Details of Module and its Structure

Module Detail	
Subject Name	Sociology
Paper Name	Sociology of Health
Module Name/Title	Rural Private Practitioners in India
Pre-requisites	No pre requisites
Objectives	To understand the concept rural private practitioners in India To examine the role of rural private practitioners in providing access to health care. To analyse whether rural private practitioners deserve to be recognized as health care providers in India.
Keywords	Rural Private practitioners, Health Care, State Regulatory Mechanism, Community, local healers, unqualified practitioners.

Structure of Module / Syllabus of a module (Define Topic / Sub-topic of module)	
Rural Private Practitioners in India	Introduction, Who is a Rural Private Practitioner? Types of Rural Practitioners, Treatment Preference and Choice of a Practitioner, Qualities of a Good Doctor, Different Systems of Medicines, Arguments in Support of Rural Private Practitioners, Equity Issus in Health Care, Conclusion.

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11. Rural Private Practitioners in India

Introduction:

Public health is good health enforced by the state, implying primarily the state's responsibility. It prioritizes prevention over curative services. Government doctors work at three-tier hospital system i.e. Primary health centres and sub-centres located in rural areas, community health centres located in semi-urban areas while the district hospitals and state level tertiary hosprpitals located in urban areas Private health services in India began in order to supplement the government health services initially but increasingly health care has been converted from a need to a commodity as profit has become the only motive. Private nursing homes have been defined as those institutions having bed strength below 40 while hospitals usually have bed strength of 40 and above A large number of doctors engage in their medical practice in these private clinics in India. As most of the qualified doctors work in private hospitals and nursing homes located in urban areas, unqualified practitioners, alternate medicine practitioners etc., have established clincs in rural areas catering to the rural masses. Several studes indicated that about 65% of the people go to the private practitioners, of which a large majority of them are rural private practitioners.

Who is a rural private practitioner?

Rural private practitioners are also called as RMPs an acronym for 'Registered Medical Practitioner'. The term Registered Medical Practitioner creates ambiguity because those who have MBBS degree as per law today are the registered medical practitioners. They are registered with a state or national board and graduated from a recognized medical college. However, the term RMP is used in colloquial sense to mean any one who practices medicine in smalller clinics in rural India with or without legal permission. Given the issues of accessibility to qualified medical practitioners working in large private hospitals, nursing homes and government hospitals, the rural communities consider RMPs as doctors not based on their formal qualification but upon their

experience and social acceptability. Rhode and Viswanathan (1998) point out the formal process of granting registration to medical practitioners as given below:

> "Apparently this practice of granting registration to any practitioner who could prove that he had been practicing for a long time was extended in the late 1950s and early 1960s. This is to bring all those currently practicing medicine in rural areas under some type of control and standnardization, A cut-off date for registration was set sometime between 1968 and 1972. In a way, this ruling was a silent acknowledgement of the worth of empirical evidence since it implied that if a practitioner had practiced medicine in a locality consistently for a decade and had not been driven out by force or failure, then he must be reasonably capable. The ruling would serve to recognize and permit such persons who had stood the test of time and public opinion to continue and yet prevent any new entrants into the field, beginning this date".

In 1971, Neumann described the situation thus: 'In some states there are three categories of registration: Institutionally qualified practitioners, traditional practitioners who have produced satisfactory evidence from a magistrate that they have been practicing successfully for about 10 years, and third, "enlisted" practitioners who function as RMPs while completing the required period of practice to qualify for full registration with the state. Some states group the first two categories together, while other states do not differentiate between the categories at all.'

Mark Nichter has also attempted to define the RMP thus: 'This term covers a wide range of practitioners officially'registered within the state government on the basis of either formal or informal academic qualifications. Formal qualifications include a degree or licentiate diploma from a course in pure Ayurveda or integrated Allopathy / Ayurveda; while informal education refers to an apprenticeship and sponsorship by a hereditary or a trained practitioner. Several different kinds of registration exist in each state, which have little bearing on medical practice.'

Three-tier health services in the government sector with good referral system was conceived in the post-Independence period. It was presumed that this institutional mechanism would serve the needs of lower classes especially in rural India. However, within two decades, the limited availability and accessibility of health services to the rural masses came to the fore. Therefore, in the early 1970s, in providing large scale Primary Health Care Services at the village level, the Government of India proposed that the existing rural practitioners (commonly called as RMPs) be invited to join the government service accepting a low stipend from the government as their monthly salary. The pre-condition of the government was that rural practitioners should complete two years of licentiate degree, follow the government procedures and norms in their treatment practices, and refrain from private practice. This proposal was rejected by the rural practitioners as their own private practice was more lucrative than the government stipend. Later the government mooted health guide scheme essentially drawing the volunteers from the local communities. Today, the term RMP continues to be used ambiguously, ranging from a totally untrained and unqualified practitioner to a graduate of the best medical college duly registered with the state boards.

