# HOW DO PRIVATE FACILITIES COMPETE FOR MATERNITY CASES?

## An analysis of the market for delivery care in Uttar Pradesh, India

February 2018

The private sector dominates delivery of healthcare in India. While use of private facilities is lower for maternal health than for curative care, it is still substantial and increasing.

However, there is little evidence on the characteristics and business practices of these private providers, although this information is essential for the design of effective interventions.

To address this gap, **this study assessed the market structure for delivery care, and the competitive practices of private facilities**.

### Methods

Data were collected in 5 districts in Uttar Pradesh (Kanpur Nagar, Kanpur Dehat, Kannauj, Rampur and Bareilly). Methods included:

- Mapping of all healthcare facilities in the three study sites (3,833 private facilities of which 368 (10%) provided deliveries)
- Quantitative survey of facilities providing deliveries (262 facilities)
- In-depth interviews with facility staff, allied providers (e.g. ambulance drivers, pathology labs, ASHAs), and other key informants (92 interviews)

*Top image: Private room in high-level facility*
*Image credit: Meenakshi Gautham/LSHTM /India/2016*
*Bottom image: Delivery room in a mid-level facility*
*Image credit: Catherine Goodman/LSHTM/India/2016*

## Key Findings

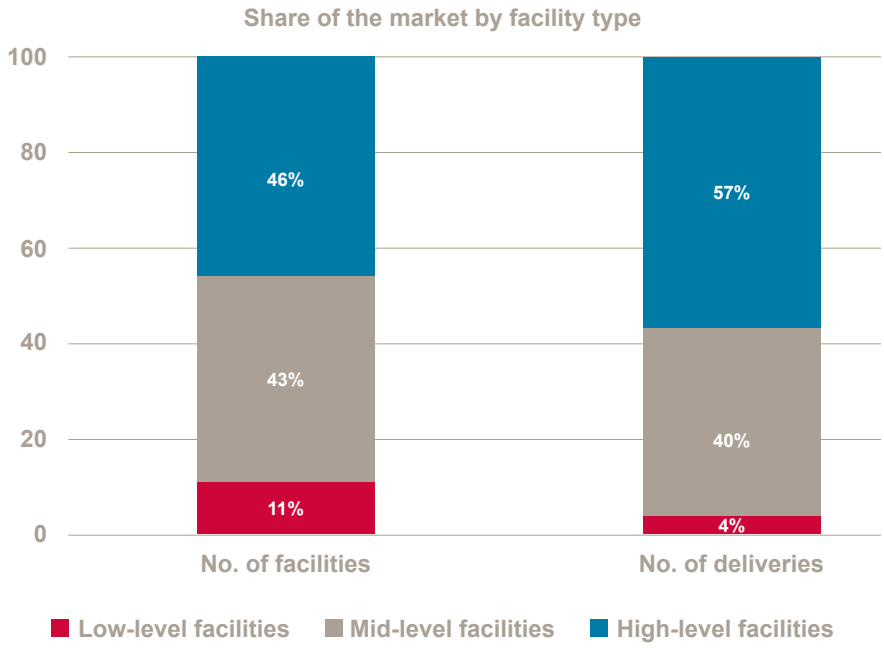
### Market Structure

- 21% of delivery facilities were public, 78% private for-profit and only 1% private not-for-profit
- Private facility numbers had grown very rapidly, reflecting economic growth and poor public sector quality and inadequate C-section availability in rural areas
- Private delivery facilities were heavily clustered in big cities (Kanpur and Bareilly) and district and block towns, where they hugely out-numbered public maternity facilities, while some rural areas remained distinctly under-served by both sectors

**The market was segmented into three broad categories:**

- High-level facilities with critical care facilities (e.g. NICU/ICU)
- Mid-level facilities providing c-sections and normal deliveries, but no advanced critical care (40% of private sector deliveries)
- Low-level facilities providing normal deliveries only

Both high and mid-level facilities had substantial market shares, with the mid-level segment growing most rapidly. Low-level facilities providing only normal deliveries accounted only 4% of private deliveries.




