, Delhi		

## 4.6 Role during COVID-19 Pandemic

In December 2019, a novel strain of Corona virus (2019-nCoV) was detected in Wuhan, China. On 30<sup>th</sup> January 2020, World Health Organization declared this outbreak as a Public Health Emergency of International Concern. On 11<sup>th</sup> February 2020 this disease was named Corona Virus Disease or COVID-19. A month later, on 12<sup>th</sup> March when this was declared as a pandemic, India had only 10 confirmed cases. The first case in India was detected on 30<sup>th</sup> January 2020 in Kerala and gradually spread across the country at a slow rate in the beginning and gained pace from mid-March. Delhi registered its first confirmed case on 1<sup>st</sup> March 2020. One month later (on 1<sup>st</sup> April 2020), it rose to 152 cases and two months later (1<sup>st</sup> May 2020) it rose to 3738 cases. As on 1<sup>st</sup> January 2021, the total number of confirmed cases in India is 11 million with Delhi alone contributing more than 0.6 million<sup>24</sup>. There have been more than 10000 deaths in Delhi till 1<sup>st</sup> January 2021.

Since the early days of the pandemic outbreak, apprehensions regarding the preparedness of the existing healthcare infrastructure in India and their ability to respond (Lahariya et.al. 2020) were being discussed and debated widely. The lockdown period was strategic to prepare our existing healthcare infrastructure to deal with the increasing number of infections which would require hospitalization on a large scale. All three levels of care – primary, secondary and tertiary have to work in tandem during the crisis. On 7<sup>th</sup> September 2020, the Director-General of the WHO Dr. Tedros Adhanom Ghebreyesus emphasized the

---

<sup>24</sup> Data collected from <https://www.covid19india.org/> accessed on 22<sup>nd</sup> November 2020 at 12.32am

need to invest in public healthcare, especially primary care, invest in population-based services for preventing, detecting and responding to diseases<sup>25</sup>.

On 7<sup>th</sup> April 2020 the MoHFW launched three types of COVID dedicated facilities for screening the suspected cases and preventing hospitalization. The three types of clinics included COVID Care Centres to deal with the mild cases; Dedicated COVID Health Centres to deal with the moderate cases and Dedicated COVID Hospitals which would provide comprehensive care to clinically severe cases<sup>26</sup>. MoHFW also directed for the setting up of 'Fever Clinics' in hospitals and CHCs, in rural areas where there is adequate space to minimize the risk of cross infections. In urban areas, the civil or general hospitals, Urban CHCs and Municipal Hospitals may also be designated as Fever Clinics. A medical officer at these fever clinics would suspect cases and refer to COVID Care Centre, Dedicated COVID Health Centre or Dedicated COVID Hospital, depending on the clinical severity of the case. This document elaborately outlined the process of identification, detection, referring, isolation and treatment of COVID cases.

In Delhi, the Mohalla Clinics were assigned the role of fever clinics; however they were not exclusively fever clinics. Mohalla Clinics were dealing with all kinds of

---

<sup>25</sup> WHO Director General's opening remarks at the media briefing on COVID-19 - 7 September 2020, World Health Organisation website, Accessed on 22<sup>nd</sup> November 2020 at 12:59 am from <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---7-september-2020>

<sup>26</sup> Ministry of Health and Family Welfare, Guidance document on appropriate management of Suspect/confirmed cases of COVID-19, Directorate General of Health Services, EMR Division, Accessed on 24<sup>th</sup> November 2020 from <https://www.mohfw.gov.in/pdf/FinalGuidanceonMangaementofCovidcasesversion2.pdf>

illnesses along with people who were coming with COVID-19 like symptoms<sup>27</sup>. Bailwal et al. (2020) have made a comparative study of primary healthcare facilities in Kerala and Himachal Pradesh and argued that Delhi's mohalla clinic network has been argued that these clinics have the potential to deal with the pandemic at the primary level. While the people are wary of visiting the OPDs of hospitals due to upsurge in number of COVID cases, these mohalla clinics served as a boon to the patients. They could provide services besides COVID-19 to people during lockdown<sup>28</sup> and also helped to reduce overcrowding at the tertiary hospitals especially during pandemic<sup>29</sup>. The Delhi government assured that these clinics would remain open and healthcare services would continue to be provided to people<sup>30</sup>. The doctors in the clinics were being trained by CDMOs to follow necessary guidelines while screening suspected patients and report all suspected cases to the designated hospitals<sup>31</sup>. It was reported that in the initial phase of lockdown the doctor and staff were

---

<sup>27</sup> A. Bedi & S. Dasgupta. (12<sup>th</sup> July 2020). Star of Dharavi success, but few takers in Delhi — how fever clinics have fared across India. *The Print*. Accessed from <https://theprint.in/health/star-of-dharavi-success-but-few-takers-in-delhi-how-fever-clinics-have-fared-across-india/458166/> on 22<sup>nd</sup> July 2020 at 10:47pm.

<sup>28</sup> A. Dutt & R. Chitlangia. (30<sup>th</sup> April 2020). In times of Covid-19, mohalla clinics, small hospitals take lead in treating other illnesses. *Hindustan Times*. New Delhi. Accessed from <https://www.hindustantimes.com/delhi-news/in-times-of-covid-19-mohalla-clinics-small-hospitals-take-lead-in-treating-other-illnesses/story-vdjilQYPfZcSEpAoxRIDDO.html> on 22<sup>nd</sup> July 2020 at 9:43pm.

<sup>28</sup> Goswami, S. (26<sup>th</sup> March 2020). Covid-19 lockdown: Essential services allowed, mohalla clinics won't be shut, says Kejriwal. *Hindustan Times*. New Delhi Accessed from <https://www.hindustantimes.com/delhi-news/covid-19-lockdown-essential-services-allowed-mohalla-clinics-won-t-be-shut-says-kejriwal/story-mh6781SxWIBjo9nuIwJKVL.html> on 30<sup>th</sup> March 2020 at 9:56pm.

<sup>31</sup> Saxena, A. (20<sup>th</sup> March 2020). Delhi Mohalla Clinics get ready to step up to a tough new challenge. *The New Indian Express*. New Delhi. Accessed from <https://indianexpress.com/article/cities/delhi/coronavirus-delhi-mohalla-clinics-get-ready-to-step-up-to-a-tough-new-challenge/> on 21<sup>st</sup> March 2020 at 5:27pm

unable to reach the clinics, hence about 270 clinics remained shut in the last week of March<sup>32</sup> and 150 clinics remained shut in the first week of April<sup>33</sup>. It was however ensured by the government that clinics would remain open and services would be available to people during the pandemic. Despite the shortage of protective gear, face shields, masks and gloves and delayed salaries, the doctors and staff continued to provide healthcare services to patients. However, some changes had to be implemented as blood and urine samples ceased to be collected and the patients requiring these services were being referred to nearby dispensaries<sup>34</sup>. Mohalla clinics could serve as effective platforms to create awareness about prevention and early detection of COVID cases. They could play a crucial role in fighting the pandemic owing to their easy accessibility. The government had asked mohalla clinics to distribute pamphlets, to patients who visited the clinics, which included the essential ‘dos and don’ts’ to prevent COVID<sup>35</sup>. Apart from referring the suspected patients to the dispensaries or hospitals, there was little that the doctors in these clinics could do. To bring more people under the testing and detection net, the government announced that all the dispensaries and

---

<sup>32</sup> Babu, N.M. (27<sup>th</sup> March 2020). Over 270 mohalla clinics shut in city. *The Hindu*. Accessed from <https://www.thehindu.com/news/cities/Delhi/over-270-mohalla-clinics-shut-in-city/article31187169.ece> on 23<sup>rd</sup> April 2020 at 2:34pm.

<sup>33</sup> Babu, N.M. (7<sup>th</sup> April 2020). Staff unable to reach, 150 mohalla clinics shut in Delhi. *The Hindu*. Accessed from <https://www.thehindu.com/news/cities/Delhi/coronavirus-staff-unable-to-reach-150-mohalla-clinics-shut-in-delhi/article31284197.ece> on 23<sup>rd</sup> April 2020 at 5:16pm

<sup>34</sup> Sirur, S. & Dasgupta, S. (14 June, 2020). Delhi Mohalla Clinics battle mask shortage, delayed salary but continue quiet fight in pandemic. *The Print*. Accessed from <https://theprint.in/health/delhi-mohalla-clinics-battle-mask-shortage-delayed-salary-but-continue-quiet-fight-in-pandemic/440256/> on 16<sup>th</sup> June 2020, 9:27pm.

<sup>35</sup> T. Sah, N. Bailwal & R. Kaushik. (27<sup>th</sup> June 2020). Delhi's Mohalla Clinic Network Should Have Been Used in the Fight Against COVID-19. *The Wire*. Accessed from <https://thewire.in/health/covid-19-delhi-mohalla-clinics> on 7th July, 2020 at 6:12pm.

polyclinics would carry out rapid antigen test<sup>36</sup>. On 21<sup>st</sup> March 2020, a Mohalla clinic doctor from Maujpur was diagnosed with COVID-19, who is suspected to have been infected by a Dilshad Garden patient who returned from Saudi Arabia. His wife, who is a doctor at another clinic in Baburpur and his daughter are also infected<sup>37</sup>. Delhi's Integrated Disease Surveillance Programme (IDSP) tried to track all people who came in contact with the doctor couple as well as the patient who is suspected to have spread the infection. Eventually 800 people were traced and advised 14 days quarantine<sup>38</sup>.

In early September, as COVID-19 cases were escalating rapidly, the Delhi Government also proposed to increase tests gradually<sup>39</sup>. The possibility of selected mohalla clinics being converted into temporary COVID-19 testing centres by shutting general OPD services temporarily was being explored<sup>40</sup>. It was declared by the Delhi government that

---

<sup>36</sup> Dutt, A. (11<sup>th</sup> July 2020). Rapid tests begin at Delhi govt dispensaries. *Hindustan Times*. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/rapid-tests-begin-at-delhi-govt-dispensaries/story-PoClOUssOK3oBXIAQduERK.html> on 12<sup>th</sup> July 2020 at 10:52pm.

<sup>37</sup> Dutt, A. (1<sup>st</sup> April 2020). 2nd Delhi mohalla clinic doctor's contacts being traced. *Hindustan Times*. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/2nd-delhi-mohalla-clinic-doctor-s-contacts-being-traced/story-PcZukzXNblzBrvy70Y3YL.html> on 3<sup>rd</sup> April 2020 at 7:31pm

<sup>38</sup> Unknown Author. (26<sup>th</sup> March 2020). 800 people who came in contact with Covid-19 positive mohalla clinic doctor quarantined, says Delhi govt. *Hindustan Times*. New Delhi. Accessed from <https://www.hindustantimes.com/delhi-news/800-people-who-came-in-contact-with-covid-19-positive-mohalla-clinic-doctor-quarantined-says-delhi-govt/story-alXbyfcLcel2xKfmdG0v8L.html> on 30<sup>th</sup> March 2020 at 10:28 am.

<sup>39</sup> Goswami, S. (2<sup>nd</sup> September 2020). Delhi govt. says efforts on to double Covid-19 testing, but in gradual manner. *Hindustan Times*. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/delhi-govt-says-efforts-on-to-double-testing-but-in-gradual-manner/story-kPcq1sXV80VFO6NEUXJ1eL.html> on 4<sup>th</sup> September 2020 at 5:20pm.

<sup>40</sup> Goswami, S. (3<sup>rd</sup> September 2020). The Health Minister also proposed if in selected mohalla clinics general OPD services could be shut and they could be converted into temporary COVID-19 testing centres. *Hindustan*

Mohalla clinics would be turned into COVID-19 testing centres, as a tool to increase the number of patients tested. The clinics would test patients between 2 to 6pm after routine OPD consultations got over and would be sanitized thoroughly before it would be open for OPD consultations the following day<sup>41</sup>. However, the doctors and staff were anxious about this order as they complained that they did not have adequate protective equipment and sanitizers. Later, it was also assured by the government that they would not start testing in clinics immediately and would first train the doctors and staff and take necessary action before rolling out the process<sup>42</sup>. On 10<sup>th</sup> September 2020, a new order was issued which stated that testing for COVID-19 would be started in mohalla clinics with immediate effect in order to augment the COVID-19 testing drive. The order also stated that the required logistic support for conducting the tests would be provided by the CDMO-cum-Mission Directors, including PPEs, testing kits, management support and training of the doctors and the staff. The tests would be conducted free of cost and all patients would be tested using the rapid-antigen method. The people would be again tested using RT-PCR technique when the result from the former test comes as negative<sup>43</sup>. On 16<sup>th</sup> September 2020, the Delhi High Court advised not to wait for the Rapid-Antigen false negative report and gave directives to the

---

*Times*. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/how-delhi-is-ramping-up-its-covid-19-testing/story-ptKkzt8DCJ3lyFIxXkWzYN.html> on 4<sup>th</sup> September 2020 at 5:24pm.

<sup>41</sup> Saxena, A. (4<sup>th</sup> September 2020). Delhi mohalla clinics now Covid testing centres. *The New Indian Express*. New Delhi. Accessed from <https://indianexpress.com/article/cities/delhi/delhi-coronavirus-update-mohalla-clinics-now-covid-testing-centres-6582235/> on 24<sup>th</sup> September 2020 at 8:30pm.

<sup>42</sup> Bedi, A. (4<sup>th</sup> September 2020). Delhi withdraws order roping in mohalla clinics for Covid tests, but doctors still anxious. *The Print*. New Delhi. Accessed from <https://theprint.in/india/delhi-withdraws-order-rope-in-mohalla-clinics-for-covid-tests-but-doctors-still-anxious/496048/> on 6<sup>th</sup> September 2020 at 6:20pm.

<sup>43</sup> Unknown Author. (11<sup>th</sup> September 2020). Delhi govt asks mohalla clinics to conduct Covid-19 tests. *Live Mint*. Accessed from <https://www.livemint.com/news/india/delhi-govt-asks-mohalla-clinics-to-conduct-covid-tests-timings-other-details-11599819867493.html> on 13<sup>th</sup> September 2020, 9:40pm.

Delhi Government to conduct RT-PCR right away. It also instructed that convert community halls and Mohalla Clinics may be converted into testing facilities<sup>44</sup>.

Although it is argued that mohalla clinics have not been used to their maximum capacity to mitigate the pandemic (Bailwal.et al., 2020), yet Lahariya (2020) reaffirms that these clinics have played a crucial role in the maintaining the continuity of essential non-COVID-19 healthcare services during the pandemic period, especially when the healthcare services in higher levels were either temporarily suspended or inaccessible by non-COVID patients. It was declared in November 2020 that these clinics, along with polyclinics, dispensaries and hospitals would be used for vaccination purpose<sup>45</sup>.

#### **4.7 Conclusion**

Despite the hurdles and bureaucratic problems in the initial phase of the project, the Mohalla clinics can be effective instruments of change of the healthcare landscape in Delhi. The healthcare provided in these clinics is bereft of any user fee and the cost of establishment of these clinics is also quite less. These clinics provide a whole range of services from doctor consultation to diagnostic tests and also provide medicines free of cost – which make these clinics accessible to the people. Although the target of 1000 clinics is yet to be achieved, yet the existing ones have been successful in providing

---

<sup>44</sup> Unknown Author. (16<sup>th</sup> September 2020). Corona test at Mohalla clinics: Delhi High Court gives this order to Arvind Kejriwal government. *National Chronicle*. Accessed from <https://nationalchronicle.in/national/corona-tests-at-mohalla-clinics-delhi-high-court-gives-this-order-to-arvind-kejriwal-government/> on 26<sup>th</sup> September 2020, 6:29pm.

<sup>45</sup> Unknown Author. (29<sup>th</sup> November 2020). Will deliver COVID-19 vaccines through mohalla clinics: Delhi Health Minister Satyendar Jain. *The New Indian Express*. Accessed from <https://www.newindianexpress.com/thesundaystandard/2020/nov/29/will-deliver-covid-19vaccine-through-mohalla-clinics-delhi-health-minister-satyendar-jain-2229374.html> on 22<sup>nd</sup> November 2020, 10:47pm.



affordable healthcare at the doorstep. It is also anticipated that these clinics will serve as effective units to battle the pandemic – as testing centres, by detecting and referring cases, providing treatment to non-COVID-19 patients, by reducing pressure on the secondary and tertiary care hospitals and by functioning as inoculation centres. The first phase of COVID-19 vaccination has started in India on 16<sup>th</sup> January, 2021 and mohalla clinics are expected to play an important role in the inoculation drive. Since these clinics are located in the neighbourhood and have a higher reach among the people, these clinics have the potential to help in mitigating the current pandemic and such situations which might occur in the future.

## **Chapter 5: Accessing Healthcare in the Neighbourhood: Primary Health Care Services at Mohalla Clinics**

### **5.1 Introduction**

In the previous chapter we have discussed about the idea of mohalla clinics, the objectives with which they are being established and the role they are expected to play in the delivery of primary healthcare services in Delhi. The objective of this chapter is to understand the role of these clinics in providing and enhancing the accessibility and utilization of primary health care services among people in Delhi and to understand the linkages created by the mohalla clinics and their contribution in improvement of the overall health care system in Delhi.

This chapter is based on data obtained from primary field survey carried out in selected clinics in Delhi between July 2019 and February 2020. It includes observational study within and around the clinics, interaction with patients visiting the clinics and residents of area around the clinics, interaction with the healthcare providers namely the doctors and staff working in the clinics through semi-structured interviews, discussions and photographs. Besides information obtained from interaction with patients, residents and doctors and staff, interaction with other stakeholders such as government officials and politicians have also been considered.

## 5.2 Sample Characteristics

A total of 90 respondents are selected from two locations – Lado Sarai Village and Peeragarhi Relief Camp. Semi-structured interviews were conducted among the patients visiting the clinics and residents in the surrounding areas of the clinics within a distance of 1.5 kilometre radius. The sample characteristics have been summarized in the following tables.

Gender		Total	Age Groups		
			Below 14 years	15 to 49 years	Above 49 years
Male	Frequency	36	6	20	10
	Percent	40%	16.7%	55.6%	27.8%
Female	Frequency	54	8	34	12
	Percent	60%	14.8%	63.0%	22.2%
Total	Frequency	90	14	54	22
	Percent	100%	15.6%	60.0%	24.4%

Data collected by author during field survey 2019-2020

Of the 90 respondents who have been surveyed, there are 36 males and 54 females which indicate higher utilization of healthcare services in mohalla clinics by the females. Largest section of females belongs to the age group 15 to 49 years (63.0%), followed by females above 49 years (22.2%) and below 15 years (14.8%). While percentage of males in age group 15 to 49 years (55.6%) is lesser than their female counterparts, yet the males above 49 years (27.8%) and below 15 years (16.7%) is higher than the female counterparts. The largest section of population belongs to 15-49 age group (60%), followed by people above 49

years (24.4%) and below 15 years (15.6%). The respondents are mainly followers of Hinduism (84.4%), followed by Islam (11.1%) and Sikhism (7.4%).

<b>Table 5.2: Sample Characteristics: Religion of the Household</b>					
Gender		Religion			Total
		Hindu	Muslim	Sikh	
Male	Count	32	4	0	36
	% within Males	88.9%	11.1%	0.0%	100.0%
Female	Count	44	6	4	54
	% within Females	81.5%	11.1%	7.4%	100.0%
Total	Count	76	10	4	90
	% within Total	84.4%	11.1%	4.4%	100.0%
Data Source: Compiled by author from data collected in the field during 2019-2020					

Of the 90 respondents, about 31% belong to the scheduled castes, less than 7% belong to the scheduled tribes, 22% belong to other backward classes and the remaining 40% belong to other castes. This composition has been summarized in the following table:

<b>Table 5.3: Sample Characteristics: Social Groups</b>						
Gender		Caste/tribe of the household				Total
		Scheduled Castes	Scheduled Tribes	Other Backward Classes	Others	
Male	Count	12	2	4	18	36
	% within Males	33.3%	5.6%	11.1%	50.0%	100.0%
Female	Count	16	4	16	18	54
	% within Females	29.6%	7.4%	29.6%	33.3%	100.0%
Total	Count	28	6	20	36	90
	% within Total	31.1%	6.7%	22.2%	40.0%	100.0%
Data Source: Compiled by author from data collected in the field during 2019-2020						

### 5.3 Assessing Access to Mohalla Clinics

It is argued that mohalla clinics can be significant primary health care units which will serve as alternative to expensive private health care (Basu and Barria, 2018) and help in reduction of OOP expenditure (Lahariya, 2017) since they provide health care free of cost which can be effective in enhancing accessibility and utilization of health care services for the people of Delhi. These clinics will also help in reducing the patient pressure on the secondary and tertiary care hospitals (Lahariya, 2016; 2017). In this chapter we shall evaluate in what ways these clinics are enhancing the access and utilization of primary health care services and how they are helping to strengthen the overall health care system in Delhi.

