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Review on Prospects and Problems of Private Medical Practitioners in India

KEYWORDS

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ABSTRACT *Health care is one of India's largest sectors, in terms of revenue and employment, and the sector is expanding rapidly. During the 1990s, Indian healthcare grew at a compound annual rate of 16%. The private sector plays an important role in India's health care delivery system. Through a wide network of healthcare facilities, this sector caters to the needs of both urban and rural populations and has expanded widely to meet increasing demands. The share of private sector investment in total health infrastructure, e.g. hospitals, investment in medical equipment and technology, is also quite significant. The growth of this sector has also been triggered by factors such as a new economic policy regime in India, the rapid influx of medical technology, and a rising middle-income class. Infrastructural bottlenecks in public system have made the State and Central Governments to invite private players to deliver quality healthcare. There is a big opportunity for private healthcare to fill up this gap. As such there is a huge growth potential for the private players in this growing market. It is found that private sector is dominating in the Indian healthcare system which includes changing consumer perception, increasing awareness about quality of medical care, greater penetration of insurance, increased purchasing power, changing demographic structure, etc. Recent innovations include focus on ambulatory and retail healthcare designed to focus on non-communicable diseases. Inherent factors like improved efficiency, better quality, greater reliability and transparency have also aided in the growth of private sector in healthcare. However, exploring the opportunities and a trade-off between 'social welfare' and 'business orientation' is critical to private sector. Further, quality needs to standardize in a highly fragmented healthcare delivery system of India.*

1. INTRODUCTION

The private sector plays an important role in India's health care delivery system. Through a wide network of healthcare facilities, this sector caters to the needs of both urban and rural populations and has expanded widely to meet increasing demands. The significance of the private health care sector in India can be summarized as follows: Total health expenditure in India is estimated to be about 6% of GDP, of which private health care expenditure is 75% or 4.25% of GDP. About one-third of this expenditure is on secondary and tertiary in-patient care, the rest meeting the curative needs at primary level (World Bank 1995). Insurance mechanisms are negligible and most of this expenditure is out-of-pocket. Private health care expenditure in India has grown at the rate of 12.5% per annum since 1960-61. For each 1% increase in per capita income, private health care expenditure has increased by 1.47% (Bhat 1996). The share of private sector investment in total health infrastructure, e.g. hospitals, investment in medical equipment and technology, is also quite significant. At present about 80% of 390000 qualified allopathic doctors registered with medical councils in India are working in the private sector (Jassani 1989; Bhat 1996). There are over 650000 providers of other systems of medicine practicing in India (Planning Commission 1998) and most of them are in private practice. Utilization studies show that one-third of in-patients and three-quarters of out-patients utilize private health care facilities (Duggal and Amin 1989; Yesudian 1990; Visaria and Gumber 1994)

From perspectives of health expenditure, number of qualified doctors working in the health sector, and delivery of curative care at primary level, the present private/public mix of health care is highly skewed in favour of the private sector. The growth of this sector has also been triggered by factors such as a new economic policy regime in India, the rapid influx of medical technology, and a rising middle-income class.

The Indian healthcare sector constitutes of the following:

- Medical care providers: physicians, specialist clinics, nursing homes and hospitals;
- Diagnostic service centres and pathology laboratories;
- Medical equipment manufacturers;
- Contract Research Organizations (CROs) and pharmaceutical manufacturers; and
- Third party support service providers (catering and laundry).

Health sector is one of India's largest sectors in terms of revenue and employment and the sector is expanding rapidly. During the 1990's, Indian healthcare grew at a compounded annual rate of 16 per cent. Today, the value of this sector is contributing to 5.2 per cent of GDP. By 2012, Indian healthcare sector is projected to grow to nearly $40 billion.

2. SIGNIFICANCE OF THE STUDY

The Indian public health systems' huge infrastructure is not currently used to its full potential because of inadequate managerial capacity. In response, over the past several years the private sector has also grown and has gained considerable experience in addressing the needs of clients effectively. The public sector is responding and contemporary health system policy emphasizes Public-Private Partnerships (PPPs) as an important mechanism for both gaining from the experience of private sector managerial efficiencies and ensuring coordinated achievement of public health goals. The utilization of hospital services in public and private sector varies greatly from one state to another. The private sector has provided useful contribution in improving the healthcare provision besides the role of the public sector in of the state of Kerala and Tamil Nadu. The private sector too is keen to enter into PPP since it is the easiest route for them to enter into the market as well as to expand in lesser time. Hence private players are faced with infrastructural constraints thus entering into PPP serve their purpose through leveraging public assets.

