Economic&PoliticalWEEKLY

ISSN (Online) - 2349-8846

The Transformation of Charitable Hospitals

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Vol. 48, Issue No. 49, 07 Dec, 2013

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The reported dismissal of two doctors in one of Delhi's most prestigious charitable hospitals points to the growing commercialisation of the medical profession and the struggle of not-for-profit health services to operate amid the proliferation of for-profit hospitals.

The Hindu in its edition of 16 September 2013 had reported the dismissal of a doctor from St Stephen's Hospital for "not making enough money" for the hospital. Soon after the publication of this report, two senior doctors who were critical of this particular decision of the management were served notices. The rather dramatic turn of events raises a number of questions regarding how one of the oldest missionary hospitals is being transformed into a commercial enterprise (Perappadan: 2013a, 2013b). St Stephen's is one of the oldest charitable hospitals of Delhi, set up by the Cambridge Mission in the late 19th century. Though the hospital at Tis Hazari came up only in 1908 their charitable work dates back to the 1860s at the periphery of the walled city, around Chandni Chowk.

At Chandni Chowk, St Stephen's began functioning as a maternity hospital. In 1899, it is recorded that the hospital at Chandni Chowk had provided relief to 17,000 patients and had a record of 643 operations (Delhi Archives 1901). The hospital, in the initial years, received more than 50% of its funds from missionary and other charitable sources and a small proportion from the government and municipal sources. It also levied fees on those who could pay, mostly the Europeans, but the hospital extended its services largely to the underprivileged (Delhi Archives 1916).

There was considerable expansion of missionary hospitals all over India in the 1930s. This expansion also occurred as a consequence of the advent of women missionaries to India. While there is literature available on the larger politics of the arrival of women medical missionaries and the legitimacy they received from colonial state, there is little literature available on the daily work of these missionaries and the institutions they set up that was informed by Christian values and the service of healing. In their mission work, lot of importance was given to the personality of medical missionaries who were responsible for sustaining what they started. By the 1940s many of these hospitals closed down due to financial problems. This was largely due to a slowdown in the flow of funds from the churches in Europe during the interwar period. As a result several European women

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medical missionaries left.

The financial crisis affected St Stephen's hospital as well. The role of committed individuals within the organisation who wanted to preserve missionary values, reached out to the government, got recognition for their work and received subsidised land to consolidate and expand their operations. Across missionary hospitals, doctors received less remunerations compared to their contemporaries in government and private hospitals. Often doctors in mission hospitals were guided by a sense of duty above monetary gains. Thus the culture of these hospitals tried to embody the Christian ethos of service and duty while addressing the demands and pressures of a changing economy and society.

The transformation of a hospital cannot be seen only in terms of the forces intrinsic to the institutions but also those extrinsic factors that permeate the walls of an institution. The story of St Stephen's is unique as it has survived to tell its tale from the colonial times to the present like no other hospital in Delhi. It exemplifies the transformation that many missionary and other charitable hospitals have undergone during the last six decades. Several of these hospitals have been through a process of transformation, some have survived while others have been shut down.

Supply and Demand Factors

There are several factors that have influenced this redefinition and these are a mix of supply and demand-side factors. The changing role of the State and the opening of the markets in the 1980s was the turning point for the health sector in many ways. Subsidies given for land, slashing of import duties on technology, shifts in medical education, change in the knowledge base of medicine and the absence of public investment in healthcare all created grounds for the emergence of newer for-profit and not-for-profit hospitals. The increase in the role of the market not only gave an impetus to the supply side, where there was a growth of private sector institutions, technologies, specialisations and private insurance companies, but also created a demand-side. The changing economic context resulted in the rise of a large and heterogeneous middle class that demanded "quality" services. There was also a shift in the disease profile due to a demographic and epidemiological transition. These factors put a range of new demands on the medical institutions. There is a complex interaction between these factors and it has had an impact on their growth. This has led to the emergence of different forms of management, an increase in departments linked to various specialisations, differentiated cost structures, and a shift in patient profiles in these hospitals.

Most charitable hospitals that emerged in the pre-independence period and immediately after independence focused on one specialisation – the most common being maternal and child health, and eye. There were few general hospitals. The redefinition of the older not-for-profit hospitals in Delhi started in the 1980s and the 1990s with the coming of the newer not-for-profits and corporate hospitals that became reference points. It started with the

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ISSN (Online) - 2349-8846

emergence of Escorts and Batra who were the new not-for-profits in the 1980s and among the corporates it was Apollo in the 1990s to be followed by Max and Fortis in 2000s.

The for-profit sector became the trend setter and benchmark for the not-for-profit sector. Here, the comparison was with large private hospitals where high-end technology was equated with good "quality" care. In a competitive environment, medical professionals were to now play a key role in generating demand for technology use among patients by making referrals to diagnostics, other specialisations and so on. Availability of technology became critical for generating more revenues for the hospital.

Most of the older charitable hospitals expanded to become multi-speciality institutions. There was a distinct shift in their patient profiles too and they had to cater to a new class of people who had started seeking care from them. Hospitals made the conscious choice to create more private spaces and levy costs from patients to gain revenue. The poor, who previously constituted a large proportion of patients, became marginal to their revenues and operations. The not-for-profit hospitals in the present context cater largely to the middle classes who are the main source of revenue. With the expansion of the health insurance market the middle class is able to access these services which would otherwise be difficult even for them. The poor, on the other hand, have to prove that they deserve free care and a small proportion then get access to what is termed "free" but which, almost invariably, would have hidden costs.

Changing Roles and Authority

A hospital like any other institution provides means of orientation to a large number of actors. Although the hospital has an administrative structure, there are many power centres that are now present. There is a governing body of administrators, body of management, and a non-profit has a separate board of trustees. The actors involved with these systems of authority are a mix of doctors and non-clinical management and administrative staff. The medical profession remains relatively autonomous and subject to few non-medical regulations. This situation arises because the doctor is not the employee of the hospital but a consultant who utilises the facilities available within the hospital like a guest. But there is an apparent pressure on them to generate revenue for the hospital and the management keeps a check on this.

Changing Values

The increase in utilisation of these hospitals by the middle classes, combined with changing values in society, marked by consumerism and a change in perceptions in notions of "quality", have led to the transformation of charitable hospitals. The values and aspirations of a consumer in a market economy are no different from the medical professional who also comes from the same section of society. Both together put demands on various institutional forms and give shape to a new culture of medical practice.

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The commercialisation of medical care has changed the character of several old charitable hospitals in Delhi. Hospitals that came up post-independence like Moolchand, Jessa Ram, B L Kapoor, Sir Ganga Ram, each have their individual stories of transformation. They would all have gone through conflicts in the process and would have questioned the values of the past with those of the present. The dismissal of doctors for not making enough money for a hospital is a consequence of the changing character of the not-for-profit institution.

It is important to understand the changes in a hospital like St Stephen's in this context because this is an institution that has struggled to retain its charitable character. From a public health point of view it demands attention on how commercialisation of medical care has put pressures on doctors to behave in a way that orients them towards generating more revenue and distances them from the act of care that would be informed by rational practice. As there is a blurring of boundaries between the for-profit and the non-profit, can the not-for-profit hospital still retain a distinct space from the for-profit ones in these times? This leaves us with many questions that need to be addressed by policymakers, public health professionals, the promoters of these institutions and the medical profession who must define the larger vision, motives and values which guide them and the sector.

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