In order to understand the concept of access, the framework by Penchansky and Thomas (1981) has been adopted. They have identified five dimensions that define health care access: availability, accessibility, accommodation, affordability and acceptability. Access is defined as the degree of fit between the health system and the clients (Penchansky and Thomas, 1981), the better the fit, the better the access (Saurman, 2016). This model was further modified by Saurman (2016) to include the factor of awareness in determining health care access. In this chapter, we shall study the role of mohalla clinics in provisioning of health care services in Delhi according to these six parameters. It must be mentioned here that these parameters are often overlapping in their concepts and are inseparable. Also, certain modifications have been made in the overall model, which have been discussed within the specific dimensions of access.

### 5.3.1 Availability

According to Penchansky and Thomas (1981), availability refers to the adequate supply of health care infrastructure. It is defined as the relationship between the volume and type of the existing health care services and the volume and type of the needs of the clients. It includes the supply of health care providers, health care units and specialized programmes. In this model, availability has been extended to the availability of the free medicines and diagnostic test facilities besides the parameters already stated in the original model.

<b>Table 5.4: District-wise distribution of mohalla clinics (till December 2020)</b>	
<b>Districts</b>	<b>No. of Clinics</b>
Central	35
East	30
New Delhi	11
North	32
North East	36
North West	79
Shahdara	46
South	39
South East	52
South West	58
West	67
Total	485
Data collected from AAMC Project Cell, Dwarka, Govt. of NCT of Delhi.	

The health care infrastructure in India and particularly in Delhi is inadequate to support the rising health needs of the population, as discussed in Chapter 3. Realizing the inadequate fit between the supply and demand for health care services, the proposal of establishment of mohalla clinics has been put forward and implemented. There were 485

mohalla clinics in Delhi as on 31<sup>st</sup> August 2020. Although these clinics are not uniformly distributed across the districts (as discussed in chapter 4), nonetheless they have been important units of primary health care services in Delhi. The total number of clinics stand at 485, but are unevenly distributed across the districts in Delhi. The following table shows the district-wise distribution of the clinics. These clinics have helped in enhancing geographical access to health services (Sah et al., 2019). Patients visiting the mohalla clinics and the residents around the clinics were interviewed regarding the availability of healthcare services and the problems they have faced in health care access and utilization. According to the interviewees, the establishment of the mohalla clinics has been a good initiative by the Government of NCT of Delhi which has proved to be beneficial for them. People have said that after establishment of these clinics, acquiring primary care has become easier. Less than 15% of the interviewees have opined that there has been no change in acquiring primary care after establishment of Mohalla Clinics. About 85% have opined that acquiring primary care has become easy after the mohalla clinics were established within the locality.

<b>Table 5.5: Perception Regarding Acquiring Primary Care Services Post Establishment of Mohalla Clinics</b>		
<b>Effect on primary care Services</b>	<b>Frequency</b>	<b>Percent</b>
No change	13	14.4
Easy	39	43.3
Very easy	38	42.2
Total	90	100.0
Data collected by author during field survey 2019-2020		

Prior to the establishment of these clinics, the people either went to the overcrowded public hospitals or expensive private hospitals and clinics or consulted the quacks or relied on over-the-counter medicines. More than 35% of the people sought

treatment in public hospitals, followed by private practitioners. About 11% sought treatment in private hospitals and in government dispensaries or polyclinics each. More than 15% of the people did not seek treatment.

<b>Table 5.6: Previous Place of Treatment</b>		
<b>Place of treatment</b>	<b>Number</b>	<b>Percent</b>
Public hospital	32	35.6
Private practitioner	24	26.7
Did not seek treatment	14	15.6
Private hospital	10	11.1
Government dispensaries/polyclinics	10	11.1
Total	90	100.0
Data collected by author during field survey 2019-2020		

Of the 14 people who did not seek treatment previously, but now seek treatment in mohalla clinics, 6 have stated their main reason for not seeking treatment was that the ailment was not considered as serious; 4 of them did not seek treatment because it would lead to a loss of their daily wages or they did not have anyone to accompany them to the healthcare facility.

A government health facility close to their homes has been helpful for them in manifold ways. Treatment for chronic ailments, acute and seasonal illnesses are available within their neighbourhood, diagnostic tests are also done free of cost. Since medicines are also available free of cost from the clinic, the patients do not have to go elsewhere to procure medicines. This has drawn them away from seeking treatment in private clinics and hospitals wherein the patients have to undertake the tasks of procuring medicines and carrying out diagnostic tests at his/her own expenses elsewhere and also prevented them



from seeking treatment from the quacks. Only 4 patients out of 76 seeking treatment in mohalla clinics have sought treatment elsewhere after starting treatment here because of lack of specialized treatment in the clinics.

Mohalla Clinics have been instrumental in providing basic necessary services within a small radius and also under single roof. Since they are meant to serve small population clusters, the patient pressure on each clinic remain lower than in government hospitals. In the initial days of establishment of a clinic surveyed in South West district about 60 patients visited the clinic which has increased to 120 in 2019. In some clinics, about 150 patients seek treatment in a day. In case of clinics which witness higher footfall of patients, the working hours have been extended into double shifts. This has helped to balance the excessive pressure. Therefore, the patients prefer to visit these clinics for basic ailments which they think can be treated in these clinics rather than visiting secondary or tertiary care hospitals and facing various challenges. Some women have also stated that the presence of the clinic within the vicinity of their village in South West district has helped them seek medical care in case of need. Earlier they often delayed their treatment because the government hospitals were too far for them to go alone and the private clinics were beyond their means.

Patients usually come for basic illnesses such as chronic – diabetes, thyroidism, and acute illnesses such as cold, cough, influenza, pain, emergency services such as dressing of wound, first aid services. The following table shows the various ailments for which respondents from the sample seek treatment in mohalla clinics. It must be noted that the figures represent ailment categories and are not equivalent to number of patients. Since a single patient may seek treatment for more than one ailment, the episode

of treatment appears in more than one category of ailment. Most patients seek treatment for acute ailments such as fever and cough and cold, followed by chronic ailments such as diabetes and hypothyroidism. The patients have said since the clinics are available close to their residence, in case of any acute health condition, they first prefer to seek treatment in these clinics.

<b>Ailment name</b>	<b>Ailment type</b>	<b>Frequency</b>
Cough and Cold	Acute	18
Fever	Acute	11
Diabetes	Chronic	10
Hypothyroidism	Chronic	8
Allergy	Acute	8
Backache	Acute	6
Vomiting	Acute	2
Gynecological problem	Acute	2
Chest pain	Acute	2
Infection	Acute	2
Diarrhoea	Acute	2
Asthma	Chronic	2
Dental problem	Acute	2
Data collected by author during field survey 2019-2020		

In a clinic in North West district, specialized programmes are also available. Antenatal and post natal check-ups are available and Vasectomy is also performed in the clinic since the doctor specializes in gynaecology. Two ASHA workers are associated with this clinic who carry out surveys in the catchment area of the clinic at regular intervals and keep a record of the pregnant women. This helps the clinic to identify women for antenatal and postnatal check-ups and also helps to keep a record of children to carry out immunization. Since the data of the women and the children is available at the clinic, it is

easy for the staff to reach out to them at the stipulated time for these special programmes. The doctor at the clinic in North West district claims that complete immunization prevails among children till two years of age in the area served by this clinic. In the clinic in South West district which does not have a refrigeration facility, it is difficult to store vaccines, argued the doctor. As a result, immunization services could not be started in that clinic. However, in most of the clinics, neither antenatal, postnatal services nor immunization services are available. The doctors are hopeful that since ANMs are present in every clinic, these services might be started soon.

People have complained about the lack of specialist services in the clinics – for which they are referred to government polyclinics, dispensaries and hospitals. In their opinion, specialist services should be made available. However, since this is a primary health care unit and the first point of contact with the health care system, only the basic and necessary services are available. The ailments which can be cured at primary levels of care are treated here. The patients who require more specialized treatment are referred to higher rungs of the health system. The initiation of specialized services on a weekly basis has been proposed in some clinics, but it is yet to be operational. Since there is only one doctor per clinic, if that doctor is on leave, the clinic remains non-functional. They have to visit some other clinic or go to the nearby government dispensary. The patients have complained that doctors often remain absent without prior notice which makes it difficult for the patients to seek treatment. On one such day during the field visit, the doctor was on leave without notice. The clinic was open and the staff were present but due to the absence of the doctor, none of the services could be carried out. Patients came to see the doctor, only to be told that the doctor was unavailable. Some of them had come to take medicines for chronic ailments

while some had come for acute illnesses and several others had come for diagnostic tests. They were directed by the staff to visit the mohalla clinic in the adjacent locality or the nearest polyclinic. While some of the patients did as they were suggested, some of them resented and said that it would be difficult for them to seek treatment there. Similar problems occur in other clinics too. The absence of the doctor leads to collapse of the whole mechanism of the clinic. While the DGHS has given a directive that the doctor has to seek prior approval in case he wants a leave, there should be some alternative measure to keep the clinic functional on the day the doctor remains absent.

Another problem which has been highlighted by patients is that sometimes all medicines are not available in the clinic and the patients are directed to collect the medicines from the nearby dispensary. This problem becomes acute in case of seasonal ailments. The unavailability of medicines again cripples the structure of mohalla clinic as it destroys the very motive with which this clinic was established – providing health care at the doorstep.

The volume of patients is often a problem on the part of the doctors and the staff. Since the clinics remain open for limited number of hours, there is rush of patients all of whom ask for quick treatment. On an average the doctors treat about 120-150 patients per day. However, in some of the clinics the number was higher than this and a second shift was started in those clinics – such as Andheria Mor. This has helped to reduce the rush in the morning hours – making it easier for the doctors, staff and the patients. Also, due to the opening of evening shift clinic, the patients who have work or school or college during the morning hours can visit the evening clinic for treatment. This will lower their opportunity costs – they do not have to miss their work/school/college.

Some of the patients said that there is a lack of specialized treatment in these clinics. Although they can get treatment for minor illnesses, for specialized treatment they need to visit government hospitals where they have to face the same problems of longer distance, longer queues and travel costs. According to some patients, if specialized doctors are available in the clinic itself, it would ease their access to health care.

These clinics therefore can be important primary care units aimed at universal health care. However, 1000 clinics with one within every square kilometre will make sense only when proper quality of health care services is maintained. A problem that is associated with mohalla clinics, according to a doctor working in a clinic, is young doctors who are appointed with these clinics do not wish to continue for a long time. They move elsewhere with better prospects. Despite availability of premises for clinics, they are unable to be set up within stipulated time due to the scarcity of doctors who are ready to be associated with this project.

### ***5.3.2 Accessibility***

Accessibility, according to Penchansky and Thomas (1981), depends on the spatial and geographical location of health care providers and their uses, whereby mode of transport to the clinic, travel costs and time are taken into account. It refers to the relationship between location of the health care facilities and the location of the people who are in need of these facilities. In this model, location is considered not only as the relative location of the health facility to the location of the people who wish to access it, but also to the physical location of the clinic as to the characteristics of the place where it is located.

Of the 90 interviewees, 14 did not seek treatment during previous episode of illness. It was noted that 50% of the people who sought treatment earlier, travelled for about an hour to reach the previous place of treatment, about 45% travelled for about 15 to 30 minutes and only about 5% sought treatment in a health facility available within 15 minutes from their residence.

<b>Table 5.8: Time-Distance of Previous Place of Treatment from Residence</b>		
<b>Time taken to reach health facility</b>	<b>Frequency</b>	<b>Percent</b>
Less than 15 minutes	4	5.3
15-30 minutes	34	44.7
1 hour	38	50.0
Total	76	100.0
Data collected by author during field survey 2019-2020		

Of the 90 interviewees, there were 14 of them who were either unaware of the existence of mohalla clinics or did not seek treatment despite knowing about their existence. It was noted that more than 73% of the patients who sought treatment in Mohalla Clinics have to travel less than 10 minutes from their residence to reach the clinic. This is in sync with the previous studies that reveal that most of the patients travel about 10 minutes to reach these clinics<sup>1</sup>. About 24% have to travel about 10 to 15 minutes to reach the clinic. Less than 3% of the patients have to travel for about 15 to 20 minutes to reach mohalla clinic. This is far less than the time they would have otherwise taken to travel to other health

<sup>1</sup> C. Lahariya (2020). Access, utilization, perceived quality, and satisfaction with health services at Mohalla (Community) Clinics of Delhi, India. *Journal of Family Medicine and Primary Care*, Vol. 9, 5872-5880.

care facilities located far from their residence. This implies that the travel time has reduced to a great extent when people have started seeking treatment in mohalla clinics.

<b>Table 5.9: Time-Distance of Mohalla Clinics from Residence</b>		
<b>Time taken to reach Mohalla Clinics from residence</b>	<b>Frequency</b>	<b>Percent</b>
Less than 10 minutes	56	73.7
10 to 15 minutes	18	23.7
15 to 20 minutes	2	2.6
Total	76	100.0
Data collected by author during field survey 2019-2020		

Apart from the longer time required reaching the previous place of treatment, the respondents had to spend on the transport costs. About 55% of the patients who seek care in mohalla clinics now spent less than Rs. 100 to reach the healthcare facility while about 45% of them spent between Rs. 200 to Rs. 300.

<b>Table 5.10: Transport Cost to the Previous Place of Treatment (per episode)</b>		
<b>Amount</b>	<b>Frequency</b>	<b>Percent</b>
Less than Rs. 100	42	55.3
Rs. 200 to 300	34	44.7
Total	76	100.0
Data collected by author during field survey 2019-2020		

The mohalla clinics have been instrumental in reduction of opportunity costs in several ways. It is observed that people mostly reach these clinics by foot, since they are located within the neighbourhood. Since they come by foot, they are able to save the money they would have otherwise paid to travel to private clinics or government hospitals. Also, due

to the proximity of these clinics, women with her children and the elderly can visit the doctor alone and do not have to depend on other family members to accompany them, as would have been in the case of government and private hospitals and clinics. A lady who runs a family business says,

*‘...bus se nahin jaa sakti... yeh clinic paas mein hai; akeli hi chali jaati hoon...paidal...’*

Translated – ‘...I cannot travel by bus (to any health care facility)... This (mohalla) clinic is close by; I go alone...by foot...’

(Female, 75 years, seeking treatment for diabetes and asthma in the clinic, family business – clay pottery).

Some of the patients come to the clinic along with their neighbours. Therefore, their dependence on male members of the family to accompany them has declined. A lady with her ailing child had come to the clinic in South West district for treatment. She said that earlier her husband, who is a daily wage earner, had to take leave from the small factory where he works to take their child for treatment in government hospitals, since it was far and the long and cumbersome treatment process would take the entire day. This led to his loss of wages too. Now with the establishment of these clinics, the lady does not have to wait for her husband to accompany her and the child.





*Figure 5.1: Females and elderly people coming to the clinic to seek treatment. Photograph by author during field visit, March 2020.*

**Table 5.11: Person Accompanying the Patient to the Clinic**

Person who accompanied the patient	Frequency	Percent
Alone	42	55.3
Parents	10	13.2
Sister/Brother	10	13.2
Son/daughter	6	7.9
Neighbours/friends	4	5.3
Husband	2	2.6
Wife	2	2.6
Total	76	100.0

Data collected by author during field survey 2019-2020

Of the total 76 people who sought treatment in mohalla clinics, more than 55% had come alone which implies greater ease of accessibility of these clinics. Since these are located within the locality, there is hardly any need for another person to accompany the patient, unless he/she is unable to visit the clinic alone. About 13% of the

patients came to the clinic either with their parents or their siblings. Less than 8% visited the clinic with the children. About 5% of them had come with their neighbours or friends and less than 3% came with their spouse.

According to the doctors, these clinics are ideal for primary care. Patients usually visit these clinics for diabetes, thyroidism, high blood pressure, gastroenteritis, diarrhea, fever, fungal infection, respiratory diseases, skin diseases, arthritis and so on. Since the clinic in South West district is located at the road side, people who sustain road accident or injuries also come to the clinic for first aid. Preliminary dressing of the wound is done and medicines are provided. In case of severe injuries, after first aid, the patient is referred to Madan Mohan Malviya Hospital or Safdarjung Hospital. Patients with illnesses such as tuberculosis which requires secondary or tertiary care are referred to government hospitals – AIIMS, Safdarjung Hospital or Madan Mohan Malviya Hospital. Apart from the illnesses mentioned above, patients with gynaecological issues also visit the clinic at North West district since the doctor is specialized in gynaecology. According to the patients, these clinics within the locality are good for treating minor illnesses, as quoted below:

*‘...delivery ke time Safdarjung mein gayi thi... sardi zukham ke liye yahan aate hain...’*

Translated – ‘...I went to Safdarjung at the time of delivery...for cold and cough we come here...’

(Female, early 40s, mother of two kids, visited the clinic for treatment of her daughter who has fever)

The locational characteristics of the clinic are important because they can influence access. Clinics on the road side or within metro stations have more favourable locations. Not all clinics are well accessible. Clinics which are located within slums or *rain baseras* are accessible for the people staying there, but not easily accessible by people outside. Clinics in rented buildings in narrow alleys or at the back side of any building often go overlooked.

### **5.3.3 Accommodation**

Penchansky and Thomas (1981) define accommodation as the relationship between the organizational structures of health care services such as appointment system, opening hours and the ability of the clients to accommodate to these factors and the perception of their appropriateness. This dimension has been extended to include presence of other infrastructure that might be necessary for the patients – ramp for physically challenged patients or patients who are not in a position to walk, seating arrangement (whether adequate seats are available for people to wait for their turn to see the doctor), drinking water facility, (for example, a clinic has the drinking water facility inside the doctor's room which is almost inaccessible for the patients), toilet facility, cleanliness of the clinic and the surroundings, whether the doctors and the staff are present at the stipulated opening hours of the clinic, within how many days of blood tests are the reports ready and so on.

The poor section of population are mostly daily wage earners who do not afford to miss a day's work because it is synonymous to missing a day's wage. People have said that very often they preferred consultations in private clinics than in government hospitals though the latter provides free health care compared to payable health care in the

former. This is mainly because they did not have to spend long hours in the hospitals, hence did not have to miss work and forego wages. The private clinics are usually located close to their residence or within the locality and the waiting time in those clinics was also less compared to government hospitals. However, with the inception of the mohalla clinics, the situation has undergone a change. Most people prefer seeking treatment in these clinics than in private clinics because of their physical proximity and lesser waiting time. Since mohalla clinics start operating at 8 a.m., the people can visit the clinic, take medicines, get appropriate diagnostic tests done and can then go for his work. In this manner, he does not have to miss his work or forego wages. No prior appointment is required in the mohalla clinics. The consultation process in these clinics is based on walk-in and first-come-first-serve basis. Observation reveals that waiting time in the South West district clinic is about five minutes during lean hours and 15 minutes in the peak hours while in the clinic in North West district is less than 5 minutes in the lean hours and around 12 minutes in the peak hours. The doctor in South West district clinic said that people who are daily wage labourers often visit the clinic for minor illnesses before going on their day's work. About 45% of the patients who sought treatment have said that they had to wait for 15 to 30 minutes; about 26% of them said that they had to wait for 30 to 45 minutes; about 24% of them said that they had to wait for about an hour while about remaining 5% said that they had to wait for about 2 hours before they could see the doctor in their previous place of treatment.