It is well known that the government is not able to cope with demand of the healthcare services. The focus had been on medical care and not on comprehensive quality healthcare. Infrastructural bottlenecks in public system have made the State and Central Governments to invite private players to deliver critical healthcare. There is a big opportunity

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for private healthcare to fill up this gap. As such there is a huge growth potential for the private players in this growing market.

3. GROWTH OF PRIVATE MEDICAL PRACTITIONERS

Private providers are typically defined as individuals providing health care that operate outside the direct control of the government. Private providers in India are an extremely heterogeneous and complex group characterised by various types of providers and types of health care systems. The demand pattern for health care has changed considerably in the last two decades. On the suppliers' side, private hospitals are investing huge amounts of capital to meet the growing demand for hospital services. Many hospitals have become complex organisations with specialty and superspecialty departments. From the customers' side, they are demanding high quality services at reasonable price.

The changing attitude of the people at large is being amply demonstrated by the fact that while there is a government hospital just next door and providing almost free medical attendance; people are shelling out huge chunks of money and going to private and corporate hospitals.This demonstrates that people do not mind paying more for a better and more reliable health service. The health care customer is changing qualitatively. The rising literacy rate, higher levels of income and increasing awareness through the deeper penetration of media, has brought the Indian consumer closer to demanding quality health care. With nuclear families on the rise, the bread-earner of the family and indeed , every member of the family now have access to regular health check-ups. All these factors have not only contributed to the growth of the health care sector in India but also to the quality of health care services.

4. REVIEW OF LITERATURE

The existing literature on prospects and problems of private medical practitioners in India can be grouped under four categories.

1. Studies relating to socio-economic profile of private medical practitioners.
2. Studies concerned with practitioners' perception towards private medical practices and quality.
3. Studies concerned with prospects and satisfaction of private medical practitioners and
4. Studies relating to problems of private medical practitioners.

I - SOCIO-ECONOMIC PROFILE OF PRIVATE MEDICAL PRACTITIONERS

In this category, age, gender, education, CME (Continuing Medical Education), income, experience, nature of practice, sources of finance and investment pattern of private medical practitioners are studied. These socio-economic factors have a favourable influence on private medical practitioners' job satisfaction. Prestige and social recognition are important criteria in choosing their professional career.

Marilyn Heins,MD Joanne Hendricks,MA, Lois Martindale, Ph.D, Sie Smock, Ph.D, Margaret Stein, BA, and Jennifer Jacobs, MD (1979)[1] obtained attitudinal data from interviewing random samples of women and men physicians in metropolitan Detroit indicated that women were generally more liberal and egalitarian than men. Older women were more liberal/egalitarian than older men while younger men was closer in attitudes to younger women. Within specialties, women and men physicians frequently held similar attitudinal scores; however, controlling for age, sex accounted for more variation than did specialty. A weighted combination of variables which together most significantly discriminated between age and sex subgroups pointed to a sensitivity dimension. This was stronger in the women; yet men demonstrating a similar sensitivity were found in almost every age and specialty grouping. Although younger men physicians, both younger and older women physicians demonstrated strong liberalism/egalitarianism.

Carol J. Simon, David Dranove, and William D. White (1998)[2] determined the effects of managed care growth on the incomes of primary care and specialist physicians. The incomes of primary care physicians rose most rapidly in states with higher managed care growth, while the income growth of hospital-based specialists was negatively associated with managed care growth. Incomes of medical subspecialists were not significantly affected by managed care growth over this period. These findings are consistent with trends in postgraduate training choices of new physicians. They suggested that increasing managed care penetration results in higher incomes for primary care physicians and lower incomes for-Radiologists, Anaesthesiologists and Pathologists (RAPs) physicians, all else equal. Evidence is consistent with a relative increase in the demand for primary care physicians and a decline in the demand for some specialists under managed care. Market adjustments have important implications for health policy and physician workforce planning.

Stefanie Mache, CristianScutaru, Karin Vitzthum, David Quarcoo, Norman Schoffel, Tobias Welte, Burghard F Klapp and David A Groneberg (2009)[3] examined the type of hospital ownership is a potential factor for variation in physicians' working activities. However, based on their findings, it is not possible to generally state that working activities are performed more efficiently or that quality of care is better with or without a more pronounced commercial focus. But it should be noted that these study results can stimulate an overall improvement of health care services in Germany, not only in the public sector but in private hospitals as well. By using professional, organizational and structural resources more rationally and effectively in German hospitals, the current health care situation could be improved, as considered to be necessary.