Types of Rural Practitioners:

By 1970s, it was clear that health services both in government and private sector were catering largely to urban areas. Although government's primary health centres (PHCs) and community health centres (CHCs) were located in rural areas, they were not effective in provding services to the people in rural areas. Given this situation of inaccessibility, a range of rural private practitioners emerged. There are essentially two types of rural private practitioners (RPP) that exist in India. First, those who have received formal medical training in any type of medicine (Allopathy, Ayurveda, Homoeopathy, Siddha or Unani) from a recognized college and second those who have no formal training. Those with formal training could confined themselves in practicing either to the type of medical system they have received training or they extended their practice outside their own field

of formal training. In rural India, there are very few practitioners who belong to the first category.

A question that constantlycomes up in the discussion on the type of practitioners is that, are the practitioners who received formal training in Ayurveda, Unani or Siddha but practice Allopathy also to be labelled as unqualified practitioners?. If one takes into account this factor, then a majority of the rural private practitioners are unqualified. The practitioner who has no formal training in all or part of his field of practice could again be divided into two groups. Those who received some informal training and those who received no training at all. Informal learningcould have been picked up in an informal situation where the rural private practitioner (RPP) happened to get the opportunity to observe, assist or actually receive guidance in some hospital or clinic. Clearly, learning by doing (as in the case of a compounder of medicines or a doctor's assistant) would have more value than learning from observation alone (as in the case of a sweeper in a hospital or a watchman at a clinic).

However, even within this category of RPPs with informal learning, there would be two sub-categories. Those who learnt by observing or working with a formally trained and qualified doctor and those who learnt from observing a practitioner who himself did not have proper training. While the former may have some correct t knowledge, and could be termed an 'apprenticed practitioner', the latter could only be classified into the same group as those who did not have any training at all.

If one takes into consideration the above described type of practitioners, only a handful of all rural private practitioners in the villages providing primary health care today really fall into the 'acceptable' category. The suitability of all others is dubious but that does not alter the fact that they are the main and the preferred providers of health care for the people in rural India.

In terms of gender, the rural practitioner are almost always male, with little difference in age, years of experience, or schooling between those practising allopathy and all other

system of medicine. Several studies indicated that most of the rural private practitioners depend upon medical practice as their sole occupation. A significant proportion of them did not attend school beyond the secondary level, and quite a few have not even completed high school. A small proportion of them studied up to undergraduate level and a few did their post graduate studies. Thus rural private practitioners have diverse backgrounds in term of education, qualification and experience.

Treatment Preference and Choice of a Practitioner:

As practitioners, vary from that of traditional healers to Ayurveda, Unani, Siddha, Allopathy doctors and hybrid/mix of practitioners in rural India, one presumes that the local communities will have wider choices in seeking health care. However, several studies indicated the contrary in terms of treatment preference. For instance, Meera Chaterjee made an extensive review of literature in four states i.e. Bihar, Madhya Pradesh, Haryana and Maharashtra. The study states that 63% prefer private health care while 37% prefer the government facility. Chatterjee concludes the following:

a. A significant proportion of rural illnesses are untreated by any means, and certainly by medicine, be it traditional or modern.
b. The majority of rural "illness consultations" are to private traditional or allopathic practitioners in preference to government health facilities.
c. Among rural practitioners, modern Allopaths appear to be preferred where available and even traditional practitioners engage in a fair degree of allopathic medical practice.
d. Those who cannot afford to pay a private allopath's fee may go to government health centres, but prefer to approach town hospitals directly which results in underutilisation of community health facilities.
e. Traditional practitioners are cheaper and more empathetic; they are consulted for women's children's diseases, common ailments and chronic conditions, including some important health problems such as respiratory diseases, diarrhoea, malaria, etc.

Findings from the above study indicates that availability of health care providers does not automatically ensure the accessibility. One of the important factors for choosing a particular practitioner over the other is quick relief for their illness. Then, the economic factors particularly their ability to pay for the services play an important role. Thirdly, the distance where the practitioner is located. If women, children and dependent population will have to seek the health service, distance becomes important. Similarly, if it takes a long time to approach the doctor (long waiting periods, opening and closing time of the clinics, availability of doctor, convenience and conveyance vis-à-vis time), then time also plays significant role in chosing a particular practitioner. Impatience for a quick cure is more pronounced when a person is dealing with a private practitioner, than when one is dealing with a government doctor. As the private doctor is being paid for his services, patients exhibited greater assertiveness, and had higher expectations of speedy relief and cure, usually within 24 hours. Similarly, the issue of medicine supply. If medicines are made available in the health centre or clinic, then people prefer the practitioner than those practitioners who prescribe and ask the patients to buy elsewhere. Therefore, one needs to understand socio-cultural and economic factors that play a significant role in providing accessibility to health care services.