<b>Table 5.12: Waiting Time to See the Doctor in Previous Place of Treatment</b>		
<b>Waiting Time</b>	<b>Frequency</b>	<b>Percent</b>
Less than 5 minutes	0	0
5 to 15 minutes	0	0
15 to 30 minutes	34	44.7
30 to 45 minutes	20	26.3
About an hour	18	23.7
About 2 hours	4	5.3
Total	76	100.0
Data collected by author during field survey 2019-2020		

On the other hand, the waiting time to see the doctor in mohalla clinics is relatively lesser than the previous place of treatment. About 21% said that they had to wait for less than 5 minutes. The largest section of the patients, close to 60%, had to wait for 5 to 15 minutes. About 15% had to wait for 15 to 30 minutes and about 5% had to wait for about 30 minutes to see the doctor in mohalla clinic. Therefore, it can be said that the waiting time to see the doctor in mohalla clinics is lesser than that in the previous place of treatment. While the minimum waiting time in previous place was 15 to 30 minutes, it is less than 5 minutes in mohalla clinic. On the other hand, while the highest waiting time in previous place was about 2 hours, it was 30 to 45 minutes in mohalla clinic. This implies that treatment seeking is less time consuming in mohalla clinic compared to the previous place of treatment which enhances the accessibility to healthcare services.

<b>Waiting Time</b>	<b>Frequency</b>	<b>Percent</b>
Less than 5 minutes	16	21.1
5 to 15 minutes	45	59.2
15 to 30 minutes	11	14.5
30 to 45 minutes	4	5.3
About 1 hour	0	0
About 2 hours	0	0
Total	76	100.0
Data collected by author during field survey 2019-2020		

Seating arrangements are available in both the clinics where about 12 to 14 people could be seated at a time. When the patients were asked about their satisfaction regarding the seating arrangements in the clinics, about 23% of them said that they were less than satisfied with the kind of seating arrangement available. However, about 71% of the patients said they were somewhat satisfied with the arrangement, while about 5% said they were adequately satisfied with the arrangement available. Physically challenged people and the elderly face difficulty while walking to the doctor's chamber. Therefore the facility of ramp should be available in all clinics to facilitate the operation of a wheel-chair. Both clinics in South West district and North West district have this facility which makes the clinics easily accessible for physically challenged people as well as the elderly.

<b>Level of Satisfaction</b>	<b>Frequency</b>	<b>Percent</b>
Less than satisfied	18	23.7
Somewhat satisfied	54	71.1
Adequately satisfied	4	5.3
Total	76	100.0

Data collected by author during field survey 2019-2020

However, some people have complained that operation of these clinics only during the morning hours restricts them from seeking treatment as their working time starts before the clinic starts operating and ends after the clinic closes in the afternoon. Hence if these clinics operate in the evening time as well, it would be beneficial for them. Some clinics are operational in the evening, but only in the places where the patient pressure is high.

Availability of drinking water facility within the clinic is a necessary requirement. However, not all clinics have this facility. In the clinic in South West district it was observed that the drinking water facility was inside the doctor's chamber (behind the doctor's chair) which was accessible to the patients only after seeking approval. It was however, freely accessed by the doctor and the staff. This discriminatory attitude is unacceptable since water is a basic requirement. On probe, the doctor in the clinic said that the patients often tend to misuse the water facility if available openly. Therefore, in order to have a control over its usage, the water facility has been kept within the doctor's chamber. Since the access to drinking water facility is poor, about 91% of the patients visiting the

clinic have expressed very low level of satisfaction regarding the same and about 9% of them have said that they are somewhat satisfied and adequately satisfied.

<b>Table 5.15: Level of Satisfaction regarding Drinking Water Facilities Available in Mohalla Clinics</b>		
<b>Level of Satisfaction</b>	<b>Frequency</b>	<b>Percent</b>
Less than satisfied	69	90.8
Somewhat satisfied	6	7.9
Adequately satisfied	1	1.3
Total	76	100.0
Data collected by author during field survey 2019-2020		

Of the 76 respondents who sought treatment in the mohalla clinics, 68 of them have received medicines from the clinics. About 35% of them commented that they were less than satisfied with the medicines available at the clinics, 50% of them said they are somewhat satisfied with the medicines and close to 15% said that they were adequately satisfied with the medicines received at the clinics.

<b>Table 5.16: Level of Satisfaction regarding Medicines Received in Mohalla Clinics</b>		
<b>Level of Satisfaction</b>	<b>Frequency</b>	<b>Percent</b>
Less than satisfied	24	35.3
Somewhat satisfied	34	50.0
Adequately satisfied	10	14.7
Total	68	100.0
Data collected by author during field survey 2019-2020		



Cleanliness within and around the clinics is extremely necessary for the staff and the patients to feel comfortable to carry out the treatment seeking and imparting process. It was observed that the clinics are cleaned in the morning by a *safai karmachari* who is appointed on a contractual basis. Since during the monsoon season the floor tends to get dirty with the mud under the foot wears, the patients are instructed to take off their shoes before entering the clinic. This helps to keep the floor tidy. However, the surroundings around the clinic are unhygienic and filthy. While the surroundings are not cleaned daily, there are earthen pots filled with water for the birds and animals to drink water from. However, the shape of the pot does not give the impression that the animals can easily drink water from it. Therefore, the regular consumption of water by them and replacement with fresh water is a questionable issue. It leads to high chances of growth of favourable breeding grounds for mosquitoes.



*Figure 5.2: Water accumulated around the clinic. Photograph by author during field visit, July 2019.*



*Figure 5.3: Earthen pot beside the clinic act as breeding ground for mosquitoes. Photograph by author during field visit, July 2019.*

The samples collected for diagnostic tests are collected in the clinic during the stipulated hours and are sent to a lab for examination. In the South West district clinic the samples are usually collected between 8 and 10 a.m. and till 10:30 a.m. in the North West district clinic. Despite the notice, people keep coming beyond the stipulated time and request for collection of samples. Of the 76 respondents who sought treatment in the mohalla clinics, 22 of them had got diagnostic tests done in the clinic. Half of them were adequately satisfied with the tests, while the rest commented that they were somewhat satisfied and less than satisfied regarding the diagnostic tests available in the clinics.

<b>Level of Satisfaction</b>	<b>Frequency</b>	<b>Percent</b>
Less than satisfied	2	9.1
Somewhat satisfied	9	40.9
Adequately satisfied	11	50.0
Total	22	100.0
Data collected by author during field survey 2019-2020		

It is mandatory to show a government approved identity proof to be allowed to get any test done at the clinic, in the absence of which the tests cannot be done. The importance of a government approved identity proof lies in the fact that it helps in proper maintenance of records of patients and also allows to trace them during their subsequent visits. In the clinic at North West district, a lady had come with her daughter (age 6 years) to get a blood test done. Since the girl did not have an Aadhar Card, the staff refused to collect her blood sample. The lady was so disappointed about the whole matter that she even refused to take the free medicines from the clinic which the doctor had provided. Instead she said that she would take her daughter to a private doctor and get tests done in a private laboratory. It takes about two days for the reports to be ready. However, some patients have complained that reports are usually not ready within two days and sometimes it takes as long as a week's time for the reports to be ready. The doctors on the other hand complain that though the patients are enthusiastic in getting tests done, they often do not come to collect the test reports. Sometimes the doctors have to call them up and inform them that their reports have arrived and that they should come and collect them. A problem faced by the clinics of late is that some patients insist on getting tests done. They often request and sometimes force the

doctors to prescribe them various tests even when the doctors are sure that the tests are not required. Instances are not rare when some patients have tried to intimidate the doctors with the help of influential people. The doctors opine that they prescribe tests only when they deem necessary, otherwise they would not like the government resources to be wasted unnecessarily.

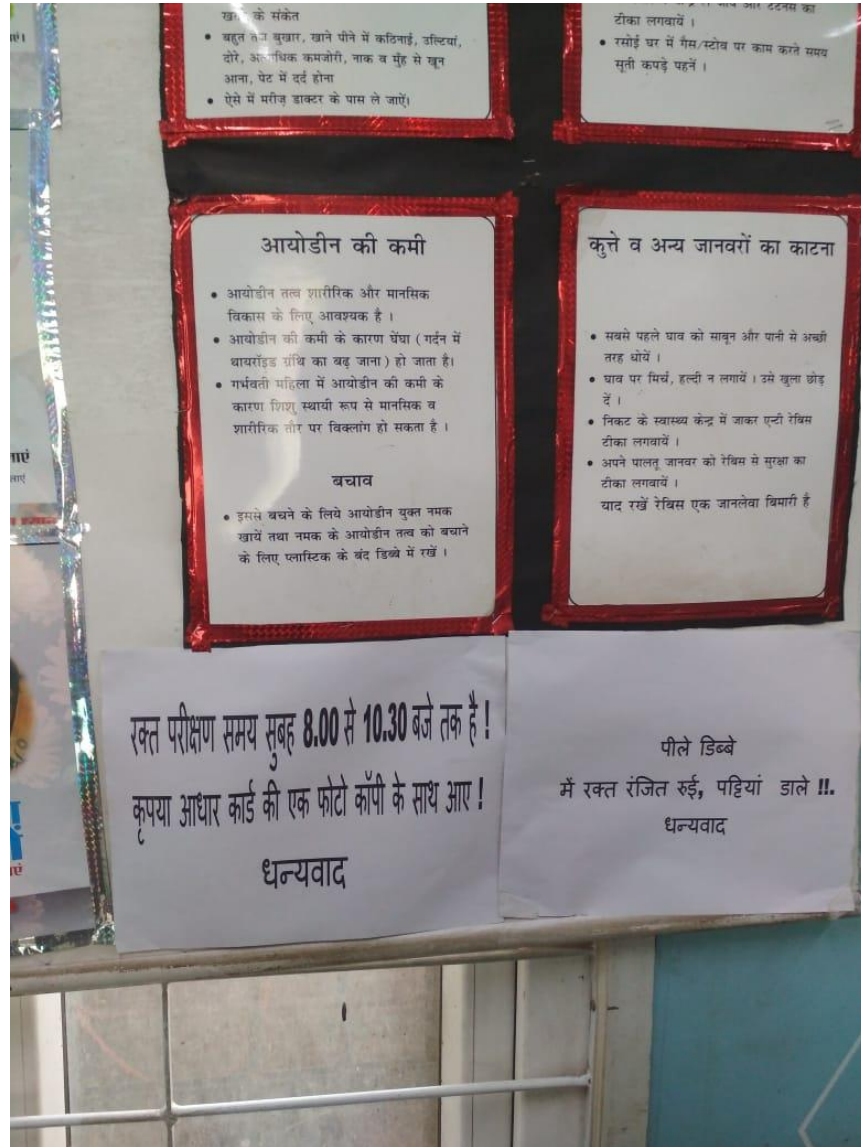


Figure 5.4: Notice mentioning stipulated time for sample collection in the clinic in North West district. Photograph by author during field visit, January 2020.



Usually doctors and the staff are present before the stipulated time of opening of the clinics and are available till the closing time. However, some patients have complained about the absence of doctors and staff, as discussed earlier.

#### ***5.3.4 Affordability***

In the Penchansky and Thomas model of healthcare access (1981), affordability includes the need for patients to have financial means to use the available health care services. It refers to the relationship between the costs of existing health care services and the resources of the client to use those services such as income and his ability to pay. Since mohalla clinics provide health care free of cost, the question of affordability gets nullified.

Patients who visited private clinics prior to the establishment of the mohalla clinics have said that they have been able to save the expenses incurred in private clinics since they receive treatment free of cost – consultation with the doctor, medicines and diagnostic tests here. In case of unavailability of any of the prescribed medicines in the mohalla clinic, they are asked to procure them free of cost from the nearby mohalla clinic, polyclinic or dispensary. Therefore the cost of treatment in these clinics is nil – which is beneficial for all people, especially the poor and the vulnerable who do not afford to seek treatment in expensive private hospitals or clinics. They can continue the treatment. This is an important step towards universal health care. It has been noted in the field that of the 76 people who seek treatment in mohalla clinics, 18.4% never sought treatment before, therefore they did not spend any amount on doctor's fee previously and at present seek free treatment available in mohalla clinics now. 50% of the people sought treatment in public hospital or

dispensary/polyclinic where they received free treatment. About 21% of the patients spent Rs. 200 to Rs. 500 as doctor's fee in the place where they sought treatment earlier and about 11% spent Rs. 500 to Rs. 1000. Therefore, more than 30% of the patients who seek treatment in mohalla clinics at present had to bear out-of-pocket expenses for treatment. This was in addition to the travel expenses already discussed in the previous section. Since treatment costs have reduced to nil, it is an important step towards enhancement of accessibility and utilization of primary healthcare services.

<b>Fee in Place of Previous Treatment</b>	<b>Frequency</b>	<b>Percent</b>
Never sought treatment before	14	18.4
Free treatment/public facility	38	50.0
Rs. 200 to 500	16	21.1
Rs. 500 to Rs. 1000	8	10.5
Total	76	100.0
Data collected by author during field survey 2019-2020		

An important cause behind not seeking treatment or having medicines was the financial burden it posed on the household. It was found that in the previous place of treatment about 49% of the interviewees had to pay for the medicines themselves while about 45% of them received free medicines from government healthcare facilities.

<b>Who paid for the medicines</b>	<b>Frequency</b>	<b>Percent</b>
Completely borne by the patient	44	48.9
Free of cost	40	44.4
Did not take medicines	6	6.7
Total	90	100.0
Data collected by author during field survey 2019-2020		

During previous episodes of illness, more than 35% procured medicines from the chemist shop, about 31% of received medicines from the public hospitals wherein they sought treatment. Only 13% received medicines from the government dispensaries and polyclinics. Less than 9% treated themselves with over-the-counter medicines; less than 5% received medicines from private hospitals and close to 7% did not seek treatment or take medicines.

<b>Table 5.20: Source of Procurement of Medicines in Previous Place of Treatment</b>		
<b>Place</b>	<b>Frequency</b>	<b>Percent</b>
Chemist shop	32	35.6
Public hospital	28	31.1
Govt. Dispensaries/Polyclinics	12	13.3
Over-the-counter	8	8.9
Did not take medicines	6	6.7
Private hospital	4	4.4
Total	90	100.0
Data collected by author during field survey 2019-2020		

In the case of diagnostic tests, more than 46% never got tests done. Although more than 35% sought treatment in public hospitals, only half of them got tests conducted there, although tests are conducted free of cost or at a nominal fee. However, some patients prefer to consult the doctor in the clinic but get their diagnostic tests done in private laboratories because of two main reasons – private laboratories usually provide test results within the same day compared to mohalla clinics which take 3-4 days for the reports to be ready; the patients do not have faith in the accuracy of the results provided by these clinics. Although free treatment is available in the government hospitals, the over-crowding and long queues for accessing all services are often discouraging for the patients. About 15% preferred private clinics for diagnostic tests. The mohalla clinics also serve as double way

referral system. About 9% of the interviewees have been referred to mohalla clinics for tests from government healthcare units such as public hospitals, government dispensaries or polyclinics. Less than 5% conducted diagnostic tests in private hospitals.

<b>Table 5.21: Place Where Diagnostic Tests Were Done</b>		
<b>Place</b>	<b>Frequency</b>	<b>Percent</b>
Never got tests done	42	46.7
Public hospital	16	17.8
Private clinic	14	15.6
Referred to Mohalla Clinic for tests	8	8.9
Did not seek treatment/take medicines	6	6.7
Private hospital	4	4.4
Total	90	100.0
Data collected by author during field survey 2019-2020		

Of the 22 patients who had been prescribed tests by doctors in mohalla clinics, 16 of them had got their tests done in the clinic, while the remaining 6 did not get their tests done yet. However, some of them said that they would get it done the following day. Since the facility of diagnostic tests is available within the clinics free of cost, there is less chance that people will avoid getting tests done. Hence the line of treatment can be more effective as the doctor can detect and continue treatment accordingly.

These clinics have been particularly helpful for people who do not afford to seek treatment in private clinics or hospitals. An old man opines,

*‘...private hospital mein toh dakaiti ka dhanda hai...seedhi saadhi loot...agar panel mein nahi hai, toh bahut dikkat hai...mera toh Fortis mein free hai...’*



Translated – ‘...private hospitals are burglary businesses...they loot you openly...if the hospital is not in the panel (of free healthcare scheme usually provided by companies) then it becomes difficult...for me treatment in Fortis is free...(since he is a retired employee of Air India)

(Male, 84 years, no illness, only gets annual health check-up done at Fortis)

Another person says that his family prefers private clinics over government health care facilities because of long queues and time for which one has to wait before seeing the doctor.

He says,

*‘...sarkari jagah mein jaan pehchaan ho toh theek hai...nahin to mushkil hai...’*

Translated – ‘...if you know someone in government places (health care facilities) then it is alright...otherwise it is difficult...’

(Male, 45 years, grocery shop owner)

The section of population which is slightly better economically, however, prefers to avoid treatment in these clinics. A household (business family, located about seven minutes away from the clinic) are skeptical about the treatment dispensed in government health care facilities. A middle aged lady and her son unanimously say that they do not have faith in public health care facilities and prefer to visit a private clinic located about 20 minutes away from their residence for minor illnesses. For serious ailments they visit Max Hospital or Apollo Hospital because although they are expensive, they are trustworthy. Despite the physical proximity of the mohalla clinic they have never visited it. They prefer private health care facilities – private practitioner for consultation and private

laboratories for diagnostic tests. On further inquiry into why they do not have faith in public institutions, the young man said,

“when I was a kid, a friend of mine sustained a bone fracture in his right hand while playing... He was taken to a public hospital where the doctors could not do the setting [of the bone] correctly... now he has a bent hand... So we don't trust public hospitals...” (Male, son of a business man, double-storied house, economically well-off)

However, this attitude is not only confined to a particular class, but is common also among economically weaker sections. Therefore it can be concluded that proximity or user-fees are not the only factors which determine the access to a particular health care facility. To seek answer to this anomaly, the factor of acceptability has to be studied with reference to affective care.

### ***5.3.5 Acceptability***

Acceptability, according to Penchansky and Thomas (1981), refers to the relationship between the clients' attitude about the characteristics of the health care providers and their actual characteristics and also the health care providers' attitude about the acceptable characteristics of the clients. The idea of affective care as propounded by Lee et. al. (2010) and Ergler et. al. (2015) has also been included within this parameter alongwith the idea put forward by Penchansky and Thomas (1981).

While the patients visit the clinic, they have some expectations about what facilities shall be available in the clinic, what type of treatment they shall receive and how the health care workers will treat them and behave with them. Of the 76 patients who sought

treatment in mohalla clinics, about 71% said that they were adequately satisfied with the behaviour of the doctor and staff in the clinic; about 21% said that they were somewhat satisfied while about 8% of them said that they were less than satisfied with the behaviour of the doctor and the staff in the clinics.

<b>Table 5.22: Level of satisfaction regarding the behaviour of the doctor and the staff in the clinics</b>		
<b>Attitude of the doctor</b>	<b>Frequency</b>	<b>Percent</b>
Less than satisfied	6	7.9
Somewhat satisfied	16	21.1
Adequately satisfied	54	71.1
Total	76	100.0
Data collected by author during field survey 2019-2020		

While some attributes of the doctors may be in tune with the expectations of the patients and thus may be highly acceptable, some others may not be readily acceptable by them. Gender, age, religion, caste of the doctor might be some decisive attributes for the patients which influence their access to health care in that particular clinic. In our country where caste and religion play significant roles in the society, an upper caste person might not be ready to accept treatment from a lower caste health care provider. It is not uncommon for people to select doctors based on their surname, which often reveals their caste or *jati*. In case of mohalla clinics, seeking treatment is supposed to depend upon the need for treatment and the availability of the clinic within the neighbourhood. Therefore the selection or elimination of doctors based on this criterion is not significant. However, gender and age of the doctor plays an important role. Female patients have often revealed that they do not feel

comfortable seeking treatment from a male doctor. However, it is not true in case of male patients who are mostly indifferent to the gender of the doctor and have lesser inhibitions in seeking treatment from female doctors. Following is an excerpt from an interview with a lady who had come to visit the doctor (male doctor) at the clinic in South West district. On further probe whether any of her family members also seek treatment at mohalla clinics, she said that her daughter also needs to visit a doctor but would prefer not to come to this clinic.

‘...I am having eye irritation for the last few days...met the doctor...he is good...gave me medicines and eye drop... My daughter is 14 years old...suffering from some gynaecological problem...she is not comfortable with male doctor here...thinking of visiting Malviya Nagar Hospital...will meet lady doctor...’