Ahmad AzamMalik,Shelby Suzanne Yamamoto, Aurelia Souares, Zeeshan Malik and Rainer Sauerborn (2010)[4] identified that intrinsic and socio-cultural factors like serving people, respect and career growth were important motivators. Among these, less pay was reported the most frequently. Fewer opportunities for higher qualifications were a demotivation among primary and secondary physicians. Less personal safety and poor working conditions were important in the public sector, particularly among female physicians. Among private tertiary physicians financial incentives other than pay and good working conditions were motivators in current jobs. Socio-cultural and intrinsic factors like less personal and social time and the inability to financially support oneself and family were more important among male physicians.

Lucy Reynolds (2011)[5] has revealed that higher prevalence countries especially, the demands of managing the response to HIV are heavy, requiring coordination between ministries of health, donors, logistics teams and local service delivery points. Supportive laws, non-discriminatory health care provision, robust infection control and reliable drug supply chains are all needed to support care and treatment for the caseload of chronic HIV patients. Attention to the affordability of Antiretroviral (ARVs) is crucial. The decision of the Botswana government to leave many patients with chronic HIV to fund their own treatment through the private sector may prove to be expensive in cost, morbidity and even mortality in the long term if higher drug resistance results, as seen in Mumbai. If patient contributions are essential, then it would be best for supply and adherence to be controlled centrally and contributions made through co-pays, rather than taking the easier option of leaving provision for these people to the private sector.

II PRIVATE MEDICAL PRACTITIONERS' PERCEPTION TOWARDS PRACTICES AND QUALITY

In this category, importance of the perceptions of private medical practitioners is studied to implement the effective medical practices and deliver quality health services. Perceptions are assumed to differ concerning (i)the existence of a health need, (ii)the importance of specific services for meeting given health needs, (iii) the appropriateness for and or-

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ganisation to provide certain services, and (iv)the availability or provision of necessary support.

Nanda P. and Baru R (1993)[6] identified the trends, characteristics and services offered by the private medical sector and described the factors that influence the choice of health care and gauge how the trends in privatization affect individual choices in Delhi. They found that a majority of these nursing home offer outpatient services but confined in patient services to maternity and surgical services. The social background of the users is related to the size of nursing homes. The small nursing homes cater mainly to low-income families; the medium sized nursing homes are used mainly by middle-income families. The study was revealed that for minor treatment both the lower and middle income use government services. The lower income group uses the private sector very little. The usage of private nursing homes increases with income levels.

Syed Aljunid (1995)[7] reviewed the role of private practitioners and their interactions with public health services in developing countries, focusing largely on the Asian region. Evidence on the distribution of health facilities, manpower, health expenditures and utilization rates shows that private practitioners are significant health care providers in many Asian countries. Limited information has been published on interactions between public and private providers despite their co-existence. Issues related to enforcement of regulations, human resources, patient referrals and disease notifications, are examined. Existing literature shows that patient characteristics (socio economic status, ethnicity, age, gender, and source of finance), types of illnesses and characteristics of the service (geographical accessibility, quality of care, price and types of services offered) influence the relative utilization of public and private health care.

Nandraj S, Ravi Duggal (1997)[8] examined the existing physical standards of health care in rural areas provided by private practitioners and hospitals. The researchers had to compile a list of the practitioners and institutions existing in the two selected talks of the district. The researchers used various sources such as handbooks, membership lists compiled by various local associations of doctors to get the information. They found that this study was brought into sharp focus the haphazard growth of the private health sector, the unreliable quality of care, the poor implementation of existing legislation and the lack of standardisation in health institutions. The study has revealed the inadequacy of the physical standards in private hospitals as well as in private clinics. It shows that the large-scale growth of private sector has not resulted in provision of health care government intervention at the earliest. Private health services should be relocated and should be brought under regulation. Maintenance of records regarding fees, patients, diagnoses, etc. should be made compulsory. Minimum physical standards should be laid down and be made legally binding to make the private health sector accountable and people oriented.