**Typical private facility profile**

- Small - Private facilities were generally quite small, with on average only 15 beds, and 14 deliveries per month
- Independently owned - almost no presence of commercial chains
- Owned by qualified doctors (MBBS) (71%), or AYUSH (traditional Indian medicine) providers (16%). 8% of owners had no health qualifications though most had MBBS doctors on staff
- Heavy reliance on visiting consultants such as obstetricians, surgeons and anaesthetists - 93% of facilities used at least one, and a facility on average worked with 6 different consultants

MATERNAL HEALTHCARE MARKETS EVALUATION TEAM

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

## Key Competitive Strategies

### Pricing

- Deliveries usually priced as all-inclusive "packages" including clinical care, hotel aspects, medicines and tests
- Considerable price variation – in mid and high-level facilities normal deliveries ranged from Rs 4,000 (USD 60) to Rs 25,000 (USD 378), and C-sections from Rs 12,000 (USD 181) to Rs 100,000 (USD 1,500)
- Most patients paid in cash. 17% of facilities were in RSBY* but it was said to be operating very poorly. Only a few high-end facilities were empaneled in other public (8%) or private (4%) insurance schemes

### Promotion and marketing

- Most facilities put considerable effort into promotion and marketing, especially new facilities without an established reputation
- Key strategies included pamphlets and hoardings, and "health camps" (open day charity and promotional events at the facility or in villages)
- Many larger facilities employed dedicated marketing agents, termed PROs

"Other hospitals hire PROs to increase their business. They bring patients there from rural areas and small hospitals ..... They have contacts with Dai's (traditional midwives) and chemists as well. They get salaries on the basis of the business they get or else they are kicked out."

**(Facility owner, Kanpur)**

### Commission and kickbacks

- Many facilities paid commission to agents who introduce patients to the facility – particularly private ambulance drivers, ASHAs**, and rural less qualified providers
- Commission was typically 30% of the full patient fee, though in some cases there is a fixed rate
- Commission was also paid to diagnostic providers and sometimes medical stores, who in turn paid facilities for referring patients to them

*High-level private delivery facility*
*Image credit: Catherine Goodman/LSHTM/India/2016*

"Like ***** hospital, they make a slip in the name of driver who drops the patients... On a bill of Rs. 1 lakh (100,000) they give Rs. 30,000 to private drivers very honestly. They have installed CCTV and they note down the ambulance driver vehicle number and name."

**(Ambulance driver, Bareilly)**

## Engaging with private delivery providers

### Current engagement is very limited

- Only 47% of facilities were registered. Health inspections were rare and ad hoc
- Only 3 or 4 high-level facilities were accredited by official national bodies (e.g. NABH), with accreditation standards out of reach for most of the market
- Most facilities had no external support for quality improvement for maternal health, such as training or social franchise membership. Only 22% were FOGSI members (OBGYN professional association)

### Strategies to enhance private sector performance should reflect the market's complexity and heterogeneity

- Continued dialogue is needed on the role and coverage of registration and inspection to enforce basic standards.

"Money is taken every year for registration. The court said that those who are not registered should not work, the rest should. Now the opposite is happening"

**(Government official, Lucknow)**

- Consider incentivizing private facility consolidation, to form practices with sufficient delivery numbers to facilitate quality assurance, regulation and empanelment
- Offer regular clinical training as part of continuous medical education requirements
- Develop and expand facility accreditation suited to both high and mid-level facilities
- Establish funding mechanisms for public-to-private referral for complex care, including C-sections
- Increase demand for appropriate care e.g. report cards, or mobile/online review platforms

**Authors:** Catherine Goodman, Meenakshi Gautham, Richard Iles, Katia Bruxvoort, Manish Subharwal, Sanjay Gupta, and Manish Jain

**Related publication:** The Nature of Competition faced by Private Providers of Maternal Health Services in Uttar Pradesh, India; April 2017

*Rashtriya Swasthya Bima Yojana (RSBY, meaning 'National Health Insurance Programme') is a government-run health insurance programme for the Indian poor.

**ASHAs (Accredited Social Health Activists) are India's community health workers.

MSD for mothers
Committed to Saving Lives

**Acknowledgement**

The research in this publication was supported by funding from MSD, through its *MSD for Mothers* program and is the sole responsibility of the authors. *MSD for Mothers* is an initiative of Merck & Co., Inc., Kenilworth, N.J., U.S.A.