(Middle aged lady, housewife, husband is a factory worker)

While the lady visited the male doctor and sought treatment, her daughter who is 14 years old is not ready to seek treatment from the male doctor, especially for gynaecological problem which is supposed to be kept a secret. Therefore, while opposite gender doctor is unacceptable for the young girl, for the mother he seems to be acceptable. They would rather spend money on travel to the hospital and also spend the entire day for treatment, but would avoid discussing gynaecological problems with the male doctor at the clinic. Some elderly women too share similar inhibitions.

In the clinic in North West district the scenario is quite different since the doctor is a female. Several ladies including pregnant women visit the clinic for their periodic examinations. At the same time, men also visit the clinic for treatment and also get testectomy done from the female doctor and the ANM who assists her. These men do not

have any inhibition regarding the gender of the doctor and say that they are only bothered about the treatment that they are receiving.



*Figure 5.5: The bed in the clinic in North West district where vasectomy is performed. Photograph by author during field visit, February 2020.*

Since primary health care services are the first point of contact with the health care system, it is important for the providers as well as the recipients of the care to feel at ease during the process of treatment. Unless the patient feels comfortable with the doctor, he/she will not be able to share the difficulties he/she is facing. While treatment is important in its effective sense, affective care is also significant for the patient. Patients not only seek effective cure but also affective care (Lee, 2010; Ergler et. al., 2015). According

to the patients, the attitude of the doctors and the staff of the clinic is important for them, besides the treatment that they are providing. All the patients said that they want affective care by the doctor and the healthcare staff in the clinic. They said that friendly and affectionate attitude of doctor makes them feel secured, reinforces trust in the doctor, helps in a participatory approach in treatment and also helps them to follow instructions in a better manner. Therefore, affection from the doctor enhances the treatment imparted by the doctor.

*‘...Pyaar se pesh aayenge toh aadhi beemari theek ho jaati hai...’*

Translated, if he (doctor) speaks affectionately, half the disease gets cured...

(Middle aged man, grocery shop owner)

Another lady who has been seeking treatment at the South West district clinic for hypothyroidism and back ache says that the doctors and the staff are extremely affectionate and caring. The assistant explains the medicines properly and the doctor listens to all her problems carefully and prescribes medicines.

*‘...Doctor said you will be fine soon...’*

(Female, 55 years old, housewife, suffering from hypothyroidism and chronic back ache, stays 10 minutes away from the clinic, visiting the clinic since 4 months).

When the doctor assures the patient that the disease will be cured and he/she will get well, it is motivating for the patients. On the other hand if the attitude of the health care providers is not warm and welcoming for the patients, they do not feel comfortable and often do not return to the clinic for the second time. A young lady opines that though her residence

is about 20-25 minutes away from this clinic, yet she prefers to seek treatment here because it is less crowded and she receives better treatment here.

*'...bees pachees minute lagta hai...auto se... Batra paas padta hai lekin yahan acha lagta hai...doctor acha ilaaj karta hai...'*

Translated – ‘...it takes 20-25 minutes by auto to reach this place... Batra is closer but I feel good here...doctor provides good treatment...’

(Female, 30 years, stays at Deoli Khanpur, seeking treatment for hypothyroidism)



**Figure 5.6: The doctor in the clinic in North West district examining a child as her mother looks on. Photograph by author during field visit, March 2020**

The confinement of drinking water facility within the room of the doctor in the clinic in South West district is not acceptable for the patients. According to

them, this attitude of the healthcare workers is a manifestation of casteist and classist mentality and is unacceptable for them. Drinking water is a basic necessity and should be made available for all those who visit the clinic. While some other patients are of the opinion that keeping the drinking water facility inside the doctor's chamber will help to keep it clean and hygienic.

Most of the interviewees visiting these clinics belong to lower income group who have lower levels of education. Women belonging to this group are further less educated and often have difficulty in understanding the instructions given by the doctors and the staff. They often request the pharmacists to repeat the methods of taking the medicines to which they do not receive a satisfactory response. The attitude of the health care providers when people repeatedly ask about the medicines or tests is not warm and welcoming for all the patients. While some patients were happy with their method of explanation, others complained about their rudeness and impatience. A female patient said that the assistant working in the clinic in South West district is a little rude to the patients but it is acceptable because she handles a lot of patients from the morning and she is also pregnant, therefore she becomes rude.

On the other hand, the doctors sometimes have a tough time to make the patients follow their instructions. For instance, a lady who has undergone hysterectomy about a month ago and is also suffering from stones in her gall bladder has been repeatedly instructed by the doctor of the North West district clinic to avoid spicy and oily food. She often does not follow the instruction and continues to have spicy food, as a result of which she suffers from acute pain in her stomach. One day she came to the doctor complaining about her pain and requested her to refer to the government hospital for gall bladder



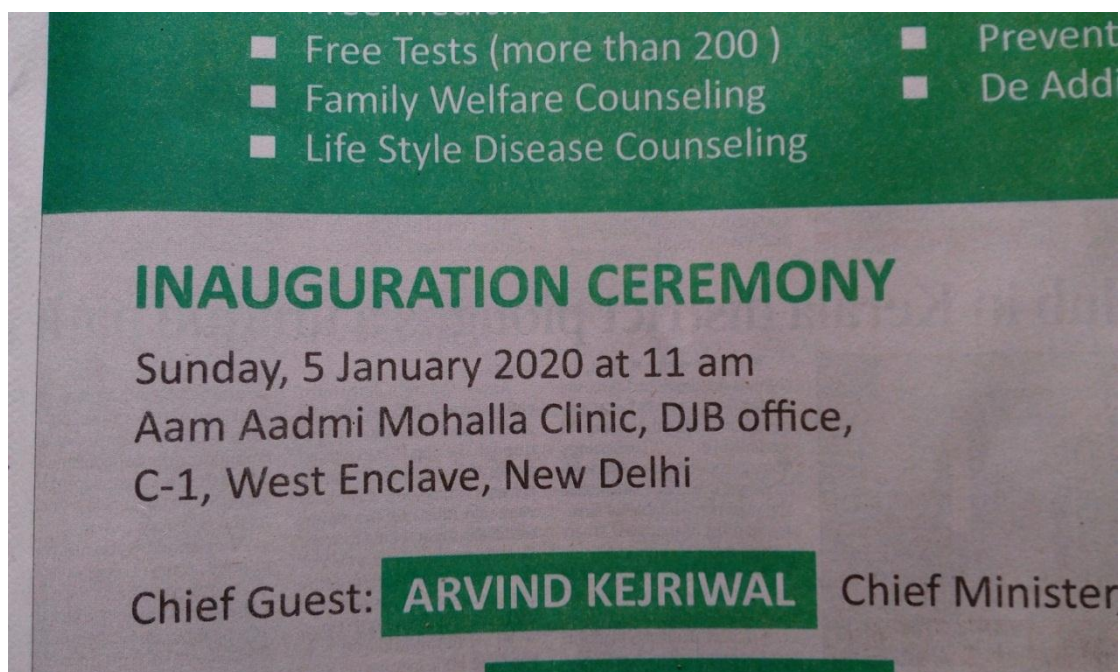
operation. The doctor tried to explain that her pain can be controlled if she refrains from having spicy food and also says that gall bladder operation cannot be performed before at least three months elapse after her hysterectomy. Doctors also often find it difficult to convince patients to come to the clinic for stipulated antenatal and postnatal check-ups since the patients often do not understand its significance and hence do not provide a positive response.

### **5.3.6 Awareness**

The aspect of awareness was added to Penchansky and Thomas' model of healthcare access by Saurman in 2016. Awareness about the existence and importance of a health care service is inseparable from the dimensions of access. Saurman (2016) argued that besides the five dimensions of access as mentioned by Penchansky and Thomas (1981), awareness has a significant role to play. The existence of a health service, its uses and importance should be made known to the people through appropriate and effective communication strategies. Awareness is not only limited to knowing about the existence of a particular service but also understanding why it is important and how and when to use it.

Elaborate programmes are organized on the inauguration ceremony of these clinics starting from life-size posters on the road side to advertisement in the newspapers, providing information through social networking sites such as twitter and intimation through short messaging service and whatsapp by the local MLAs and political party activists. One such inaugural programme held on 5<sup>th</sup> January 2020 at West Enclave, Pitampura to mark the establishment of 150 new clinics in the New Year had grand arrangements. The chief guest at this programme was the Chief Minister of Delhi – Arvind Kejriwal and Minister of

Health – Satyendra Jain along with the Chief Nodal Officer of AAMC project cell – Shelley Kamra. About 500 people had come to the programme where the stake holders discussed in detail about the health care system in Delhi under the present government and specially the mohalla clinic project which they had undertaken. They blamed the Lieutenant governor for the delay in approving the mohalla clinic project proposal, as a result of which they could not fulfill their target of 1000 clinics. They promoted the usefulness of these clinics and encouraged the audience to visit them for various health care facilities. They also promised that they would fulfill their target of 1000 clinics in the early period of their next term. On the same day other locations in Delhi such as Kusumpur Pahari also had similar inaugural programmes presided over by the respective MLAs. Such programmes had been held earlier too but this is of particular importance as this was the last Sunday before the election protocols would come into effect (as elections were scheduled on 8<sup>th</sup> February 2020).



*Figure 5.7: Advertisement showing detail of the inauguration ceremony, The New Indian Express, 5<sup>th</sup> January, 2020.*



*Figure 5.8: Chief Minister Arvind Kejriwal addressing the crowd at the inaugural ceremony in West Enclave, Pitampura, on 5<sup>th</sup> January, 2020. Photograph by author.*

Despite such programmes, many people were unaware of the existence of a particular clinic although it is located very close to their residence. Is it due to the ignorance on the part of the people or is there a lack of information from the part of the government is of question. On further inquiry the patients said that they have seen the clinic but did not know what all facilities were available in the clinic. A middle-aged lady who was seeking treatment in the clinic in South West district said,

*‘...mujhe aj pata chala yahan khoon ka jaacnh bhi hota hai!...Ab se yahin karwaungi’*

Translated as – ‘...I came to know today that blood tests are also conducted here!...From now onwards I will get them (blood tests) done here itself...’

(Female, 51 years old, widow, seeking treatment for diabetes in mohalla clinic for one year).

Some other patients who did not know about the existence of the clinic at all said that since they always consult private physicians, the need to know about a government clinic did not arise. The doctors however said that health camps are organized by the government wherein the availability of mohalla clinic facility is discussed. The clinic in North West district also has ANMs who go around in the neighbourhood and facilitate in providing information to people about the clinic and the facilities available. All respondents were asked whether they were aware of the existence of the mohalla clinics in their locality, irrespective of whether they ever sought treatment there. It was found that neighbours formed the most important information base as about 58% of them came to know about mohalla clinics from their neighbours. The next important sources of information were friends and relatives who contributed to 16% of the respondents. About 9% of the respondents were referred from other government healthcare units where they had sought treatment previously. Only about 2% came to know about mohalla clinics from media such as newspapers and a similar percentage of people learnt about it by seeing the clinic by himself/herself. The remaining 13% were unaware of the existence of a healthcare facility in the form of a mohalla clinic in the locality. Of the 76 people who seek treatment in mohalla clinics, 68.5% came to know about the clinics from their neighbours, 18.4% from their friends and relatives, 10.5% were referred from other government healthcare units and less than 3% learnt about it from media. This clearly shows the role of social capital as an

important source of information regarding the existence of healthcare facility in the form of mohalla clinic in the locality.

<b>Table 5.23: Source of Awareness about Mohalla Clinics</b>				
<b>Source</b>	<b>All Respondents</b>		<b>Patients who seek treatment in mohalla clinics</b>	
	<b>Frequency</b>	<b>Percent</b>	<b>Frequency</b>	<b>Percent</b>
Neighbours	52	57.8	52	68.5
Friends and relatives	14	15.6	14	18.4
Referred from other govt. facility	8	8.9	8	10.5
Newspapers	2	2.2	2	2.6
Saw the clinic himself/herself	2	2.2	0	0.0
Not aware of Mohalla Clinic	12	13.3	0	0.0
Total	90	100.0	76	100.0
Data collected by author during field survey 2019-2020				

The doctors also take initiative in creating awareness among the people about various diseases, their symptoms, prevention and cure, vaccination and family planning measures. One important way is through the charts and posters decorated on the inner walls of the clinics. Some of the charts are associated with the performance of the clinics – the facilities available in the clinic, the number of patients visiting the clinic for various services, diagnostic tests performed, medicines available and so on. Posters mainly display special programmes and services for the people and also include information about various diseases – their symptoms, precautionary measures and treatment. In the opinion of the doctors and the staff, these charts and posters are tools of providing information and creating awareness among the people. For example in the North West district clinic, the posters showing the

importance vasectomy as a family planning programme are worth mentioning. While the patients wait for their turn to see the doctor, through these posters they can gain awareness and become cautious about various diseases and know how they can recognize the symptoms or prevent themselves from these diseases. However, it is also important where these posters are put up. In the clinic in south west district, the posters are placed on the wall behind the seats of the patients. Therefore the usefulness of these posters is to be questioned. It is less likely that the patients will turn back and read the posters while seated. The doctor in the clinic in south west district also said that leaflets were distributed among residents of that area which described preventive measures of Vector borne diseases such as malaria, dengue, chikungunya and leprosy.



**Figure 5.9:** The inner walls of the clinic in South West district adorned with posters showing methods of prevention of vector borne diseases. Photograph by author during field visit, September 2019.





*Figure 5.10: The doctor in the clinic in North West district pointing to posters on the inner walls of the clinic which have been put up to create awareness about methods of health care. Photograph by author during field visit, January 2020.*

Most of the patients said that they have come to know about the clinic from neighbours and friends and others have just seen the structure (porta cabin) of the clinic or a poster indicating the location of the clinic. These people rely mostly on their social capital as their information base. Therefore, recommendation by a friend, neighbour or acquaintance of using a particular service is important for them as quoted below:

*‘...allergy hai pairon mein...pehle private mein dikhaya...padosiyon ne kaha clinic mein jaao...bahut acha hai...’*

Translated – ‘...I have allergy in my feet...consulted private doctor earlier...neighbours suggested this (mohalla) clinic... it is very good...’

(Female, 40 years, husband works in a shop).

Mechanic (1928) identified ‘seven general areas of medical care in which barriers to access develop: excessive cost, insufficient supply, poor distribution, inadequate scope, ineffective co-ordination, psychological and socio-cultural impediments to effective use, inadequate organizational arrangement and poor use of technology.’<sup>2</sup> However, with the development of mohalla clinics, most of these barriers have been diminished. Therefore these units can rightly be seen as primary health care units aimed at universal health care.

#### **5.4 Network with other health care units: Development of a two-way referral system**

There is double-way referral system established between mohalla clinics and other levels of healthcare in Delhi. The mohalla clinic doctors refer critically ill patients or those who need specialized treatments to dispensaries or government hospitals, or to procure medicines unavailable in the mohalla clinic. On the other hand, sometimes the doctors in the government dispensaries or hospitals also refer patients to mohalla clinics for performing diagnostic tests on an urgent basis. This will speed up the process of treatment and also reduce the burden of patients on the secondary and tertiary care hospitals. Therefore the

---

<sup>2</sup> David Mechanic, ‘Towards a coherent and co-ordinated health care policy: Issues for the development of policy options’, in Charles E. Lewis, Rashi Fein and David Mechanic (eds), *Right to Health: the Problem of Access to Primary Medical Care*, John Wiley and Sons, New York, 1928, p. 33



mohalla clinics have been important in creating a referral network among the health care units in Delhi.

The doctor in the clinic in South West district said that when any illness is beyond their treatment capacity, they refer the case to Safdarjung and Malviya Nagar hospital. They try to treat as many of the cases which come because if most of the cases are treated in these clinics, it will help to reduce the patient pressure on the secondary care hospitals. This double-way referral system has helped to strengthen the overall public health care system in Delhi by networking the various levels of the health system.

## **5.5 Conclusion**

The mohalla clinics are not only instrumental in providing healthcare at the doorstep but have also helped to increase the accessibility and utilization of healthcare services among all sections of the population. The women, children and the elderly who earlier faced several impediments in accessing healthcare can now easily seek treatment without having to depend on anyone. People who refrained from seeking treatment due to high opportunity costs and real costs, are now readily seeking treatment. The services are easily accessible and available at free of cost which makes it more acceptable and welcoming among the people. As these clinics expand and establish a more efficient network with other healthcare units, it will help in strengthening the overall healthcare system in Delhi. The data collected from the field, supported with the narratives of the patients, doctors, staff and officials, rightly direct towards the idea that these clinics are efficient primary healthcare units aimed at universal health coverage.

## **Chapter 6: A Summary of Conclusions**

This chapter summarizes the study and discusses the future prospects of the project. There are important correlations between any phenomenon in place and health because the characteristics of any place have a profound impact on the health of people. Place is not considered merely as physical location but as different attributes affecting health. Space and place play an important role in the availability, accessibility and utilization of health care services. Access to health care refers to the ease with which an individual can obtain the necessary medical services but the access is conditioned on the availability or supply of the services. Access has been defined differently by different scholars. However, in this study, the access to healthcare model by Penchansky and Thomas (1981), which has been later modified by Saurman (2016) has been considered. This model includes six aspects which define access to healthcare – availability (the adequate supply of health care infrastructure), accessibility (depends on the spatial and geographical location of health care providers and their uses, whereby travel costs and time are taken into account), accommodation (describes the organizational structures of health care service such as appointment system, opening hours), affordability (the need for patients to have financial means to use the available health care) and acceptability (relationship between user's attitude towards the providers and vice-versa) and awareness (which was added by Saurman). This model of access to healthcare has been adopted in this study to assess the role of mohalla clinics in enhancing the accessibility and utilization of healthcare services in Delhi. The following conclusions may be made from this study:

- Universal Health Care (UHC) or Health for All rests on the principle of Health as Human Right. UHC enunciates that affordable and accessible healthcare facilities at all levels should be provided to every person irrespective of their social-cultural and economic background. Daniels (1975) argues that access to health care should be available to anyone in medical need and non-medical characteristics of individuals such as gender, race, geographical location or their ability to pay should not be decisive factors in accessing health care. Health policies in India have albeit reaffirmed provisioning of healthcare services to all.

- The inadequacy of public healthcare facilities and burgeoning presence of private healthcare providers have complicated the health scenario in India. While affordable healthcare is available in public healthcare facilities, the quality is often less than satisfactory and is accompanied by huge opportunity costs in the form of missing work and forgoing wages. As a result people are compelled to seek treatment in private healthcare units which take a heavy toll on the pocket. Simultaneously, there is a group of people present who do not seek treatment at all since they are unable to fit in within either of the aforementioned healthcare models. These act as impediments in the way to achieving UHC in India.

- While it is recognized that the integration of all three levels of healthcare is crucial for the achievement of UHC, the role of primary healthcare services deserve special mention mainly because of two reasons. In the first place, primary healthcare units are the first points of contact with the healthcare system and can function as effective centres of prevention and control, besides curative care. Secondly, primary healthcare units are instrumental in achieving health for all.

- The importance of primary healthcare has been mentioned since the Bhole Committee report of 1946 and has been reaffirmed in the subsequent health policies that have been outlined in India.

- In India, there is an overwhelming population pressure on the secondary and tertiary public healthcare services, especially because of the availability of integrated services in one place. In Delhi the situation becomes more challenging since the population density is already high and people from neighbouring states also seek care besides the actual population of Delhi. High patient pressure leads to poor accessibility – longer waiting time to see the doctor, quality of healthcare below satisfactory level among others. The problem becomes worse as the availability is not at par with the population of the respective regions. All these factors along with the socio-economic characteristics of the population lead to an underutilization of existing healthcare resources. Hence UHC remains a far-fetched dream.

- It is imperative to develop a model of primary healthcare such that affordable, accessible and quality facilities are available in close proximity to the residential areas and the pressure on tertiary care services are reduced so that specialized care may be paid more attention to. Mohalla Clinics in Delhi are primary healthcare units which are an effective way to achieve this end.

- About 485 such clinics (till December 2020) distributed across Delhi are treating patients for minor illnesses such as fever, common cold, diarrhoea and chronic illnesses such as hypothyroidism, diabetes and others. Although the target of 1000 clinics is far from being achieved, the functions being performed by them are praiseworthy. Despite several bureaucratic tussles and shortcomings in the initial phase of the project, these clinics are acting as role models for primary healthcare system in many places such as Pune and

Hyderabad. They have also earned international recognition from the General Secretary of the UN and then Norwegian Prime Minister.