Ramesh Bhat (1999)[9] indicated that the perceptions of private providers about risk factors are seasonal fluctuations in patient flow, poor recovery of cost, regulatory mechanisms, awareness of patient's rights etc., have a significant bearing on provider behaviour, and thereby affect the cost and quality of services. He was identified some of the critical factor affecting the functioning of private providers are : cost of capital, and financing mechanisms, availability and cost of trained manpower, availability and price of equipment and technology, cost of land and building (which depends on location). He concludes that experience is considered as the most important factor in attracting patients to private health facilities. The financial structure of most private providers is vulnerable to high capital costs. He suggested to develop appropriate strategies to correct the overall financial structure of private providers was initiation to start up health facilities in a joint sector (government and private) with a minimum equity stake is one option and other alternative options was recognizing the private health care sector as an industry and making normal channels of finance available to the sector need to be explored.

Syed SaadAndaleeb (2000)[10] dealt with the quality of hospital services would be contingent on the incentive structure under which these institutions operate. Since private hospitals are not subsidized and depend on income from clients (i.e. marker incentives), they would be more motivated than public hospitals to provide quality services to patients to meet their needs more effectively and efficiently. In addition to marker incentives, it is proposed that four other incentives be considered to promote higher quality in hospitals in Bangladesh. These include competitive, social, internal and regulatory incentives.

QingyueMeng, XinGzhu Liu and Junshi Shi (2000)[11] found that private clinics are likely to provide services with a lower level of quality than their public counterparts that private clinics are less willing to provide preventive services, and that private clinics are more likely to provide over-treatment for their own economic benefit. The results showed that there were no differences in health service quality among the different types of village clinics. Although statistically there was a difference in willingness to provide preventive services between private and public clinics with the former requesting more subsidies for provision, more scrutiny found that the difference was only a false appearance because public clinics were already heavily subsidized, and a subsidy they received was more than the amount requested by private doctors. The results showed no sound evidence to say that private clinics are less willing to provide preventive care. In terms of the likelihood of over-treatment, they found that private clinics were equally likely (if not less likely) to provide over-treatment as compared to public clinics.

Brijesh C Purohit (2001)[12] identified the strategies to attract private sector participation and management inputs into primary health care centres (PHCs), privatization or semi-privatization of public health facilities through non budgetary measures, and tax incentives by the state governments to encourage private sector investment in the health sector. The analysis indicates that despite the promising newly emerging atmosphere, whichare limits to market forces; appropriate refinement in the role of government should be attempted to avoid undesirable consequences of rising costs, increasing inequity and consumer exploitation. This may require opening the health insurance market to multinational companies, the proper channelling of tax incentives to set up medical institutions in backward areas, and reinforcing appropriate regulatory mechanisms. He was concluded that the state and local governments from time to time have enacted various regulations and guidelines, there are not implemented effectively, owing to low awareness among private doctors. Therefore, an early implementation of the continuing education clause will be an important step, incorporating the self-regulating mechanism of peer review in clinical practices. This might help in creating an appropriate regulatory environment for the private health care sector in India.

RmpmBaltussen, Y Ye, Haddad S and RS Sauerborn (2002)[13] examined the user's opinion on the quality of care of primary health care services. The respondents were relatively positive on items related to health personnel practices and conduct and to health care delivery, but less soon items related to adequacy of resources and services and to financial and physical accessibility. In particular, the availability of drugs for all diseases on the spot, the adequacy of rooms and equipment in the facilities, the costs of care and the access to credit were valued poorly. Overall, the urban hospital was rated poorer than the average rural health care centre. They conclude that improving drug availability and financial accessibility to health services have been identified as the two main priorities for health policy action. Policy-makers should respect these patient preferences to deliver effective improvement of the quality of care as a potential means to increase utilization of health care.

Antoine Duclos, Florence Gillaizeau, Isabelle Colombet, Joel Coste and Pierre Durieux (2007)[14] revealed that the

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major determinants of the perception of various categories of healthcare professionals concerning the quality of delivered information to inpatients in their wards. This study shows that various categories of healthcare professionals have similar views about the overall quality of information provided to patients in their ward. The multilevel model confirmed existence of strong ward cluster effect and highlighted that professional category is not a determinant of the perceptions of the healthcare staff. Moreover, age is the only personal characteristic of healthcare professionals associated with their perceptions of the quality of inpatient care: professionals were more lenient in scoring quality when they were older.

Chiai Uraguchi, SunayanaSen and Maki Ukyama (2009)[15] aimed to explore whether there are gaps in the existing healthcare system in Thanjavur in rural Tamil Nadu, in the Southern part of India. They mainly focused on for analysis: quality of service, accessibility, availability, and affordability both in the private and public healthcare sectors. The result of this study showed that the most serious issue is the huge shortage in manpower in the public sector that provides healthcare to the poorer segments of the population. The cliché of unaffordable charges in the private sector does not seem to be entirely true in this geography since some people mentioned that some private doctors now charge lower fees and provide injections and tablets at an affordable price although there are some people who still have to borrow money in order to access the private sector. Despite it being an illegal medical practice, unqualified doctors ('quacks') seem to exist and often meet villagers' needs with 24-hour access and affordable medicines.