Qualities of a good doctor:

How do local communities evaluate the qualities of a good doctor? Is it based on the formal qualification of a doctor? Several studies indicated that it is based on the perceived notion of effectiveness of treatment. Ofcourse, the cost of treatment, physical accessibility, waiting time, provision (rather than prescription) of medicine, timings of the clinic, Doctor's attitude and demeanor towards the patient, cleanliness of the clinic, Doctor's qualification and training. Commenitng on the formal qualification, local communities say 'We are an uneducated lot. What do we gain by knowing about qualifications? We are only concerned about the medicine. If the medicines are effective, we don't bother about the education'. A study of private practitioners done by Chuttani et al. (1973) found that out of 230 practitioners studied from 463Villages in the rural areas of Delhi, Haryana, MadhyaPradesh, Uttar Pradesh and Rajasthan, not one had an MBBSdegree.33% had qualifications in Indian systems of medicine.

Several studies indicated that the women respondents were always quick, clear and precise about their perception of a good doctor. Mothers based on their regular assessment of the treatment providers, classified doctors into different types. For instance, a particular doctor was categorised as 'brightand clever', implying that doctor was only good for first-aid. In larger villages where several practitioners existed, they often identified different doctors for differen types of problems. For example, those doctors who are efficient in dealing with women and children, those who are efficient in diagnosing the major ailment and refer to a practitioner outside the village, a few as `kind doctors' because they agree to give injections readily etc.

Given their limited choices, rural communities have evolved different parameters for evaluating the qualities of a good doctor, not just their formal qualification.

Different Systems of Medicine:

Although rural India has formal and informal practitioners from both institutional and non-institutional systems of medicine, allopathic medicines are preferred by the local communities. A few studies indicated that nearly 90% of rural practitioners prescribed and dispensed allop**a**thic medicines in their practice. However, relatively few were *exclusive* allopaths, with only 20% confining their entire practice to this modern medical system. A significant proportion of rural practitioners used Ayurvedic medicines either exclusively or in combination with allopathic medicines in their practice. Homeopaths to a large extent used their own system of medicine, but even they were dispensing allopathic medicines. It is interesting to note that as non-allopaths regularly strayed into the field of allopathy, non-homoeopaths occasionally prescribed homoeopathic medicines in addition to their main line of medicines. As allopathic medicines are considered to be effective both by tbe practitioners and treatment seekers. Hence, most of the rural practitioners use allopathy as their main or exclusive system of medicine while a small proportion use ayurveda exclusively. Even among those who practiced ayurveda, they

are not able to sustain practice without complementing ayurvedic medicines with allopathy.

Clearly, practitioners in rural areas throughout the country are predominantly using allopathic medicines, for which only a very small minority has been properly trained. A preference for allopathy is found even among those who are trained in various Indian systems of medicine. It thus seems apparent that relatively few practitioners are to be found with appropriate training for the type of medicine they dispense. The emerging picture' thus indicates that there are rural private practitioners with varying shades of professional acceptability, ranging from those who would be considered qualified for their practice to those whose claim to the practice is dubious, if not entirely untenable.

Carl Taylor has reported through several studies carried out across Punjab, Kerala, and Karnataka that most practitioners preferred allopathic medicine, even though they had no formal training in it. However, it was also seen that most practitioners drew upon several systems in their practice though only a few stated that they preferred a mixture of systems. While few practitioners in these studies specifically stated a preference for practicing allopathic medicine, it was found that most full-time practitioners used allopathic medicines.

To estimate the real importance of the role played by these practitioners in health care, it would be important to evaluate their share in the total health care expenditure of the country.

Arguments in support of Rural Private Practitioners:

Rhode and Viswanathan argue that the existing health care system in rural India is self-financing which has been accepted by the people or even preferred by many. From the point of view of the local communities, they prefer rural private practitioners given the fact that government’s primary health care centres in India also charge money informally. Unfortunately, the quality of care provided by the rural private practitioners fall short of

the desired level. Therefore, it is essential to make the existing health care system a strong basis for primary health care and the foundation for achieving health for all.

Government of India (GOI) attempted to introduce the `registered medical practionter' (RMPs) in rural India by giving license through the approved courses. Any graduate can enroll in RMP course and after two years of training they are eligible to practice medicine. An assumption underlying the GOI's initiative was that RMP doctors with two years of training are capable of providing primary health care services. There were two sets of problems that GOI encountered. One, there was stiff resistance from the Indian Medical Association (IMA) that RMP programme will dilute and compromise on the quality of health care in India. Second, there was a proliferation of practitioners making regulation impossible. However, it seems very unlikely that the level of supply of health care through formally trained and licensed practioners and the government health services could meet the existing demand. The informal, illegal sector is already managing 50 to 70 percent of consultations in rural India. As long as the demand is present, supply is likely to be generated to meet it. Indeed, as argued above, while the demand may have lead to the creation of supply, the very supply may have increased demand and may continue to do so.