- A flagship project by AAP since 2015, these clinics often treat as many as 150-200 patients per day and offer them free consultation by the doctor, free medicines as well as conduct diagnostic tests without any user fee.

- These clinics were initially supposed to be established in portable cabins. However, in the initial stages, problems in the form of unavailability of premises emerged. Later, the government resorted to rented premises for establishing mohalla clinics.

- Doctors, pharmacists and office attendants are empanelled on a regular basis and are paid according to the number of patients treated, with a minimum guarantee of 75 patients per day. Despite the delay in the new clinics coming up, they have been successful in improving the existing healthcare infrastructure in Delhi.

- The dependent sections of the population such as women, children and the elderly, now have the opportunity to access and utilize healthcare services within their localities without having to depend upon anyone. These clinics have been instrumental in provisioning healthcare at the doorstep and by increasing the accessibility to healthcare services.

- In this study, three functions of these clinics have been emphasized: enhancement of accessibility and utilization of primary healthcare services in Delhi; creation of linkages with other levels of healthcare services; role played by these clinics during COVID-19 pandemic. All these taken together can strengthen the healthcare infrastructure in Delhi and aid in achieving UHC.

- Field survey carried out in selected clinics in Delhi has revealed that people in the vicinity of the clinics have benefitted from the free and quick services of satisfactory quality provided in these clinics. Since these clinics are located in the neighbourhood, the benefits are manifold. Travel time and travel costs have reduced, women, children and the elderly can seek healthcare without having to depend on any male member to accompany them to the healthcare facility, opportunity costs are reduced to nil as people do not have to miss work and forgo wages to seek treatment, people do not have to visit quacks and private doctors for treatment.

- These clinics provide a range of facilities under one roof, which is beneficial for the patients since they can consult the doctor, get medicines and also get diagnostic tests done in one place – without having to pay for it. It prevents patients from the trouble of getting each service at a different place.

- Facilities such as compulsory immunization of children, family planning programmes such as vasectomy, maternal programmes such as ante-natal and post-natal care are also being provided in some of the clinics, which shall be expanded to the rest in the near future.

- These clinics have also successfully created a network with higher levels of healthcare facilities. They function as two-way referral services: the complicated cases or cases which need specialized care are referred to government polyclinics, dispensaries or government hospitals. Diagnostic tests such as X-ray and ultra sound which are unavailable at mohalla clinics are also referred to government hospitals. On the other hand, the patients who are seeking treatment at government hospitals often have to wait for a long time for their turn for diagnostic tests. Sometimes the doctors refer them to mohalla clinics where

they can get their tests done quickly and get their reports soon. In this way, the process of treatment is expedited. The introduction of the mohalla clinics has strengthened the referral network within the government healthcare units in Delhi, which is an important step towards UHC in Delhi.

- During the COVID-19 pandemic, these clinics have helped to continue treatment especially for the non-COVID cases. During the time of lockdown when secondary and tertiary care hospitals were filled with COVID patients and people with other diseases were afraid of seeking treatment due to chances of cross-infection, these clinics were active in providing treatment to all kinds of patients. Due to non-availability of adequate transport facilities healthcare staff were unable to reach the clinics. As a result some clinics had to remain closed temporarily. However, the government recognized the importance of these clinics during this crucial time and hence facilitated the transport for the doctors and staff of these clinics.

- At the onset of the pandemic, due to unavailability of adequate protection equipment for the doctors and staff, some doctors contracted COVID-19 infection from the patients. Gradually this problem was solved and as the pandemic progressed and more people had to be brought under the testing net, RT-PCR and RAT facilities were extended in these clinics.

- ASHA workers and ANMs engaged with these clinics have undertaken awareness drive in the locality for COVID-19. Therefore, during the pandemic, these clinics have been crucial in detecting new cases and hence controlling the spread of infection. These clinics are also expected to play a vital role during the inoculation drive for COVID-19.

- As these clinics expand and establish a more efficient network with other healthcare units, it will help in strengthening the overall healthcare system in Delhi. The data collected from the field, supported with the narratives of the patients, doctors, staff and officials, rightly direct towards the idea that these clinics are efficient primary healthcare units aimed at universal health coverage.
- In the future, these clinics aim to expand their functions beyond OPD treatment and diagnosis. The data generated relating to every patient is being recorded and stored so that it can be retrieved at a later date for continued treatment. This data can also be used for further study and research regarding disease pattern and epidemiology which can be helpful in framing health policies.
- Although the target of 1000 clinics has not been achieved, yet these clinics hold high promise for amelioration of the existing healthcare system in Delhi. Despite the existing flaws and impediments, these clinics have been successful in revamping the medical landscape of Delhi. In an era of privatization of healthcare services, the mohalla clinics stand as instruments of transformation.
- Some families, although living close to the clinic, either are not aware of the existence of these clinics or do not prefer to seek treatment there. This depicts the revulsion towards availing public healthcare facilities. People often have the perception that quality treatment is not available in a public facility or seeking healthcare in a public facility involves long waiting hours. But the scenario in a mohalla clinic is completely different and promising. The government may undertake more initiatives to create awareness about the facilities that they can avail from these clinics. The aversion towards public healthcare



facilities has to be obliterated so that affordable healthcare can reach every individual irrespective of their background characteristics.

This decentralized model of primary healthcare provided by the government in the neighbourhood is a targeted model of healthcare delivery. However, the role that they can play in the future is often being undermined. The data of the patients seeking healthcare services in these clinics were supposed to be recorded and retrieved when he/she seeks treatment again. This data would also help in carrying out studies on epidemiology and hence help in policy formulations. It is therefore important that all data of all patients be recorded in a manner that can be retrieved when required.

Data regarding the functioning of these clinics should be made available in the public domain. This can be one way of spreading awareness about the utility of these clinics and reducing aversion towards public healthcare facilities. Since these clinics are located in the neighbourhood, the doctors have the advantage of working in actual conditions of the locality from where the patient belongs. This becomes particularly helpful to suggest preventive and promotive treatments besides curative ones, and contributes towards a participatory approach to healthcare.

On 9<sup>th</sup> March 2021, the Delhi Government has announced that 100 ‘Mahila’ Mohalla Clinics will be established in the year 2021-22, wherein gynaecological and maternal services will be provided to women in Delhi<sup>1</sup>. While this scheme might seem to be beneficial to females who can seek treatment there, some problems can also stem out from

---

<sup>1</sup> Highlights of Budget 2021-22, Govt. of NCT of Delhi. Accessed from <http://delhiplanning.nic.in/content/budget-delhi> on 18th March 2021, 5:46am.

the establishment of these clinics. In a situation where a lady wants to seek treatment in mohalla clinics along with any male member of her family, she has to visit both type of clinics as the ‘Mahila’ Mohalla Clinics will not provide treatment to males. While, these clinics may be exclusively directed towards female health related issues, the doctors present in these clinics may be males – which can be a hindrance to seeking healthcare by females. Problems might be faced by the transgender people who might not be entertained well in these clinics.

A more acceptable way of incorporating female healthcare facilities in these clinics is to have a female doctor specializing in gynaecology, besides the main doctor of the clinic. While all patients can seek treatment from the latter, females with gynaecological issues in particular would seek treatment only from the female doctor. A similar model operates in North West District wherein the doctor of the clinic is a female gynaecologist. While people seek treatment for all kinds of illnesses, the doctor also carries out gynaecological, family planning and immunization related work. Ante-natal and post-natal care is provided to women, vasectomy is performed on men as a family planning tool and children are also vaccinated.

These primary healthcare centres hold high promise of delivering affordable healthcare in the neighbourhood. However, there are several avenues which have to be explored in order to make these clinics more efficient in healthcare delivery. While it is argued as to which model of healthcare provisioning by the state is better – demand side model characterized by insurance or supply side model such as Mohalla Clinics, little remains unsaid that the latter holds enough promise towards health related SDGs. This model of primary healthcare provisioning can be easily replicated beyond the boundaries of

Delhi, especially in metropolitan cities and urban areas where large sections of population do not have access to primary healthcare services in their locality.

## Bibliography

1. Aam Aadmi Party 70 Point Action Plan: Delhi Assembly Election 2015. *Aam Aadmi Party*. Accessed from [https://aamaadmiparty.org/wp-content/uploads/2017/10/AAP-Manifesto-2015\\_70-Pt-Action-Plan.compressed.pdf](https://aamaadmiparty.org/wp-content/uploads/2017/10/AAP-Manifesto-2015_70-Pt-Action-Plan.compressed.pdf) on 1<sup>st</sup> March 2020 at 11:05pm.
2. Aday, L., & Anderson, R. (1974). A framework for the study of access to medical care. *Health Services Research, Vol. 9*, 208-220.
3. Agrawal, T., Bhattacharya, S., & Lahariya, C. (2020). Pattern of Use and Determinants of Return Visits at Community or *Mohalla* Clinics of Delhi, India. *Indian journal of community medicine. Vol. 45(1)*, 77–82.
4. Akhtar, R. & Izhar, N. (1984). Healthcare Delivery in India. *Indian Geographical Journal, Vol. 59* (1).
5. Akhtar, R. & Izhar, N. (1986). Inequalities in the Distribution of healthcare in India. *Geographical Aspects of Health and Disease in India*, 437-460.
6. Akhtar, R. (1978). Spatial Distribution and Growth of Health Facilities in Rajasthan. *Geographical Review of India, Vol. 40* (3), 206-214.
7. Akhtar, R. (1982). *The Geography of Health: An Essay and a Bibliography*. New Delhi: Marwah Publications.
8. Akhtar, R. (2004). *India: Health Care Patterns and Planning*. New Delhi: APH Publishing.
9. Alberta Medical Association. (1996). Primary Medical Care. Edmonton, Canada: Alberta Medical Association.

10. Anthamatten, P. & Hazen, H. (2016). *An Introduction to the Geography of Health*, India: Routledge (special Indian edition)
11. Arrow, K. (1963). Uncertainty and the Welfare Economics of Medical Care. *American Economic Review*, Vol. 52, 941-973.
12. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, National Health Authority, Ministry of Health and Family Welfare, Government of India, accessed on 11th October 2020, 1:25 am, from <https://pmjay.gov.in/about/pmjay>
13. Babu, N.M. (27<sup>th</sup> March 2020). Over 270 mohalla clinics shut in city. The Hindu. Accessed from <https://www.thehindu.com/news/cities/Delhi/over-270-mohalla-clinics-shut-in-city/article31187169.ece> on 23<sup>rd</sup> April 2020 at 2:34pm.
14. Babu, N.M. (7<sup>th</sup> April 2020). Staff unable to reach, 150 mohalla clinics shut in Delhi. The Hindu. Accessed from <https://www.thehindu.com/news/cities/Delhi/coronavirus-staff-unable-to-reach-150-mohalla-clinics-shut-in-delhi/article31284197.ece> on 23<sup>rd</sup> April 2020 at 5:16pm.
15. Bailwal, N., Kaushik, R. & Sah, T. (2020). Importance of Primary Healthcare in Delhi in the Times of COVID-19. *Indian Journal of Human Development*, Vol.14 (3), 527–535.
16. Bajpai, V. & Saraya, A. (2018). *Health Beyond Medicine: Some Reflections on the Politics and Sociology of Health in India*. New Delhi: Aakar Publication.
17. Banerji, D, (1996). Political Economy of Public Health in India. (295-314). In M. DasGupta, L.C.Chen & T.N. Krishnan (ed). *Health Poverty and Development in India*, Delhi: Oxford University Press.

18. Banerji, D. (1974). Social and Cultural Foundations of Health Services Systems. *Economic and Political Weekly*, Vol. 9 (32/34), Special Number, 1333-1335,1337-1341,1343,1345-1346.
19. Banerji, D. (1993). Simplistic Approach to Health Policy Analysis World Bank Team on "Indian Health Sector", *Economic and Political Weekly*, Vol. 28 (24), 1207-1210.
20. Baru, R. V. (1994), Structure and Utilization of Health Services: An Inter-State Analysis. *Social Scientist*, Vol 22 (9-12), 98-111.
21. Baru, R. V., Acharya, A., Acharya, S., Kumar, A.K.S. & Nagaraj, K. (2010). Inequities in Access to Health Services in India: Caste, Class and Region. *Economic & Political Weekly*, Vol. 45 (38), 49-58.
22. Basu, A. & Barria, S. (15<sup>th</sup> December, 2018). AAP's Health Policy Reforms in Delhi. *Economic and Political Weekly*, Vol. 53 (49), 16-21.
23. Bedi A. & Dasgupta, S. (12<sup>th</sup> July 2020). Star of Dharavi success, but few takers in Delhi — how fever clinics have fared across India. *The Print*. Accessed from <https://theprint.in/health/star-of-dharavi-success-but-few-takers-in-delhi-how-fever-clinics-have-fared-across-india/458166/> on 22<sup>nd</sup> July 2020 at 10:47pm.
24. Bedi, A. (4<sup>th</sup> September 2020). Delhi withdraws order roping in mohalla clinics for Covid tests, but doctors still anxious. *The Print*. New Delhi. Accessed from <https://theprint.in/india/delhi-withdraws-order-roping-in-mohalla-clinics-for-covid-tests-but-doctors-still-anxious/496048/> on 6<sup>th</sup> September 2020 at 6:20pm.

25. Bhandari, A, Bhardwaj, I & Sawhney, S. (2017). Quality and Accessibility of Government Hospitals and Mohalla Clinics, Delhi Citizens Handbook 2017. *Centre for Civil Society*, 94-125.
26. Brief Write up on Aam Aadmi Mohalla Clinics. *Health and Family Welfare, Govt. of NCT of Delhi*. Accessed from [http://www.delhi.gov.in/wps/wcm/connect/doi\\_health/Health/Home/Directorate+General+of+Health+Services/Aam+Aadmi+Mohalla+Clinics](http://www.delhi.gov.in/wps/wcm/connect/doi_health/Health/Home/Directorate+General+of+Health+Services/Aam+Aadmi+Mohalla+Clinics) on 19<sup>th</sup> March 2019 at 10:31 am.
27. Chatterjee, P. (2<sup>nd</sup> March 2016). Delhi Govt. Announces Pilot Project for Next 100 Mohalla Clinics. *The Indian Express*. Accessed from <https://indianexpress.com/article/cities/delhi/delhi-govt-announces-pilot-project-for-next-100-Mohalla-clinics/> on 28<sup>th</sup> March 2019, 10:24am.
28. Chawla, M. (3<sup>rd</sup> January 2018). Mohalla Health in Porta Cabins in photographs. *The Citizen*. Accessed from <https://www.thecitizen.in/index.php/en/newsdetail/index/9/12666/mohalla-health-in-porta-cabins> on 20th August 2018, 5:35pm.
29. Choudhary, B.K. (8<sup>th</sup> November 2014). Health, illness and disease: A Political Ecology Perspective. *Economic and Political Weekly*, Vol. 49 (45), 60-68.
30. Constitution of the World Health Organisation (1946). *World Health Organisation*. Accessed from [https://www.who.int/governance/eb/who\\_constitution\\_en.pdf](https://www.who.int/governance/eb/who_constitution_en.pdf) 18th August 2019 at 4:20pm.
31. Daniels, N. (1975). *Just Health Care*. Cambridge: Cambridge University Press.
32. Davidson, J., Bondi, L. & Smith, M. (2007). *Emotional Geographies*. England: Ashgate Publishing Limited.

33. Deodhar, N. S. (March 1982). Primary Health Care in India. *Journal of Public Health Policy*. Vol. 3 (1), 76-99.
34. District Level Household and Facility Survey 2007-08, *Ministry of Health and Family Welfare*, Government of India, 2010
35. Donabedian, A. (September 1988). The quality of care: how can it be assessed? *JAMA*, Vol. 260 (12), 1743-1748
36. Donaldson M., Yordy K., Lohr K. & Vanselow N. (Eds). (1996) *Primary Care: America's Health in a New Era*. Institute of Medicine. Washington, DC: National Academy Press.
37. Duggal, R. (2018). A financing strategy for Universal Access to Health Care: Maharashtra Model. In P. Prasad & A. Jesani (Eds), *Equity and Access: Health Care Studies in India*, (339-359). India: Oxford University Press.
38. Dutt, A. (11<sup>th</sup> July 2020). Rapid tests begin at Delhi govt dispensaries. Hindustan Times. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/rapid-tests-begin-at-delhi-govt-dispensaries/story-PoClOUssOK3oBXlAQduERK.html> on 12<sup>th</sup> July 2020 at 10:52pm.
39. Dutt, A. (1<sup>st</sup> April 2020). 2nd Delhi mohalla clinic doctor's contacts being traced. Hindustan Times. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/2nd-delhi-mohalla-clinic-doctor-s-contacts-being-traced/story-PcZukzXNblzBrvy70Y3YL.html> on 3<sup>rd</sup> April 2020 at 7:31pm.
40. Dutt. A. & Chitlangia, R. (30<sup>th</sup> April 2020). In times of Covid-19, mohalla clinics, small hospitals take lead in treating other illnesses. *Hindustan Times*. New Delhi. Accessed



from <https://www.hindustantimes.com/delhi-news/in-times-of-covid-19-mohalla-clinics-small-hospitals-take-lead-in-treating-other-illnesses/story-vdjilQYPfZcSEpAoxRIDDO.html> on 22<sup>nd</sup> July 2020 at 9:43pm.

41. Emily S. (January 2016). Improving access: modifying Penchansky and Thomas's Theory of Access. *Journal of Health Services Research & Policy*. Vol 21 (1), 36-39.
42. Ergler, C., Sakdapolrak, P., Bohle, H.G. & Kearns, R. (2015). From Effective Cure to Affective Care: Access Barriers and Entitlements to Health Care Among Urban Poor in Chennai, India. In I. Luginaah & R.B. Kerr (Eds.), *Geographies of Health and Development* (93-113). England: Ashgate Publishing Limited.
43. Eyles, J. & Woods, K. (1983). *The Social Geography of Medicine and Health*. London: Croom Helm.
44. Flick, U. (2014). *An Introduction to Qualitative Research*, London: Sage.
45. Gavin J.A. (2018). Health and Place. In T. Brown et. al. (Eds.) *Health Geographies: a critical introduction* (39-56). New Jersey: Wiley Blackwell.
46. Ghai, O.P. (1985). *Management of Primary Health Care*. New Delhi: Interprint.
47. Ghosh, S. (10<sup>th</sup> August 2019). 36 Mohalla clinics to start working on 12-hour shifts. *The New Indian Express*. New Delhi. Accessed from: <https://www.newindianexpress.com/cities/delhi/2019/aug/10/36-mohalla-clinics-to-start-working-on-12-hour-shifts-2016924.html> on 18th August 2019, 8:36pm.
48. Goswami, S. (26<sup>th</sup> March 2020). Covid-19 lockdown: Essential services allowed, mohalla clinics won't be shut, says Kejriwal. Hindustan Times. New Delhi Accessed from <https://www.hindustantimes.com/delhi-news/covid-19-lockdown-essential-services->

allowed-mohalla-clinics-won-t-be-shut-says-kejriwal/story-mh6781SxWIBjo9nuIwJKVL.html on 30<sup>th</sup> March 2020 at 9:56pm.

49. Goswami, S. (2<sup>nd</sup> September 2020). Delhi govt. says efforts on to double Covid-19 testing, but in gradual manner. Hindustan Times. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/delhi-govt-says-efforts-on-to-double-testing-but-in-gradual-manner/story-kPcq1sXV80VFO6NEUXJ1eL.html> on 4<sup>th</sup> September 2020 at 5:20pm.
50. Goswami, S. (3<sup>rd</sup> September 2020). The Health Minister also proposed if in selected mohalla clinics general OPD services could be shut and they could be converted into temporary COVID-19 testing centres. Hindustan Times. New Delhi. Accessed from <https://www.hindustantimes.com/india-news/how-delhi-is-ramping-up-its-covid-19-testing/story-ptKkzt8DCJ3lyFIxXkWzYN.html> on 4<sup>th</sup> September 2020 at 5:24pm.
51. Government of India, National Family and Health Survey 4 – India Report, 2016, Ministry of Health and Family Welfare.
52. Government of India. (1983). National Health Policy. *Ministry of Health and Family Welfare*, New Delhi.
53. Government of India. (2002). National Health Policy. *Ministry of Health and Family Welfare*, New Delhi.
54. Government of India. (2017). National Health Policy. *Ministry of Health and Family Welfare*, New Delhi.
55. Green, J. & Thorogood, N. (2004). *Qualitative Methods for Health Research*, London: Sage.