Ann Levin and MiloudKaddar (2011)[16] have revealed a literature review on the role of the private sector in low and middle-income countries. The review indicated that relatively few studies have researched the role of the private sector in immunization service delivery in these countries. The studies suggest that the private sector is playing different roles and functions according to economic development levels, the governance structure and the general presence of the private sector in the health sector. In some countries, generally low-income countries, the private for-profit sector is contributing to immunization service delivery and helping to improve access to traditional Expanded Programme of Immunization (EPI) vaccines. In other countries, particularly middle-income countries, the private for-profit sector often acts to facilitate early adoption of new vaccines and technologies before introduction and generalization by the public sector.

Nirali.M Shah, Wenjuan Wang and David.MBishai (2011)[17] dealt that franchised systems of private family planning providers, with their carrot and stick approach of demanding standards and establishing supply chains, can greatly improve the quality of care in family planning. Depending on the country, the accessibility of franchised private clinics to the poor can be similar to that of non-franchised private clinics (e.g. Pakistan). Thus the quality improvements in the private sector can be delivered to the poor in some settings.

Ramanujam P.G. (2011)[18] study revealed that the corporate hospitals in Hyderabad, to a large extent are providing quality service to the customers. In fact, with regard to tangibles, the hospitals care performing extremely well. On the assurance aspect of health care service that is most critical to the patients, the hospitals have excelled in delivering quality service to their customers. In dimensions such as reliability and responsiveness the hospitals are performing satisfactorily. However, the major matter of concern for the corporate hospitals is the empathy dimension which has been perceived by the patients as 'moderate' in delivering service quality. Corporate hospitals need to concentrate more on the empathy dimension. This study clearly indicates there is scope for service quality improvement by corporate hospitals in Hyderabad, especially on empathy and then on the responsiveness and reliability dimensions.

III - PROSPECTS AND SATISFACTION OF PRIVATE MEDICAL PRACTITIONERS

The globalization of India's healthcare sector in recent years has significance for India's cross-border engagements in health services. Rapid growth as well as the emergence of international quality private players in India's healthcare sector has created opportunities for trade, investment, and collaboration, cutting across all four General Agreement on Trade Services (GATS) modes of delivery. GATS mode 1: Cross-border supply of healthcare takes the form of electronic delivery of healthcare across countries. GATS mode 2: Consumption abroad takes the form of medical value travel. GATS mode 3: Foreign commercial presence takes place through investments in the healthcare sector, and GATS mode 4: Cross border movement of service providers involves the circulation of doctors and nurses among countries.

According to secondary sources and discussions with industry experts, there are many existing and prospective opportunity segments for India to trade health services. India has prospects in many aspects of e-health, including teleradiology, telediagnostics, telepathology, intensive care (or remote monitoring via tele-ICU), ophthalmology remote diagnosis of skin problems, tele-psychiatry (using videoconferencing, TV cameras, and microphones to connect patients and psychiatrists for diagnosis, assessment, medication management and second opinions) and continuous online remote monitoring. These prospects are driven by India's cost advantage and the quality of its radiologists and specialized technical staff.

Julia E. McMurray, Eric Williams, Mark D. Schwartz, Jeffrey Douglas, Judith Van Kirk, Robert Konrad, Martha Gerrity, Judy Ann Bigby, and Mark Linzer (1997)[19] aimed to develop a current and comprehensive model of physicians' job satisfaction. They found that physicians were satisfied with day-to-day practice issues, relationships with patients and colleagues, and positive aspects of administrative issues such as "concentration on patient care with management done by professionals. Physicians were dissatisfied with stress-related aspects of day-to-day practice, such as workload and patient volume. Future concerns emphasized the anticipated effects of managed care on physician relationships with colleagues and patients and the negative effects that an intensified focus on cost containment and productivity would have on the quality of care. They suggested that different components of overall job satisfaction may be more or less relevant to specific physician subgroups. For example, balance of work and family commitments was an issue for women physicians, a sense of mission was important to minority and inner-city physicians, and administrative issues were relevant for those in managed care.