An alternative suggestion has been to improve public health services to the point that they would effectively undermine the demand for private service by providing cheaper and better quality of health care as once envisioned. While this approach may seem ideal, it is truly unrealistic given the present financial commitment of the government in terms of health budget. In addition the quality of services provided through the public systems, especially those in the rural areas was lacking so much that it is hard to imagine how they could be improved to an extent that they could effectively win over the public from the existing private health care system.

Rhode and Viswanathan argued that the only realistic option is to accept the reality of the rural private practitioners (RPPs) and attempt to bring him/her in line with the desirable practices, accepting him/her as an integral part of the basic primary health care network.

They also argued that neither the government nor formally licensed practitioners are prepared to recognise or oversee direct relationship and improve the rural practice. The study also indicates that choice of drugs by these practitioners is made to a large extent through interaction with commercial chemists in nearby cities and towns. Their choice may be dictated not only by the claims of the effect of the drug but also by the profits offered through its sale.

A more realistic approach would be to recognize that a large array of essential drugs can and should be used more widely than only by licensed MBBS doctors, a fact already accepted by the government health care system through their paramedical staff. A comprehensive list of essential drugs that should be handled by rural practitioners using standard guidelines for diagnosis and treatment would be a key feature to improve the quality of medical care. An organization of rural practitioners will serve to bring them together where they can learn and benefit from each other's experience as well as to provide regular inputs, scientific information and improve the quality of allopathic practice.

A formal organization will enable the government and other professional bodies to communicate with the rural practitioners and also to learn from their needs and requirements as seen through their eyes to improve health in the rural communities they serve. Such a link with a formal health care system in most cases, the government system, will increase his/her prestige, ensure proper feedback, improve his/her performance and yet assure a self-financing primary base to the existing health care structure. By actively discouraging the prevailing practices which are detrimental to good medical care such as the over use of injections, poly pharmacy in the form of multiple medications for a given problem and the extremely brief duration of treatment offered by most practitioners, more advocacy and better safe practices can be ensured.

The existing network of rural private practitioners (RPPs) is the de-facto primary health care system in rural India. It enjoys a broad acceptance through culturally sensitive approaches to the communities in which the practitioners are located. It is entirely self-financing system which adjusts both its fees and means of payment to their capacities of

the public it serves and therefore, a far more equitable system than many prevailing in the public sector.

Equity is not often associated with private practice yet this widespread distribution of these practitioners, their accessibility to the poor, their willingness to provide services for payment in kind or gratis makes an equitable outcome even in the private sector. Finally, rural private practitioners are already highly oriented to the use of Allopathy even if they were trained in other indigenous or traditional approaches in medical care.

Equity Issues in Health Care:

India being an agrarian society, it is important to understand the socio-economic conditions of the people in rural India. Ill-health and health expenditures are the reason for more than half of households which fall into poverty. In 2004-5, about 30.6 million rural Indian fell into poverty as a result of out-of-pocket expenditure each year. These estimate, one should note that they do not take into account the impact on people already below the poverty line who are pushed even deeper into poverty or those groups who are forced to forego health care as a result of the financial barriers to access.

The financial burden of both in-patient and out-patient care is consistently greater for rural households compared to urban households. The impact of health expenditures are greater in rural areas and in poorer states, where a greater proportion of the population live near the poverty line, with burden falling heavily on scheduled tribes and scheduled castes.

Conclusion:

Anyone interested in understanding health care will have to analyze a wide range of rural private practitioners, both qualified and unqualified who have been out there in rural India. Acessibility is a contentious issue. In the post-Independence period, Government of India initiated three tier health care system in the first two decades. Primary Health Centres & Sub-Centres at village level, Community Health Centres (CHCs) at block or mandal level and Tertiary Hospitals at district and state levels. This decentralized,

institutional health care by the government had limitations in providing health care services in rural India. On the other hand, private health sector recruited qualified and competent doctors but its interests were skewed towards urban areas. In filling this void, rural private practitioners emerged. In a sense the RPPs are accessible. In order to remain in business, RPPs go along with the patients' wishes. For instance, if a patient likes injections to be given every day instead of tablets, rural private practitioners would go for it. Not only because this provides quick relief, but it also generates additional income for rural private practitioners (RPPs).

The main predicament is whether unqualified, untrained practitioners should be allowed to remain in practice. What risks does it entail if rural private practitioners are allowed to practice? Given the vast majority of rural communities and their sources of livelihood, it is essential that government ensures decentralized health care system works effectively. At the same time, government needs to bring more health personnel particularly rural private practitioners into the health services network by adequately training them. Such networks of strengthening primary care services is a fundamental step towards redressing the health inequities that exist in India.