56. Hazarika, N., Srinivasan, N. & Sharma, T. (2016) Mohalla Clinics: Will they address the health needs of Aam Aadmi in Delhi? Delhi Citizens Handbook 2016. *Centre for Civil Society*, 130–147.
57. Hsiao, W.C. (2003). What is a Health System? Why Should We Care. Working Paper Series, Department of Health Policy and Management, *HSPH*.
58. Human Rights. *World Health Organisation*. Accessed from [https://www.who.int/topics/human\\_rights/en/](https://www.who.int/topics/human_rights/en/) on 14th September 2019, at 4:24 pm.
59. Hunter, J.M., Shannon, G.W. & Sambrook, S.L. (1986). Rings of Madness: Service Areas of 19<sup>th</sup> Century Asylums in North America. *Social Science and Medicine*, Vol. 23 (10), 1033-1050.
60. Hyma, B., Ramesh, A. and Iyengar, N.L.S. (April 1986). Geographical Approach towards the Study of Health-Care System. *Ancient Science of Life*. Vol. V (4), 216- 227.
61. Izhar, N. (2004). *Geography and Health: A Study in Medical Geography*. New Delhi: APH Publishing Corporation.
62. Joseph, A. & Phillips, D. (1984). *Accessibility and utilization: Geographical perspectives on health care delivery*, London: Harper & Row.
63. Kahol, K. & Balasubramaniam, P. Health Technology Infrastructure for Universal Health care. *Public Health Foundation of India*.
64. Kapadia-Kundu, N. & Kanitkar, T. (Dec. 21-27, 2002). Primary health care in urban slums. *Economic and Political Weekly*, Vol. 37 (51), 5086-5089.
65. Kayastha, S.L. & Singh, M.B. (1984). Spatial Temporal Analysis of Health Facilities in India, *National Geographer*, Vol. 19 (2). 115-125.

66. Kearns, R.A. & Moon, G. (2002). From medical to health geography: novelty, place and theory after a decade of change. *Progress in Human Geography*, Vol. 26 (5), 605–625.
67. Kearns, R.A. (1993). Place and Health: Towards a Reformed Medical Geography. *Professional Geographer*, Vol. 45 (2), 139-147.
68. Kumar, A. & Gupta, S. (2012). Health Infrastructure in India: Critical Analysis of Policy Gaps in the Indian Health care Delivery. *Vivekananda International Foundation*, Occasional Paper.
69. Lahariya C. (2020). Access, utilization, perceived quality, and satisfaction with health services at Mohalla (Community) Clinics of Delhi, India. *Journal of Family Medicine and Primary Care*, Vol. 9, 5872-5880.
70. Lahariya, C. (2017). Mohalla Clinics of Delhi, India: Could these become platform to strengthen primary health care? *Journal of Family Medicine and Primary Care*, Vol. 6 (1), 1–23.
71. Lahariya, C. (27 May 2017). Decongest hospitals with Mohalla clinics. *Deccan Herald*, Bengaluru. Accessed from <https://www.deccanherald.com/content/613762/decongest-hospitals-Mohalla-clinics.html> on 20<sup>th</sup> March 2019, 5:40pm.
72. Lahariya, C. (January 2016). Delhi's Mohalla Clinics Maximising Potential. *Economic & Political Weekly*, Vol. 51 (4), 15-17.
73. Lahariya, C. (June 2018). 'Ayushman Bharat' Program and Universal Health Coverage in India. *Indian Pediatrics*, Vol. 55, 495-506.
74. Lahariya, C., Kang, G. and Guleria, R. (2020). *Till We Win: India's Fight against the COVID-19 Pandemic*, Gurgaon, India: Penguin.

75. Lahariya, C., Sundararaman, T., Ved, RR., Adithyan, G S, De Graeve, H., Jhalani, M. & Bekedam, H. (2020). What makes primary healthcare facilities functional, and increases the utilization? Learnings from 12 case studies. *Journal of Family Medicine and Primary Care, Vol 9*, 539-546.
76. Lakshmi, T.S. & Sahoo. (2013). D. Health Infrastructure and Health Indicators: The Case of Andhra Pradesh, India. *IOSR Journal of Humanities and Social Science, Vol. 6 (6)*, 22-29.
77. Last, J.M. (1988). *Public Health and Human Ecology*, E. Norwalk, CT: Appleton & Lange.
78. Lee, J.Y., Kearns, R.A. & Friesen, W. (2010). Seeking affective health care: Korean immigrants' use of homeland medical services. *Health and Place*, 16(1), 108–15.
79. Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, 12 (18).
80. Lewis, C. E., Fein, R. & Mechanic, D. (1976). *Right to Health: The Problem of Access to Primary Medical Care*. New York: John Wiley & Sons.
81. May, J.M. (1978). Report to the Commission on Medical Geography of the international Geographical Union 1952. *Social Science and Medicine. Vol. 12 (D)*, 211-219.
82. Meade, M.S. & Earickson, R.J. (2000). *Medical Geography*, New York: The Guilford Press.
83. Mechanic, D. (1928). Towards a coherent and co-ordinated health care policy: Issues for the development of policy options. In Charles E. Lewis, Rashi Fein and David Mechanic

(Eds.), *Right to Health: The Problem of Access to Primary Medical Care* (33-40). New York: John Wiley & Sons.

84. Mukherjee, S. (1997). Aspects of Distribution, Accessibility and Utilization of Health Care Facilities in Urban Delhi. Unpublished thesis. New Delhi: Jawaharlal Nehru University.
85. Nandraj, S. & Nambiar, D. (2018). Kerala's Early Experience: Moving Towards Universal Health Coverage. In Purendra Prasad and Amar Jesani (Eds.), *Equity and Access: Health Care Studies in India* (323-337). India: Oxford University Press.
86. National Digital Health Mission, National Health Authority, *Ministry of Health and Family Welfare*, Government of India, accessed on 10<sup>th</sup> October 2020 at 7:27pm, at <https://ndhm.gov.in/home/ndhm>
87. National Sample Survey Organization (2015). Key Indicators of Social Consumption in India: Health. *Ministry of Statistics and Programme Implementation*, Government of India.
88. Pacione, M. (1986). (Ed). *Medical Geography: Progress and Prospect*, Wolfeboro: Croom Helm.
89. Penchansky, R. & Thomas, J.W. (1981). The concept of access: definition and relationship to consumer satisfaction. *Medical Care*, Vol.14 (2), 127–140.
90. Phillips, D. R. (1986). The demand for and Utilisation of Health Services. In M. Pacione (Ed.) *Medical Geography: Progress and Prospect*. (200-247). Wolfeboro: Croom Helm.
91. Planning Commission of India (2011). High Level Expert Group Report on Universal Health Coverage for India. New Delhi.

92. Powell, M. (1995). On the outside looking in: Medical geography, medical geographers and access to health care. *Health and Place, Vol.1*, 41-50.
93. Powell-Jackson, T, Acharya, A. & Mills, A. (2013). An Assessment of the Quality of Primary Health Care in India. *Economic & Political Weekly, Vol. 48* (19), Special Article, 53-61.
94. Prasad, P. & Jesani. A. (Eds.) *Equity and Access: Health Care Studies in India*, India: Oxford University Press.
95. Priya, Ritu. (2018). State, Community and Primary Health Care: Empowering or disempowering discourses? In Purendra Prasad and Amar Jesani (Eds.) *Equity and Access: Health Care Studies in India* (25-49). India: Oxford University Press.
96. Purohit, B.C. & Siddiqui, T.A. (1994). Utilisation of Health Services in India, *Economic and Political Weekly, Vol. 29* (18), 1071-1080.
97. Rai, P. & Komal. (2017). Health Infrastructure: A Study of Mohalla Clinics. *International Journal of Research in Economics and Social Sciences, Vol. 7* (5), 133-135.
98. Rao, K. S. (2017). *Do We Care? India's Health System*. India: Oxford University Press.
99. Rao, M. (25 May 2016). The Clinic at Your Doorstep: How the Delhi Government is Rethinking Primary Health care. *Scroll.in*. Accessed from <https://scroll.in/pulse/807886/the-clinic-> on 20<sup>th</sup> March 2019, 7:42pm.

100. Reddy, K.S. & Mathur, M.R. (2018). Universal Health Coverage: How viable? In Purendra Prasad and Amar Jesani (Eds.) *Equity and Access: Health Care Studies in India* (305-322). India: Oxford University Press.
101. Reddy, K.S. (2019). *Make Health in India: Reaching a Billion Plus*. Hyderabad: Orient BlackSwan.
102. Report of the Health Survey and Development Committee – Vol. I. *The Manager of Publications*, Delhi, 1946.
103. Russell, D. J., Humphreys, J. S., Ward, B., Chisholm, M., Buykx, P., McGrail, M., & Wakerman, J. (2013). Helping policy-makers address rural health access problems. *The Australian Journal of Rural Health*, 21(2), 61–71.
104. Sah, T., Bailwal, N. & Kaushik, R. (27<sup>th</sup> June 2020). Delhi's Mohalla Clinic Network Should Have Been Used in the Fight Against COVID-19. *The Wire*. Accessed from <https://thewire.in/health/covid-19-delhi-mohalla-clinics> on 7th July, 2020 at 6:12pm.
105. Sah, T., Kaushik, R., Bailwal, N. & Tep, N. (2019). Mohalla Clinics in Delhi: A Preliminary Assessment of their Functioning and Coverage. *Indian Journal of Human Development*, Vol. 13(2), 195–210.
106. Saxena, A. (20<sup>th</sup> March 2020). Delhi Mohalla Clinics get ready to step up to a tough new challenge. *The New Indian Express*. New Delhi. Accessed from <https://indianexpress.com/article/cities/delhi/coronavirus-delhi-mohalla-clinics-get-ready-to-step-up-to-a-tough-new-challenge/> on 21<sup>st</sup> March 2020 at 5:27pm.
107. Saxena, A. (4<sup>th</sup> September 2020). Delhi mohalla clinics now Covid testing centres. *The New Indian Express*. New Delhi. Accessed from



<https://indianexpress.com/article/cities/delhi/delhi-coronavirus-update-mohalla-clinics-now-covid-testing-centres-6582235/> on 24<sup>th</sup> September 2020 at 8:30pm.

108. Sekhar, P. S. (1995). Utilization of Health Services. *Economic and Political Weekly*, Vol.30 (14), 776.
109. Shannon G.W., Skinner J.L. & Bashshur R.L. (1973). Time and Distance: The Journey for Medical Care. *International Journal of Health Services*. Vol. 3(2), 237-244.
110. Shannon, G.W. & Dever, G.E.A. (1974). *Health care Delivery: Spatial Perspectives*. New York: McGraw-Hill.
111. Shannon, G.W., Bashshur, R. L. & Metzner, C. A. (1969). The concept of distance as a factor in accessibility and utilization of health care. *Medical Care Review* Vol. 26(2), 143–161.
112. Sharma, D C. (2016). Delhi Looks to Expand Community Clinics Initiative. *The Lancet*, Vol 388 (10062), 2855.
113. Sinha S. & Mukherjee M. (2004). Structure of Health Care Distribution and Utilization in Urban Delhi. In R. Akhtar (Ed.) *India: Health Care Patterns and Planning*. (197-208). New Delhi: APH Publishing.
114. Sirur, S. & Dasgupta, S. (14 June, 2020). Delhi Mohalla Clinics battle mask shortage, delayed salary but continue quiet fight in pandemic. The Print. Accessed from <https://theprint.in/health/delhi-mohalla-clinics-battle-mask-shortage-delayed-salary-but-continue-quiet-fight-in-pandemic/440256/> on 16<sup>th</sup> June 2020, 9:27pm.
115. Starfield, B. (1998). *Primary Care: Balancing Health Needs, Services and Technology*, New York: Oxford University Press.

116. Starfield, B., Shi, L. & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*, Vol. 83 (3), 457–502.
117. Swedish Agency for Growth Policy Analysis (2013). India's Health Care System: Overview and Quality Improvements. Sweden.
118. Unknown Author. (11<sup>th</sup> September 2020). Delhi govt asks mohalla clinics to conduct Covid-19 tests. Live Mint. Accessed from <https://www.livemint.com/news/india/delhi-govt-asks-mohalla-clinics-to-conduct-covid-tests-timings-other-details-11599819867493.html> on 13<sup>th</sup> September 2020 at 9:40pm.
119. Unknown Author. (12<sup>th</sup> March 2019). Mohalla clinics to remove CM's photos. The Hindu. New Delhi. Accessed from <https://www.thehindu.com/news/cities/Delhi/mohalla-clinics-to-remove-cms-photos/article26505419.ece> on 16<sup>th</sup> March, 2019 at 9:59pm.
120. Unknown Author. (16<sup>th</sup> September 2020). Corona test at Mohalla clinics: Delhi High Court gives this order to Arvind Kejriwal government. National Chronicle. Accessed from <https://nationalchronicle.in/national/corona-tests-at-mohalla-clinics-delhi-high-court-gives-this-order-to-arvind-kejriwal-government/> on 26<sup>th</sup> September 2020 at 6:29pm.
121. Unknown Author. (19<sup>th</sup> July 2015). Naming Clinics as 'Aam Aadmi' Political Nepotism: BJP. NDTV. Accessed from <https://www.ndtv.com/delhi-news/naming-clinics-as-aam-aadmi-political-nepotism-bjp-783076> on 26<sup>th</sup> July, 2015 at 7:39pm.
122. Unknown author. (20<sup>th</sup> July 2015). Delhi Gets First “Aam Aadmi Clinic”, CM Kejriwal Says 1000 More in Line. *The New Indian Express*, Delhi. Accessed from

<https://indianexpress.com/article/cities/delhi/delhi-gets-first-aam-aadmi-clinic-cm-kejriwal-says-1000-more-in-line/> on 16<sup>th</sup> February, 7:26pm.

123. Unknown Author. (20<sup>th</sup> October 2019). Arvind Kejriwal spells out healthcare target: One mohalla clinic per square km. *The New Indian Express*. Accessed from <https://indianexpress.com/article/cities/delhi/arvind-kejriwal-spells-out-healthcare-target-one-mohalla-clinic-per-square-km-6078179/> on 31<sup>st</sup> October 2019 at 8:31pm.
124. Unknown Author. (26<sup>th</sup> March 2020). 800 people who came in contact with Covid-19 positive mohalla clinic doctor quarantined, says Delhi govt. *Hindustan Times*. New Delhi. Accessed from <https://www.hindustantimes.com/delhi-news/800-people-who-came-in-contact-with-covid-19-positive-mohalla-clinic-doctor-quarantined-says-delhi-govt/story-alXbyfcLcel2xKfmdG0v8L.html> on 30<sup>th</sup> March 2020 at 10:28 am.
125. Unknown author. (28<sup>th</sup> January, 2017). Kofi Annan Praises Mohalla Clinics. *The Hindu* accessed from <https://www.thehindu.com/news/cities/Delhi/KofiAnnanpraisesMohallaclinics/article17105541.ece> on 18<sup>th</sup> March 2019, 11:35pm.
126. Unknown author. (29<sup>th</sup> August, 2018). Arvind Kejriwal Pays Surprise Visit to Mohalla Clinic, Blasts Officials. *NDTV*. Accessed from <https://www.ndtv.com/delhi-news/arvind-kejriwal-pays-surprise-visit-to-Mohalla-clinicblastsofficials-1907729> on 11<sup>th</sup> March 2019, 3:56pm.
127. Unknown Author. (29<sup>th</sup> November 2020). Will deliver COVID-19 vaccines through mohalla clinics: Delhi Health Minister Satyendar Jain. *The New Indian Express*. Accessed from <https://www.newindianexpress.com/thesundaystandard/2020/nov/29/will->

deliver-covid-19vaccine-through-mohalla-clinics-delhi-health-minister-satyendar-jain-2229374.html on 22<sup>nd</sup> November 2020 at 10:47pm.

128. Unknown author. (29<sup>th</sup> October 2019). Delhi Mohalla Clinics cross 300-mark, target 1,000. *The New Indian Express*, Accessed from <https://www.newindianexpress.com/good-news/2019/oct/20/delhi-mohalla-clinics-cross-300-mark-target-1000-2050471.html> on 31st October 2019 at 8:56pm.
129. Unknown Author. (2<sup>nd</sup> February 2019). DDA creating hurdles for mohalla clinics: Delhi government to HC. *The Times of India*. Accessed from <https://timesofindia.indiatimes.com/city/delhi/dda-creating-hurdles-for-mohalla-clinics-delhi-govt-to-hc/articleshowprint/67800511.cms> on 26<sup>th</sup> February 2019 at 10:09pm.
130. Unknown author. (3<sup>rd</sup> August, 2018). Delhi Mohalla Clinics Have Patients Raving About it, But Doctors Have a Sad Tale to Tell. *CNN-News 18*. Accessed from <https://www.news18.com/news/india/delhi-Mohalla-clinics-have-patients-raving-about-it-but-doctors-have-a-sad-tale-to-tell-1832939.html> on 15<sup>th</sup> March 2019, 9:10 am.
131. Unknown author. (7<sup>th</sup> September, 2018). AAP's Mohalla Clinic project in Delhi draws praise from Ban Ki-moon. *Business Standard*. Accessed from [https://www.business-standard.com/article/current-affairs/aap-s-Mohalla-clinic-project-in-delhi-draws-praise-from-ban-ki-moon-118090700602\\_1.html](https://www.business-standard.com/article/current-affairs/aap-s-Mohalla-clinic-project-in-delhi-draws-praise-from-ban-ki-moon-118090700602_1.html) on 20th March 2019, 11:44am.
132. Unknown author. (8<sup>th</sup> August, 2018). Delhi Government Says Will Meet Target of 1,000 Mohalla Clinics Soon. *The Times of India*. Accessed from <https://timesofindia.indiatimes.com/city/-delhi/govt-says-will-meet-target-of-1000-Mohalla-clinics-soon/articleshow/65314320.cms> on 19<sup>th</sup> March 2019, 10:56 am.

133. White, A.H. (1979). Accessibility and Public Facility Location. *Economic Geography*, Vol. 55 (1), 18-35.
134. WHO Director General's opening remarks at the media briefing on COVID-19 - 7 September 2020, World Health Organisation website, Accessed on 22<sup>nd</sup> November 2020 at 12:59 am from <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---7-september-2020>
135. World Health Organisation (2000). Why do Health Systems Matter? Health Systems: Improving Performance.
136. World Health Organisation (2008). Primary Health Care – Now More Than Ever. World Health Report.

## Appendices

### INTERVIEW SCHEDULE FOR PATIENTS VISITING MOHALLA CLINICS

Name of the interviewer: \_\_\_\_\_

Date & time of interview: \_\_\_\_\_ Interview number: \_\_\_\_\_

Location: \_\_\_\_\_

#### **Introduction and informed consent**

I am Sonali Smriti Biswas, an M.Phil. student in Jawaharlal Nehru University. I am working on the infrastructure and accessibility of health care delivery system in Delhi in general and Aam Aadmi Mohalla Clinics in particular for my MPhil dissertation. Therefore I would like to talk to you regarding your treatment preferences – like where you usually go for treatment, which type of treatment do you prefer and whether the Mohalla clinics are helping you to have higher accessibility to and utilization of health care services. My interest lies in understanding as to how these mohalla clinics have addressed the issues that government dispensaries and such other hospitals could not.

The interview will take about 20-25 minutes times. All the information that will be collected through this interview will be used strictly for research purpose only and your identity will be kept anonymous. If I ask you any question you do not wish to answer, just let me know and I will go on to the next question or you can stop the interview whenever you wish to.

Now, may I proceed with the interview?