Mary Guptill Warren, Rose Weitz and Stephen Kulis (1998)[20] analysed the impact of changes in the health care environment on physician satisfaction. They found that the background physician attributes did not predict satisfaction, nor did most organizational attributes. However, participation in Individual Practice Associations (IPAs) predicted higher satisfaction, while payment according to a third party payer's fee-for-service schedule predicted lower satisfaction. In addition, physicians were more likely to be satisfied if they wrote the orders than non-physicians had to follow, were paid what they wanted, did not need to subordinate their clinical judgment to that of non-physicians, and believed that their patients had confidence in physicians.

Erica Frank, Julia E. McMurray, Mark Linzer, and Lisa Elon (1999)[21] examined personal and professional characteristics that were correlated with three major outcomes: career satisfaction, desire to become a physician again, and desire to change one's specialty. They found that women physicians were generally satisfied with their careers. However, 31% would maybe, probably, or definitely not choose to be a physician again, and 38% would maybe, probably, or definitely prefer to change their specialty. Physician's age, control of the work environment, work stress, and a history of harass-

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ment were independent predictors of all three outcomes, with younger physicians and those having least work control, most work stress, or having experienced severe harassment reporting the most dissatisfaction. The strongest association was between work control and career satisfaction. They conclude that women physicians generally report career satisfaction, but many, if given the choice, would not become a physician again or would choose a different specialty. Correctable factors such as work stress, harassment, and poor control over work environment should be addressed to improve the recruitment and retention of women physicians.

Julia E. McMurray, Mark Linzer, Thomas R. Konrad, Jeffrey Douglas, Richard Shugerman, and Kathleen Nelson (2000)[22] described gender differences in Job Satisfaction, Work Life Issues, and Burnout of U.S. Physicians. Compared with male physicians, female physicians were more likely to report satisfaction with their specialty and with patient and colleague relationships, but less likely to be satisfied with autonomy, relationships with community, pay, and resources. Female physicians reported significantly less work control than male physicians regarding day-to-day aspects of practice including volume of patient load, selecting physicians for referrals, and details of office scheduling. They concluded that gender differences exist in both the experience of and satisfaction with medical practice. Addressing these gender differences will optimize the participation of female physicians within the medical workforce.

Stoddard, Hargraves, Reed and Vratil (2001)[23] examined the degree to which professional autonomy, compensation and managed care are determinants of career satisfaction among physicians. They hypothesized that professional autonomy is as strong predictor of career satisfaction among physicians, after controlling for the effects of other important determinants such as income and managed care. They tested both for the direct effects of managed care on satisfaction and for indirect effects exerted through autonomy and income. Multivariate analysis demonstrated that traditional core professional values and autonomy were the most important determinants of career satisfaction after controlling for all other factors. Relative income was also an important independent predictor. Their results suggested that when managed care erodes professional autonomy, the result is a highly negative impact on physician career satisfaction.

QianFeng (2004)[24] identified perspectives of doctors in Singapore on doctors' professional and career satisfaction. They found that the majority of doctors in Singapore are quite satisfied with their autonomy to treat patients and relationship with patients. However, most of them are dissatisfied with the amount of leisure time and promotion and career development prospects.

MarjoleinDieleman, JurrienToonen, HamadassaliaToure and Tim Martineau (2006)[25] showed that the main motivators of health workers were related to responsibility, training and recognition, next to salary. These can be influenced by performance management (job description, supervisions, continuous education and performance appraisal). Performance Management is not optimally implemented in Mali, as job descriptions were not present or were inappropriate; only 13% of interviewees received 4% per year supervision and training needs were not analysed. Some 48% of the interviewees knew their performance had been appraised in the last two years; the appraisals were perceived as subjective. No other methods were in place to show recognition. The results enabled the research team to propose adaptations or improvements upon existing performance management. The results showed the importance of adapting or improving upon performance management strategies to influence staff motivation. This can be done by matching performance management activities to motivators identified by operational research.

HolgerGothe, Ann-DorotheeKoster, Philipp Storz, Hans-Dieter Nolthing, and Bertram Haussler (2007)[26] reviewed the international literature on the subject of work and job satisfaction on health care. Firstly they dealt with the influence of individual determinants on the work and job satisfaction as one of the central, physician side components such as administrative tasks and need for documentations, autonomy versus experience of external control over own professional actions, medical training, and education and secondly considers effects on the reality of health care. They were doctor related results (psychological and physical wellbeing, non-work related satisfaction and satisfaction with family and leisure time); care related results (quality of care, intensity of care and costs); and patient related results (doctor-patient relationships, frequency of demand and patients' satisfaction). It was to be borne in mind that determinants of doctors' job satisfaction may actually influence the result variables directly, not only through work and job satisfaction i.e., economic incentives and incomes as well as arrangements to share risk, forms and types of organization where doctors practice, control over clinical medical decisions, cooperation between doctors /managers, Doctors' professional and social prestige, doctor-patient relationship, socio demographic and psychosocial aspects.

Till Barnighausen and David E Bloom (2009)[27] analysed that health workers are motivated not only by financial compensation but also by other factors, such as altruism, the satisfaction of successfully applying their skills in caring for their patients and recognition from their peers. For instance, a study in Benin and Kenya found in semi-structured interviews that nurse and doctors more commonly referred to 'healing patients", "vocation" "professional satisfaction" and "recognition by supervisors" than to "remuneration" when asked what currently encourages them to do their work well.

James Farah and Leila A Halawi (2010)[28] studied to gain a more complete understanding of the factors that pertain to independent physician hob satisfaction. This group of physicians consists of physicians who own their own practice or who are employed in a privately owned medical practice in the State of Florida. They suggested that the independent physician practice is increasingly attractive as a choice. Rising demands for physicians, increasing incomes, and the increasing role of primary-care physicians in controlling the total health-care services of their patients contribute to increased satisfaction among physicians. Clinical freedom is the best example of higher satisfaction. This study also suggests opportunities for maintaining satisfaction in an increasingly managed health-care environment. Clinical freedom continues to be a very important aspect of physician job satisfaction.

RupaChanda (2011)[29] concludes that although there are several promising areas for India-EU relations in health services, it will be difficult to realize these opportunities given the pre-dominance of public healthcare delivery in the EU and sensitivities associated with commercializing healthcare. Hence, a gradual approach based on pilot initiatives and selective collaboration would be advisable initially, which could be expanded once there is demonstrated evidence on outcomes. Overall, the paper makes a contribution to the social science and health literature by adding to the limited primary evidence base on globalization and health, especially from a developing-developed country and regional perspective.

IV PROBLEMS OF PRIVATE MEDICAL PRACTITIONERS

Problems faced by Indian healthcare providers in providing health services are:

1. Restrictions on outsourcing certain kinds of health services;
2. Data protection and data exclusivity laws;
3. Accreditation and certification requirements for healthcare establishments and compliance issues with international;
4. Insurance portability restrictions and coverage issues;
5. Recognition of professional qualifications and registration requirements;

6. Immigration and visa regulations affecting mobility of providers; and
7. National treatment restrictions and discriminatory treatment which put Indian healthcare providers on an uneven playing field and undermined their market access vis-à-vis competitor countries in the world.

Armida Fernandez, JayshreeMondkar and Sheila Mathai (2003)[30] dealt with urbanization was rapidly spreading throughout the developing world; an urban slum poses special health problems due to poverty, overcrowding, unhygienic surroundings and lack of an organized health infrastructure. The primary causes of neonatal mortality are sepsis, perinatal asphyxia and prematurity. Home deliveries, late recognition of neonatal illness, delay in seeking medical help and inappropriate treatment contribute to neonatal mortality. Measures to reduce neonatal mortality in urban slums should focus on health education, improvement of antenatal practices, institutional deliveries, and ensuring quality perinatal care. Success of a comprehensive health strategy would require planned health infrastructure, strengthening and unification of existing health care program and facilities: forming a system of referral and developing a programme with active participation of community.

Elizabeth Smith, RiairiBrugha and Anthony Zwi (2004)[31] the cost of the healthcare services is really uncontrollable and the real victims are the poor people. It is really very difficult for the government to determine the charge of the health services because of its heterogeneous nature; creating a real challenge in the health sector. It has been seen particularly in case of specialized treatment, where the patients do not have any idea what has been done actually as service. In India, for example, physicians work in a highly competitive private sector market, especially in urban areas. However, in certain cases, the price is being regulated like in medicine where maximum retail price is mentioned.

RaoP.H (2005)[32] found that one of the common problems faced by the Private Medical Practitioners (PMPs) are the inability of subjects to pay for the treatment received, lack of adequate facilities for conducting pathological tests, non-availability of latest medicines and lack of chemist shops in the villages they practice. Majority of the PMPs were found to be practising allopathic though they were not formally trained in the modern system of medicine. It is suggested that steps should be taken to include the PMPs for participation in national health and family welfare programmes. However, this needs to be preceded with appropriate training inputs to Private Medical Practitioners to improve their knowledge and skills for delivering quality services through national health and family welfare programmes. This seems absolutely necessary since more than 50 per cent of the PMPs have been practising in rural areas for 10 years or more with little or no formal training.