#### **Identification**

1. District: \_\_\_\_\_

2. Ward: \_\_\_\_\_

3. Location of the clinic: \_\_\_\_\_

## Demographic and Health Characteristics

Sl. No.	Name	Age	Gender	Relationship with head of the family	Marital status	Educational level	Employment status	Occupation	Ailment in last 30 days	Type of ailment	Place of treatment	Treatment type	Distance from home	Scheme for health expenditure support
(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(20)	(21)
1														
2														
3														
4														
5														
6														

**Codes: Gender:** Male – 1, Female – 2, Other – 3

**Marital Status:** Currently married – 1, Never married – 2, Separated/divorced – 3, Widow/widower – 4

**Educational level:** Not literate – 1, Literate without formal schooling -2, Below primary – 3, Primary – 4, Middle – 5, Secondary – 6, Higher secondary – 7, Graduation – 8, Post graduate and above – 6

**Occupation:** Daily wage earner – 1, Contractual worker – 2, Permanent worker – 3, Business – 4, Not working – 5, Housewife – 6, Student – 7

**Place of treatment:** Mohalla Clinic – 1, Public hospital – 2, Private hospital – 3, Private practitioner – 4, Mobile health clinics – 5, Jholachap doctor – 6, Ayurveda/Vaidhya/Hakin – 7, Home remedies – 8, Chemist shop (over-the-counter) – 9, Did not seek treatment – 0

**Health expenditure support:** Government funded insurance scheme (e.g. RSBY, Arogyasri, CGHS, ESIS, etc.) – 1, employer supported health protection (other than govt.) – 2, arranged by household with insurance companies – 3, others-4, not covered-5

### Household characteristics

22. How long have you been residing in this location : \_\_\_\_\_months, \_\_\_\_\_years or since birth/marriage

23. If resided elsewhere, name of place \_\_\_\_\_

24. Ownership of present residence: \_\_\_\_\_

*own – 1, rented by self – 2, rented institutionally - 3*

25. Religion: \_\_\_\_\_

*Hindu – 1, Muslim – 2, Christian – 3, Sikh – 4, Others – 5*

26. Caste/Tribe: \_\_\_\_\_

*Scheduled caste – 1, Scheduled tribe – 2, Other backward classes – 3, Others – 4*

### Treatment seeking in Mohalla Clinics

27. Where do you usually go for treatment in case of simple illnesses like cough and cold, fever?  
*Mohalla Clinic – 1, Public hospital – 2, Private hospital – 3, Private practitioner – 4, Mobile health clinics – 5, Jholachap doctor – 6, Ayurveda/Vaidhya/Hakim – 7, Home remedies – 8, Chemist shop (over-the-counter) – 9, Do not seek treatment – 0*

28. When was the first time you visited Mohalla clinic? \_\_\_\_\_

29. From which source did you first come to know about Mohalla clinics?

*Neighbours – 1, Friends and relatives – 2, Newspapers – 3, Radio/television – 4, Saw the clinic himself/herself – 5, Government leaflets – 6*

30. Due to which illness are you visiting the clinic now? \_\_\_\_\_

31. Since when are you seeking treatment for this (present) illness?  
\_\_\_\_\_days\_\_\_\_\_months

32. How long does it take for you to reach this clinic from your house?

*Less than 10 minutes – 1, 15 minutes – 2, More than 20 minutes – 3*

33. Did anybody accompany you to this clinic today? *Yes – 1, No – 0*

34. For treatment of which diseases do you usually visit mohalla clinics? (Record all choices)

*Cold and fever – 1, Pain – 2, Chronic illness such as diabetes, hypo/hyperthyroidism/ rheumatism/others – 3, others – 4 (please specify) \_\_\_\_\_*

35. Do you have to miss work for visiting mohalla clinics? *Yes – 1, No – 0*

36. If yes, do you have to forgo wages for missing work? *Yes – 1, No – 0*



37. Tell me something about your experience during your visit to Mohalla Clinic. Prior to this episode, did you visit mohalla clinic in the past 6 months? *Yes – 1, No – 0*
38. If yes, No. of times \_\_\_\_\_; illnesses \_\_\_\_\_
39. How long did you have to wait to see the doctor?  
*15 minutes – 1, about 30 minutes – 2, about 45 minutes – 3, about 1 hour – 4, about 2 hours – 5, More than 2 hours – 6*
40. Did the doctor explain you about the nature and cause of your illness?  
*Yes – 1, No – 0, I did not ask – 2*
41. Did you get all medicines from the clinic? *Yes – 1, No – 0*
42. Were all medicines given in proper condition (includes expiry date, whether tampered / seal broken)? *Yes – 1, No – 0*
43. Who explained how and when you had to take specific medicines?  
*Doctor – 1, Assistant – 2, Asked fellow patients – 3, No one explained/understood from prescription on your own – 4*
44. Did anyone inform you about the possible side-effects of the prescribed medicines?  
*Doctor – 1, Assistant – 2, Checked from internet – 3, Unaware of any possible side-effects – 4*
45. Did the doctor prescribe any diagnostic tests? *Yes – 1, No – 0*
46. Did you get the tests done in the clinic? *Yes – 1, No – 0*
47. When did you get the tests done in the clinic?  
*Immediately after the doctor said – 1, Evening – 2, Next day – 3, Never – 4*
48. When did you receive the test reports?  
*Evening – 1, Next day – 2, Did not collect reports – 3*
49. Who collected blood sample? *Doctor – 1, Assistant – 2, no tests done – 3*
50. Did you visit the doctor after collecting the reports? *Yes – 1, No – 0*
51. Did the doctor prescribe some other medicines after seeing the report? *Yes – 1, No – 0*
52. How many days did it take to cure the ailment?  
*1 or 2 days – 1, Less than 7 days – 2, About 15 days – 3, More than 15 days – 4, not yet been cured – 5*

### **Treatment seeking prior to Mohalla Clinics**

53. Where did you go for treatment before Mohalla clinic had been established?

*Public hospital – 1, Private hospital – 2, Private practitioner – 3, Mobile health clinics – 4, Jholachap doctor – 5, Ayurveda/Vaidhya/Hakim – 6, Home remedies – 7, Chemist shop (over-the-counter) – 8, Did not seek treatment – 9*

54. What was the reason for not seeking treatment?

*No medical facility available in the neighbourhood – 1, facility of satisfactory quality not available – 2, facility of satisfactory quality involves long waiting – 3, Ailment not considered serious – 4, financial constraint – 5, treatment would lead to loss of daily work – 6, There was nobody to accompany me – 7, others – 9*

55. How much time did it take to reach there?

*Less than 15 minutes – 1, about 30 minutes – 2, about 1 hour – 3, More than 1 hour – 4*

56. How much money did you spend on transport to reach there (both to and fro)?

Rs. \_\_\_\_\_

57. How much was the doctor's fees? Rs. \_\_\_\_\_

58. How long did you have to wait to see the doctor?

*15 minutes – 1, about 30 minutes – 2, about 45 minutes – 3, about 1 hour – 4, about 2 hours – 5, More than 2 hours - 6*

59. From where did you get the medicines?

*Public hospital – 1, Private hospital – 2, Chemist shop – 3, Mobile health clinics – 4, Dispensary – 5, Over-the-counter – 6, Ayurveda/Vaidhya/Hakim – 7, Did not seek treatment – 8*

60. Were the medicines: *Free of cost – 1, partially free – 2, Completely borne by patient – 3?*

61. How much money was spent for medicines? Rs: \_\_\_\_\_

62. Where did you get the diagnostic tests done?

*Public hospital – 1, Private hospital – 2, Private clinic – 3, Never got tests done – 4*

63. Were the diagnostic tests: *Free of cost – 1, partially free – 2, Completely borne by patient – 3, Never got tests done – 4*

64. How much money was spent for diagnostic tests? Rs: \_\_\_\_\_

65. What was the frequency of follow up visit? \_\_\_\_\_ 7  
*days – 1, 10-15 days – 2, 1 month – 3, never – 4*

66. Due to illness, how many days

i. *You had to take leave from work?* \_\_\_\_\_

ii. *You were on restricted activity?* \_\_\_\_\_

iii. *You were confined to the bed?* \_\_\_\_\_

iv. *You could not carry out normal functioning?* \_\_\_\_\_

67. Which do you prefer: *Place where treatment was sought earlier – 1, Mohalla clinics – 2 ?*

68. Why do you prefer to come to Mohalla clinics now instead of going to the previous place?  
(record all choices)

*Better treatment – 1, Co-operative doctors – 2, Free treatment – 3, Facility available near home – 4, Lesser waiting time – 5, Immediate availability of medicines – 6, Diagnostic tests facilities available – 7*

69. Did you ever visit any other health facility other than these after the first time you visited the Mohalla clinic? *Yes – 1, No – 0*

70. Which health facility did you visit?

*Public hospital – 1, Private hospital – 2, Chemist shop – 3, Mobile health clinics – 4, Dispensary – 5, Ayurveda/Vaidhya/Hakim – 6*

71. Why did you visit that facility instead of going to Mohalla clinic?

*Major ailment – 1, Clinic doctor was unable to cure the ailment – 2, to avail specialized services not available in clinic – 3, Clinic doctor referred – 4, Clinic was closed – 5, Clinic was overcrowded – 6, Quality treatment not available – 7, Did not trust clinic for that ailment – 8*

72. Do you think acquiring primary health care is easy or difficult for you now after establishment of Mohalla clinics in your locality?

*Very difficult – 1, difficult – 2, no change – 3, easy – 4, very easy – 5*

### **Satisfaction level and expectation**

73. In Mohalla clinics, were you satisfied with the following? Rate the following on a scale of 1 to 5, where ,

*1 – Poor, 2 – Below Average, 3 – Average, 4 – More than Average, 5 – Very satisfied/Very good*

- a. Treatment received: \_\_\_\_\_
- b. Behaviour of the doctor/staff: \_\_\_\_\_
- c. Medicines available: \_\_\_\_\_
- d. Diagnostic test facilities available: \_\_\_\_\_
- e. Seating arrangement: \_\_\_\_\_
- f. Drinking water facilities: \_\_\_\_\_
- g. Toilet facilities: \_\_\_\_\_
- h. Token vending machine: \_\_\_\_\_
- i. Medicine vending machine: \_\_\_\_\_
- j. Air conditioner: \_\_\_\_\_



## INTERVIEW SCHEDULE FOR HOUSEHOLDS NEAR MOHALLA CLINICS

Name of the interviewer: \_\_\_\_\_

Date & time of interview: \_\_\_\_\_ Interview number: \_\_\_\_\_

Location: \_\_\_\_\_

### Introduction and informed consent

I am Sonali Smriti Biswas, an M.Phil. student in Jawaharlal Nehru University. I am working on the infrastructure and accessibility of health care delivery system in Delhi in general and Aam Aadmi Mohalla Clinics in particular for my MPhil dissertation. Therefore I would like to talk to you regarding your treatment preferences – like where you usually go for treatment, which type of treatment do you prefer and whether the Mohalla clinics are helping you to have higher accessibility to and utilization of health care services. My interest lies in understanding as to how these mohalla clinics have addressed the issues that government dispensaries and such other hospitals could not.

The interview will take about 20-25 minutes times. All the information that will be collected through this interview will be used strictly for research purpose only and your identity will be kept anonymous. If I ask you any question you do not wish to answer, just let me know and I will go on to the next question or you can stop the interview whenever you wish to.

Now, may I proceed with the interview?

### Identification

4. District: \_\_\_\_\_

5. Ward: \_\_\_\_\_

6. Address: \_\_\_\_\_

7. Name of the nearest clinic: \_\_\_\_\_

8. Address of the clinic: \_\_\_\_\_

## Demographic and Health Characteristics

Sl. No.	Name	Age	Gender	Relationship with head of the family	Marital status	Educational level	Employment status	Occupation	Ailment in last 30 days	Type of ailment	Place of treatment	Treatment type	Distance from home	Scheme for health expenditure support
(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(20)	(21)
1														
2														
3														
4														
5														
6														

**Codes: Gender:** Male – 1, Female – 2, Other – 3

**Marital Status:** Currently married – 1, Never married – 2, Separated/divorced – 3, Widow/widower – 4

**Educational level:** Not literate – 1, Literate without formal schooling -2, Below primary – 3, Primary – 4, Middle – 5, Secondary – 6, Higher secondary – 7, Graduation – 8, Post graduate and above – 6

**Occupation:** Daily wage earner – 1, Contractual worker – 2, Permanent worker – 3, Business – 4, Not working – 5, Housewife – 6, Student – 7

**Place of treatment:** Mohalla Clinic – 1, Public hospital – 2, Private hospital – 3, Private practitioner – 4, Mobile health clinics – 5, Jholachap doctor – 6, Ayurveda/Vaidhya/Hakim – 7, Home remedies – 8, Chemist shop (over-the-counter) – 9, Did not seek treatment – 0

**Health expenditure support:** Government funded insurance scheme (e.g. RSBY, Arogyasri, CGHS, ESIS, etc.) – 1, employer supported health protection (other than govt.) – 2, arranged by household with insurance companies – 3, others-4, not covered-5

## Household characteristics

78. How long have you been residing in this location : \_\_\_\_\_ months, \_\_\_\_\_ years or since birth/marriage

79. If resided elsewhere, name of place \_\_\_\_\_

80. Ownership of present residence: \_\_\_\_\_

*own – 1, rented by self – 2, rented institutionally - 3*

81. Religion: \_\_\_\_\_

*Hindu – 1, Muslim – 2, Christian – 3, Sikh – 4, Others – 5*

82. Caste/Tribe: \_\_\_\_\_

*Scheduled caste – 1, Scheduled tribe – 2, Other backward classes – 3, Others – 4*

## Treatment seeking in Mohalla Clinics

83. Where do you usually go for treatment in case of simple illnesses like cough and cold, fever?  
*Mohalla Clinic – 1, Public hospital – 2, Private hospital – 3, Private practitioner – 4, Mobile health clinics – 5, Jholachap doctor – 6, Ayurveda/Vaidhya/Hakim – 7, Home remedies – 8, Chemist shop (over-the-counter) – 9, Do not seek treatment – 0*

84. When was the first time you visited Mohalla clinic? \_\_\_\_\_

85. From which source did you first come to know about Mohalla clinics?

*Neighbours – 1, Friends and relatives – 2, Newspapers – 3, Radio/television – 4, Saw the clinic himself/herself – 5, Government leaflets – 6*

86. Due to which illness did you visit the clinic the last time (latest episode)?

\_\_\_\_\_

87. Since when are you seeking treatment for this (present) illness?  
\_\_\_\_\_ days \_\_\_\_\_ months

88. How long does it take for you to reach the nearest clinic from your house?

*Less than 10 minutes – 1, 15 minutes – 2, 20 minutes – 3*

89. Who usually accompanies you to the clinic? *Nobody – 1, Family members – 2, Neighbours/friends – 3*

90. For treatment of which diseases do you usually visit mohalla clinics? (Record all choices)

*Cold and fever – 1, Pain – 2, Chronic illness such as diabetes, hypo/hyperthyroidism/ rheumatism/others – 3, others – 4 (please specify) \_\_\_\_\_*

91. Do you have to miss work for visiting mohalla clinics? *Yes – 1, No – 0*
92. If yes, do you have to forgo wages for missing work? *Yes – 1, No – 0*
93. Tell me something about your experience during your last visit to Mohalla Clinic. Prior to this episode, did you visit mohalla clinic in the past 6 months? *Yes – 1, No – 0*
94. If yes, No. of times \_\_\_\_\_; illnesses \_\_\_\_\_
95. How long did you have to wait to see the doctor?  
*15 minutes – 1, about 30 minutes – 2, about 45 minutes – 3, about 1 hour – 4, about 2 hours – 5, More than 2 hours – 6*
96. What was the illness due to which you had visited the clinic? (Check from table)  
 \_\_\_\_\_
97. Did the doctor explain you about the nature and cause of your illness?  
*Yes – 1, No – 0, I did not ask – 2*
98. Did you get all medicines from the clinic? *Yes – 1, No – 0*
99. Were all medicines given in proper condition (includes expiry date, whether tampered / seal broken)? *Yes – 1, No – 0*
100. Who explained how and when you had to take specific medicines?  
*Doctor – 1, Assistant – 2, Asked fellow patients – 3, No one explained/understood from prescription on your own – 4*
101. Did anyone inform you about the possible side-effects of the prescribed medicines?  
*Doctor – 1, Assistant – 2, Checked from internet – 3, Unaware of any possible side-effects – 4*
102. Did the doctor prescribe any diagnostic tests? *Yes – 1, No – 0*
103. Did you get the tests done in the clinic? *Yes – 1, No – 0*
104. When did you get the tests done in the clinic?  
*Immediately after the doctor said – 1, Evening – 2, Next day – 3, Never – 4*
105. When did you receive the test reports?  
*Evening – 1, Next day – 2, Did not collect reports – 3*
106. Who collected blood sample? *Doctor – 1, Assistant – 2, no tests done – 3*
107. Did you visit the doctor after collecting the reports? *Yes – 1, No – 0*
108. Did the doctor prescribe some other medicines after seeing the report? *Yes – 1, No – 0*
109. How many days did it take to cure the ailment?  
*1 or 2 days – 1, Less than 7 days – 2, About 15 days – 3, More than 15 days – 4, not yet been cured – 5*



## Treatment seeking prior to Mohalla Clinics

110. Where did you go for treatment before Mohalla clinic had been established?

*Public hospital – 1, Private hospital – 2, Private practitioner – 3, Mobile health clinics – 4, Jholachap doctor – 5, Ayurveda/Vaidhya/Hakim – 6, Home remedies – 7, Chemist shop (over-the-counter) – 8, Did not seek treatment – 9*

111. What was the reason for not seeking treatment?

*No medical facility available in the neighbourhood – 1, facility of satisfactory quality not available – 2, facility of satisfactory quality involves long waiting – 3, Ailment not considered serious – 4, financial constraint – 5, treatment would lead to loss of daily work – 6, There was nobody to accompany me – 7, others – 9*

112. How much time did it take to reach there?

*Less than 15 minutes – 1, about 30 minutes – 2, about 1 hour – 3, More than 1 hour – 4*

113. How much money did you spend on transport to reach there (both to and fro)?

Rs. \_\_\_\_\_

114. How much money was spent to get token? Rs. \_\_\_\_\_

115. What was the doctor's fees? Rs. \_\_\_\_\_

116. How long did you have to wait to see the doctor? 15

*minutes – 1, about 30 minutes – 2, about 45 minutes – 3, about 1 hour – 4, about 2 hours – 5, More than 2 hours - 6*

117. From where did you get the medicines?

*Public hospital – 1, Private hospital – 2, Chemist shop – 3, Mobile health clinics – 4, Dispensary – 5, Over-the-counter – 6, Ayurveda/Vaidhya/Hakim – 7, Did not seek treatment – 8*

118. Were the medicines: *Free of cost – 1, partially free – 2, Completely borne by patient – 3?*

119. How much money was spent for medicines? Rs: \_\_\_\_\_

120. Where did you get the diagnostic tests done?

*Public hospital – 1, Private hospital – 2, Private clinic – 3, Never got tests done – 4*

121. Were the diagnostic tests: *Free of cost – 1, partially free – 2, Completely borne by patient – 3, Never got tests done – 4*

122. How much money was spent for diagnostic tests? Rs: \_\_\_\_\_

123. What was the frequency of follow up visit? \_\_\_\_\_ *7 days – 1, 10-15 days – 2, 1 month – 3, never – 4*

124. Due to illness, how many days

- i. You had to take leave from work? \_\_\_\_\_
  - ii. You were on restricted activity? \_\_\_\_\_
  - iii. You were confined to the bed? \_\_\_\_\_
  - iv. You could not carry out normal functioning? \_\_\_\_\_
69. Which do you prefer: *Place where treatment was sought earlier – 1, Mohalla clinics – 2 ?*
70. Why do you prefer to come to Mohalla clinics now instead of going to the previous place?  
(multiple options may be chosen)  
*Better treatment – 1, Co-operative doctors – 2, Free treatment – 3, Facility available near home – 4, Lesser waiting time – 5, Immediate availability of medicines – 6, Diagnostic tests facilities available – 7*
71. Did you ever visit any other health facility other than these after the first time you visited the Mohalla clinic? *Yes – 1, No – 0*
72. Which health facility did you visit?  
*Public hospital – 1, Private hospital – 2, Chemist shop – 3, Mobile health clinics – 4, Dispensary – 5, Ayurveda/Vaidhya/Hakim – 6*
73. Why did you visit that facility instead of going to Mohalla clinic?  
*Major ailment – 1, Clinic doctor was unable to cure the ailment – 2, to avail specialized services not available in clinic – 3, Clinic was closed – 4, Clinic was overcrowded – 5, Quality treatment not available – 6, Did not trust clinic for that ailment – 7*
74. Do you think acquiring primary health care is easy or difficult for you now after establishment of Mohalla clinics in your locality?  
*Very difficult – 1, difficult – 2, no change – 3, easy – 4, very easy – 5*

### **Satisfaction level and expectation**

75. In Mohalla clinics, were you satisfied with the following? Rate the following on a scale of 1 to 5, where ,

*1 – Poor, 2 – Below Average, 3 – Average, 4 – More than Average, 5 – Very satisfied/Very good*

- l. Treatment received: \_\_\_\_\_
- m. Behaviour of the doctor/staff: \_\_\_\_\_
- n. Medicines available: \_\_\_\_\_
- o. Diagnostic test facilities available: \_\_\_\_\_

- p. Seating arrangement: \_\_\_\_\_
- q. Drinking water facilities: \_\_\_\_\_
- r. Toilet facilities: \_\_\_\_\_
- s. Token vending machine: \_\_\_\_\_
- t. Medicine vending machine: \_\_\_\_\_
- u. Air conditioner: \_\_\_\_\_
- v. Crowd management: \_\_\_\_\_
- w. Security: \_\_\_\_\_

76. Do you receive exactly the same behaviour and attitude from the doctor and the staff which you expect?

*Worse than expected – 0, Exactly as expected – 1, Better than expected – 2*

77. Do you think more friendly and affectionate attitude of the doctor :

- a. Makes you feel secure/relieved: *Yes – 1, No – 0*
- b. Helps to reinforce the trust in the doctor: *Yes – 1, No – 0*
- c. Helps you to understand treatment instructions well: *Yes – 1, No – 0*
- d. Helps you to be comfortable with the doctor and ask any questions: *Yes – 1, No – 0*

78. Was there any effort from the government to create awareness about the following:  
*Prevention of vector borne diseases – 1, prevention of water borne diseases – 2, immunization programmes – 3, Mother and child care programmes - 4*

**Suggestions**

79. What changes/additions would you suggest for the improvement of the clinic?

\_\_\_\_\_

**Interviewer’s notes/remarks/observation**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## INTERVIEW SCHEDULE FOR DOCTORS AND STAFF AT MOHALLA CLINICS

Name of the interviewer: \_\_\_\_\_

Date & time of interview: \_\_\_\_\_ Interview number: \_\_\_\_\_

Location: \_\_\_\_\_

### **Introduction and informed consent**

I am Sonali Smriti Biswas, an M.Phil. student in Jawaharlal Nehru University. I am working on the infrastructure and accessibility of health care delivery system in Delhi in general and Aam Aadmi Mohalla Clinics in particular for my MPhil dissertation. Therefore I would like to talk to you regarding the infrastructure available in these clinics and also about the patients' behaviour. My interest lies in understanding whether these clinics are helping the patients to have higher accessibility to and utilization of health care services.