Stefane M Kabene, Carole Orchard, John M Howard, Mark A Soriano and Raymond Leduc (2006)[33] analysed challenges in the health care systems in Canada, the United States of America and various developing countries are examined, with suggestions for ways to overcome these problems through the proper implementation of human resources management practices. Comparing and contrasting selected countries allowed a deeper understanding of the practical and crucial role of human resources management in health care.

Scott A Fritzen (2007)[34] studied issues relating to strategic management challenges emerging from the growing literature in this area. Workforce issues are strategic: they affect overall system performance as well as the feasibility and sustainability of health reforms. Viewing workforce issues strategically forces health authorities to confront the yawning gaps between policy and implementation in many developing countries. Issues emerged in four areas. One concerns imbalances in workforce structure, whether from a functional specialization, geographical or facility lens. These imbalances pose a strategic challenge in that authorities must attempt to steer workforce distribution over time using a limited range of policy tools. A second group of lessons concerns the difficulties of central-level steering of the health workforce, often critically weak due to the lack of proper information systems and the complexities of public sector decentralization and service commercialization trends affecting the grassroots.

A third cluster examines worker capacity and motivation, often shaped in developing countries as much by the informal norms and incentives as by formal attempts to support workers or to hold them accountable. Finally, a range of reforms centring on service contracting and improvements to human resource management are emerging. Since these have as a necessary (but not sufficient) condition some flexibility in personnel practices, recent trends towards the sharing of such functions with local authorities are promising.

Mohanan Nair V.R. and VijayachandranPillaiV (2009)[35] revealed that the hospitals in the cooperative sector experience problems in different areas of their operation. These specific areas are casualty and emergency services, outpatient services, in patient services, diagnostic services, and supportive services such as nursing, pharmacy, medical records, laundry, and housekeeping services such as transport, maintenance, communication and mortuary.

They suggested that to improve the housekeeping services of cooperative hospitals. Sufficient number of wards, beds etc., may be arranged in order to accommodate the needy patients. For this purpose, special governing bodies may be formed by including the representatives of local bodies, government officials, public servants, doctors, important personalities in the local area, representatives of voluntary associations and non-governmental organisations. More financial freedom should be allowed this body in respect of raising and utilisation of funds subject to the annual audit by government department. They can create a rapport with industrialists, agriculturists and business people and with their help the governing body can make necessary arrangements to sponsor these facilities.

Sophie Witter, Bui Thi Thu Ha, BakhutiShengalia and Marko Vujicic (2011)[36] examined the perception of the problem by national level stakeholders; the motivation for joining the profession by doctors; their views on the different factors affecting their willingness to work in rural areas (including different income streams, working conditions, workload, equipment, support and supervision, relationships with colleagues, career development, training, and living conditions). It presents findings on their overall satisfaction, their ranking of different attributes, and willingness to accept different kinds of work. Finally, it discusses recent and possible policy interventions to address the distribution problem.

Gerald Bloom, Hilary Standing, Henry Lucas, Abbas Bhuiya, OladimejiOladpo and David H Peters (2011)[37] focused largely on the micro and meso levels. However, it is important to also recognize macro-level influences. The emergence of large informal markets reflects a history of failure by the public health services to meet the health-related needs of the poor, with the emergence of markets in response to demands for services and drugs. The unorganized nature of these markets reflects the unwillingness and inability of government to establish an appropriate regulatory framework; their future development will be strongly influence by government.

5. CONCLUSION

It is concluded that Indian health care infrastructure has evolved over the past six decades after the Indian independence. The role of private sector has been critical in the provision of medical care services. Private sector is dominating the Indian healthcare delivery market includes changing consumer perception, increasing awareness about quality of medical care, greater penetration of insurance, increased purchasing power, changing demographic structure, etc. Recent innovations include focus on ambulatory and retail healthcare, designed to focus on non-communicable diseases. Inherent fac-

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tors like improved efficiency, better quality, greater reliability and transparency have also aided in the growth of private sector in healthcare. Private sector holds to key to improving healthcare delivery in India. However, exploring the opportunities and a trade-off between 'social welfare' and 'business orientation' is critical to private sector. Further, quality needs to standardize in a highly fragmented healthcare delivery system of India.

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