The interview will take about 20-25 minutes times. All the information that will be collected through this interview will be used strictly for research purpose only and your identity will be kept anonymous. . If I ask you any question you do not wish to answer, just let me know and I will go on to the next question or you can stop the interview whenever you wish to.

Now, may I proceed with the interview?

### **Identification**

9. District: \_\_\_\_\_

10. Ward: \_\_\_\_\_

11. Location of the clinic: \_\_\_\_\_

**Background characteristics**

- 12. Name of the interviewee: \_\_\_\_\_
- 13. Designation: \_\_\_\_\_
- 14. Age: \_\_\_\_\_ years
- 15. Place of residence: \_\_\_\_\_
- 16. Gender: \_\_\_\_\_

*Male – 1, Female – 2, Other – 3*

- 17. Religion: \_\_\_\_\_

*Hindu – 1, Muslim – 2, Christian – 3, Sikh – 4, Others – 5*

- 18. Caste/Tribe: \_\_\_\_\_

*Scheduled caste – 1, Scheduled tribe – 2, Other backward classes – 3, Others – 4*

- 19. Marital Status: \_\_\_\_\_

*Currently married – 1, Never married – 2, Separated/divorced – 3, Widow/widower – 4*

- 20. Educational Qualification: \_\_\_\_\_

**Job profile**

- 21. How long have you been associated with this clinic? \_\_\_\_\_

*Less than a month – 1, 1-6 months – 2, 6-12 months – 3, More than 1 year – 4, since the establishment of the clinic – 5*

- 22. At present do you work/practice somewhere else apart from this clinic? \_\_\_\_\_

*Government hospital – 1, Dispensary – 2, Private practice – 3, Nowhere else – 0*

- 23. Where did you work before you joined this clinic? \_\_\_\_\_

- 24. What was your previous designation? \_\_\_\_\_

- 25. What is your term of appointment here? \_\_\_\_\_

*Permanent – 1, Contract for less than 1 year – 2, Contract for 1-2 years – 3, Contract for less than 5 years – 4*

26. Are you entitled to any leaves? *Yes – 1, No – 0*
27. Do you get holidays on occasions like Dusshera/Diwali/Holi/Makar Sankranti/Shiv Ratri/others? (*tick the appropriate ones; multiple options may be selected*)

**About the clinic**

28. What is the duration of the clinic (time)? \_\_\_\_\_
29. How many days does the clinic function in a week? \_\_\_\_\_
30. How many patients on an average come to visit the clinics daily?  
*On weekdays: \_\_\_\_\_; on weekends: \_\_\_\_\_*
31. Which age group of patients mostly visits the clinic? \_\_\_\_\_  
*Infants – 1, Children below 5 years – 5, adults – 3, elderly people – 4*
32. Do more females visit the clinic than males? *Yes – 1, No – 0*
33. Compared to the time of establishment of this clinic, has the number of patients *increased/decreased/remained same* at present?
34. Are all medicines which you prescribe available in the clinic? *Yes – 1, No – 0*
35. If any medicine is not available in the clinic, is there any provision to procure it from elsewhere to give to the patients? *Yes – 1, No – 0*
36. If yes, from where? \_\_\_\_\_
37. If any medicine is not available in the clinic, do the patients have to buy it themselves? *Yes – 1, No – 0*
38. How many diagnostic tests are done in this clinic? \_\_\_\_\_
39. When are the test reports ready to be given?  
*Same day – 1, Next day – 2, Within a week – 3*
40. Where do you refer patients in case of emergency?  
*Government dispensaries – 1, Public hospitals – 2*
41. From where do the medicines for the clinic come?  
*Government supplies – 1, Dispensaries – 2, Nearest public hospital – 3*
42. What is the frequency in which the medicines are brought to the clinic?  
*Once a week – 1, once in 10 days – 2, once in 15 days – 3, once a month – 4, only when asked for-5*
43. Who keeps a record of the medicines available in the clinic?  
*Doctor – 1, Assistant – 2*

### About the patients

44. What are the common ailments for which people visit the clinic?  
*Cold and fever – 1, Pain – 2, Chronic illness such as diabetes, hypo/hyperthyroidism/ rheumatism/others – 3, others – 4 (please specify) \_\_\_\_\_*
45. Where did these patients mostly go for treatment before the clinic was established?  
*Public hospital – 1, Private hospital – 2, Private practitioner – 3, Mobile health clinics – 4, Jholachap doctor – 5, Ayurveda/Vaidhya/Hakim – 6, Home remedies – 7, Chemist shop (over-the-counter) – 8, Did not seek treatment – 9*
46. Do patients from outside this locality also visit the clinic? *Yes – 1, No – 0*
47. Do the patients come first to these clinics or do they consult other medical experts before coming here?  
*First come to clinic – 1, consult elsewhere before coming here – 2*
48. Do you explain the nature and cause of their illness to the patients? *Yes – 1, No – 0*
49. Are the patients keen on understanding the nature and cause of their illness? *Yes – 1, No – 0*
50. Do they ask any questions regarding what is the cause of their illness and what they can do to prevent it apart from taking medicines? *Yes – 1, No – 0*
51. Do the patients fully understand the instructions given to them? *Yes – 1, No – 0*
52. Do the patients come back for follow-up? *Yes – 1, No – 0*

### Satisfaction level and expectation

53. Are you satisfied with the following? Rate the following on a scale of 1 to 5, where ,  
*1 – Poor, 2 – Below Average, 3 – Average, 4 – More than Average, 5 – Very satisfied/Very good*
- Working conditions: \_\_\_\_\_
  - Medicines available: \_\_\_\_\_
  - Diagnostic test facilities available: \_\_\_\_\_
  - Drinking water facilities: \_\_\_\_\_
  - Toilet facilities: \_\_\_\_\_
  - Remuneration which you receive: \_\_\_\_\_
  - Behaviour of the co-worker: \_\_\_\_\_
  - Behaviour of the patients: \_\_\_\_\_

- i. Token vending machine: \_\_\_\_\_
- j. Medicine vending machine: \_\_\_\_\_
- k. Air conditioner: \_\_\_\_\_
- l. Security: \_\_\_\_\_

54. Do you think more friendly and affectionate attitude of the doctor :
- a. Makes the patient feel secure/relieved: *Yes – 1, No – 0*
  - b. Helps to reinforce the trust in the doctor: *Yes – 1, No – 0*
  - c. Helps the patient to understand treatment instructions well: *Yes – 1, No – 0*
  - d. Helps the patient to be comfortable with the doctor and ask any questions: *Yes – 1, No – 0*
55. Do you think co-operative and participatory attitude of the patient:
- a. Makes the interaction between doctor and patient easier: *Yes – 1, No – 0*
  - b. Helps the doctor to explain the nature and cause of illness and dosage and side effects of medicines to the patient easily: *Yes – 1, No – 0*
56. Do you think acquiring primary health care is easy or difficult for the patients now after establishment of Mohalla clinics in the locality?

*Very difficult – 1, difficult – 2, no change – 3, easy – 4, very easy – 5*

### **Creation of awareness and promotion of public health**

57. Have you ever organized any health awareness programmes in the locality? *Yes – 1, No – 0*
58. Have you ever conducted immunization programmes and free health camps? *Yes – 1, No – 0*
59. Do you think that by creating awareness among people, some diseases may be prevented in the locality? *Yes – 1, No – 0*

### **Problems and Suggestions**

60. Are there any other problems which you would like to mention?
- \_\_\_\_\_

61. What changes/additions would you suggest for the improvement of the clinic and overall health facilities in Delhi?
- \_\_\_\_\_



## INTERVIEW SCHEDULE FOR GOVERNMENT OFFICIALS

Name of the interviewer: \_\_\_\_\_

Date & time of interview: \_\_\_\_\_ Interview number: \_\_\_\_\_

Location: \_\_\_\_\_

### Introduction and informed consent

I am Sonali Smriti Biswas, an M.Phil. student in Jawaharlal Nehru University. I am working on the infrastructure and accessibility of health care delivery system in Delhi in general and Aam Aadmi Mohalla Clinics in particular for my MPhil dissertation. Therefore I would like to conduct an interview with you regarding health services provided by your clinic and related aspects such as relationships with patients, as well as the health department. My interest lies in understanding as to how these mohalla clinics have addressed the issues that government dispensaries and such other hospitals could not. .

The interview will take about 20-25 minutes time. All the information that will be collected through this interview will be used strictly for research purpose only and your identity will be kept anonymous. . If I ask you any question you do not wish to answer, just let me know and I will go on to the next question or you can stop the interview whenever you wish to.

Now, may I proceed with the interview?

### Identification

62. Name of the interviewee: \_\_\_\_\_

63. Designation: \_\_\_\_\_

64. Office address: \_\_\_\_\_

65. Contact details: Email: \_\_\_\_\_

Phone: \_\_\_\_\_

### **Background characteristics**

66. Age: \_\_\_\_\_ years  
67. Place of residence: \_\_\_\_\_  
68. Gender: \_\_\_\_\_

*Male – 1, Female – 2, Other – 3*

69. Educational Qualification: \_\_\_\_\_

### **Job profile**

70. When have you taken in charge of this department: \_\_\_\_\_  
71. Is there any other department that you are in charge of: \_\_\_\_\_  
72. What was your previous designation? \_\_\_\_\_

### **About the AAMC project**

73. Tell me something about the mohalla clinic project: \_\_\_\_\_  
74. When was it first proposed? \_\_\_\_\_  
75. What according to you was the main motive behind the establishment of mohalla clinics? \_\_\_\_\_  
76. There were various government hospitals and dispensaries, what was the need of establishing another new set of health institutions in the form of mohalla clinics? \_\_\_\_\_  
77. In the initial period of proposal, there was a delay in getting approval for the project, can you please elaborate on this issue? \_\_\_\_\_  
78. How many clinics were proposed in the pilot project? \_\_\_\_\_  
79. On the basis of which criterion are the locations chosen? \_\_\_\_\_  
80. What was the cost of establishment of each mohalla clinic in pilot project? \_\_\_\_\_  
81. Did you encounter any problems regarding funds procurement for pilot project? \_\_\_\_\_  
82. Do you face any problem regarding funds procurement now? \_\_\_\_\_

83. After the initial pilot project, there was a gap after which further clinics were established, what was the reason behind the delay?\_\_\_\_\_
84. What kinds of problems have you encountered in the way of establishment of these clinics?\_\_\_\_\_
85. What are you doing in order to solve the problem of land availability?\_\_\_\_\_
86. What kind of applications have you received for renting premises for mohalla clinics?\_\_\_\_\_
87. Who decides the suitability of the rented locations for establishment of the clinics?\_\_\_\_\_
88. At present total how many clinics are there in portable clinics\_\_\_\_\_ and rented premises\_\_\_\_\_?
89. How many clinics are working in double shifts?\_\_\_\_\_
90. Is there any plan to start the other clinics in double shift as well?\_\_\_\_\_
91. Is there a proposal to merge the mohalla clinics with the polyclinics in future or will they continue to function independently and act as referral units?\_\_\_\_\_
92. Is there any official who goes for supervision to these clinics at regular intervals?\_\_\_\_\_
93. What is the main focus of these clinics? Curative care/preventive care?

#### **About the clinics**

94. How are the records of the patients maintained?\_\_\_\_\_
95. What is the duration of the clinic (time)? Single shift \_\_\_\_\_ double shift
96. How many days does the clinic function in a week? \_\_\_\_\_
97. How many patients on an average come to visit the clinics daily?  
*On weekdays: \_\_\_\_\_; on weekends: \_\_\_\_\_*
98. Which age group of patients mostly visits the clinic?\_\_\_\_\_
- Infants – 1, Children below 5 years – 5, adults – 3, elderly people – 4*
99. Do more females visit the clinic than males? *Yes – 1, No – 0*
100. Compared to the time of establishment of this clinic, has the number of patients *increased/decreased/remained same* at present?
101. What is the system of procurement of medicines in the clinics \_\_\_\_\_
- Government supplies – 1, Dispensaries – 2, Nearest public hospital – 3*

102. What is the frequency in which the medicines are brought to the clinic?  
*Once a week – 1, once in 10 days – 2, once in 15 days – 3, once a month – 4, only when asked for-5*
103. If any medicine is not available in the clinic, is there any provision to procure it from elsewhere to give to the patients? *Yes – 1, No – 0*
104. If yes, from where? \_\_\_\_\_
105. If any medicine is not available in the clinic, do the patients have to buy it themselves? *Yes – 1, No – 0*
106. Is there any proposal to install medicine vending machines in all clinics? \_\_\_\_\_
107. Do all clinics have CCTV? \_\_\_\_\_
108. How many diagnostic tests are done? \_\_\_\_\_
109. When are the test reports ready to be given?  
*Same day – 1, Next day – 2, Within a week – 3*
110. Where are the patients referred to in case of emergency?  
*Government dispensaries – 1, Public hospitals – 2*
111. Who keeps a record of the medicines available in the clinic?  
*Doctor – 1, Assistant – 2*

### **About the patients**

112. What are the common ailments for which people visit the clinic?  
*Cold and fever – 1, Pain – 2, Chronic illness such as diabetes, hypo/hyperthyroidism/ rheumatism/others – 3, others – 4 (please specify) \_\_\_\_\_*
113. Where did these patients mostly go for treatment before the clinic was established?  
*Public hospital – 1, Private hospital – 2, Private practitioner – 3, Mobile health clinics – 4, Jholachap doctor – 5, Ayurveda/Vaidhya/Hakim – 6, Home remedies – 7, Chemist shop (over-the-counter) – 8, Did not seek treatment – 9*
114. Do patients from outside the locality also visit the clinic? *Yes – 1, No – 0*
115. Do the patients come first to these clinics or do they consult other medical experts before coming here?  
*First come to clinic – 1, consult elsewhere before coming here – 2*
116. Does the doctor explain the nature and cause of their illness to the patients? *Yes – 1, No – 0*
117. Are the patients keen on understanding the nature and cause of their illness? *Yes – 1, No – 0*

118. Do they ask any questions regarding what is the cause of their illness and what they can do to prevent it apart from taking medicines? *Yes – I, No – 0*
119. Do the patients fully understand the instructions given to them? *Yes – I, No – 0*
120. Do the patients come back for follow-up? *Yes – I, No – 0*
121. Do you think the establishment of the clinics have enhanced accessibility (provided scope) for treatment to patients who earlier used to avoid treatment for various reasons (accessibility and affordability issues)?\_\_\_\_\_

### **About the doctors**

122. What is the minimum qualification of doctors for mohalla clinics?\_\_\_\_\_
123. Are the doctors satisfied with the income from these clinics?\_\_\_\_\_
124. Are they allowed to carry out private practice or be attached to any hospital besides working in mohalla clinics?\_\_\_\_\_

### **Creation of awareness and promotion of public health**

125. Do the clinics organise any health awareness programmes in the locality? *Yes – I, No – 0*
126. Are immunization programmes and free health camps conducted in the locality? *Yes – I, No – 0*
127. Do you think that by creating awareness among people, some diseases may be prevented in the locality? *Yes – I, No – 0*

### **Future prospects**

128. Are there any other problems which you would like to mention?  
\_\_\_\_\_
129. Do you think these clinics will be important instruments for universal health care to people of Delhi?\_\_\_\_\_
130. Is there any proposal of having specialists visiting these clinics from government hospitals?\_\_\_\_\_
131. What changes/additions would you suggest for the improvement of the clinic and overall health facilities in Delhi?  
\_\_\_\_\_
132. Many states have adopted this model of health care, what is your opinion regarding those?\_\_\_\_\_

## Data for figures

**Figure 4.10: OPD consultations and Laboratory Investigations in Mohalla Clinics, 2015-20**

<b>No. of OPD consultations and laboratory investigations in Mohalla Clinics 2015-20</b>			
<b>Year</b>	<b>No. of Clinics</b>	<b>OPD</b>	<b>Laboratory investigations</b>
2015-16	107	6616	3588
2016-17	162	3709139	141108
2017-18	166	4443351	707872
2018-19	189	5739547	390664
2019-2020*	380	6692908	676000
*Till December 2019			
Data collected from AAMC Project Cell, Dwarka, Delhi			

**Figure 4.11: OPD consultations and Laboratory Investigations in Mohalla Clinics, 2018-19**

<b>No. of OPD consultations and laboratory investigations in Mohalla Clinics 2018-19</b>			
<b>Districts</b>	<b>No. of Clinics</b>	<b>OPD</b>	<b>Laboratory investigations</b>
North	8	253221	5402
East	15	63731	9135
North East	11	379274	18636
South East	11	366523	19298
New Delhi	5	116867	20173
South	13	326307	21471
North West	29	817595	23864
Shahdara	25	823870	35835
West	34	1160495	47379
South West	25	519147	68325
Central	13	480280	109943
Total	189	5307310	379461
Data Source: Annual Report 2018-19, DGHS			

**Figure 4.12: Age Wise distribution of patients seeking treatment in Mohalla Clinics, 2018-19**

Age (in years)	No. of Patients	%
Below 5	1355635	11
6 to 9	728446	6
10 to 14	898379	7
15 to 19	789097	6
20 to 24	932925	8
25 to 29	1121755	9
30 to 49	3847511	31
50 to 60	1527220	12
Above 61	1060206	9
Total	12261174	100
Data collected from AAMC Project Cell, Dwarka, Delhi		