A PROCESS OF DEFINING THE PARAMETERS FOR CATEGORISING THE HOSPITALS

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by:

Dr. Kanuj Sethi,

PG/10/016

International Institute of Health Management Research,

New Delhi-110075,

May, 2012

Acknowledgment

I owe my deep sense of gratitude to **Dr. Saumya Kumar Mishra**, Regional Manager (North)- Provider Management Team, ICICI LOMBARD GENERAL INSURANCE COMPANY for giving me an opportunity to learn various aspects of Health Insurance with special emphasis on Hospital Grading.

My special thanks to Dr. Vandana Bhardwaj and Dr. Aniruddha Gaur for their guidance, support, interest, involvement and encouragement. They left no stone unturned in updating me about the subject.

I also thank Dr. Preetha GS for her guidance throughout the training period.

My sincere gratitude to Dr. L.P. Singh, Director, and Dr. Rajesh Bhalla, Dean International Institute of Health Management Research, New Delhi, who always have been a source of motivation and inspiration.

Dr. Kanuj Sethi

(Post Graduate Diploma in Health and Hospital Management)

International Institute of Health Management Research, New Delhi

Certificate of Internship Completion

Date……..

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Kanuj Sethi** has successfully completed her three months internship in our organization from January 18, 2012 to April 18, 2012. During this internship he has worked on **Grading of Hospitals** under the guidance of me and my team at **ICICI LOMBARD GENERAL INSURANCE COMPANY, Green Park**. He has been regular in his activities and has worked with full dedication. We wish him good luck for his future assignments.

Saumya Kumar Mishra
Regional Manager (North).

Provider Management Team.

Certificate of Approval

The following dissertation titled "**A Process Of Defining The Parameters For Categorising The Hospitals**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
_____	_____
_____	_____
_____	_____

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Kanuj Sethi,** a graduate student of the **Post-Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled " **A Process Of Defining The Parameters For Categorising The Hospitals**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Mentor

Dr. Preetha GS,
Assistant Professor
IIHMR, New Delhi

Date: _____

Organizational Advisor

Dr. Saumya Kumar Mishra
Regional Manager(North)
ICICI LOMBARD GIC LTD.

Date:_____

Abstract

INTRODUCTION

While ever increasing demand for healthcare products and services bring enormous opportunities; some common threats exist like soaring costs, inequitable costs and mismanaged access and inconsistent quality. Increasing cost of medical treatment drives the Indian Health Insurance Industry towards an untapped potential but there are some major challenges faced by Health Insurers like lack of awareness and limited influence over provider network.

METHODOLOGY

The main aim of the study is Grading Of Hospitals. It will help in determining value i.e service provided versus price charged by the Hospital, so that neither the payer (Insurance Companies) nor the Provider (Hospitals) is at loss. Therefore the study is descriptive in nature based on personal visit to different Hospitals and Nursing Homes which were selected by using Non Random Convenience Sampling method. For the purpose of classifying a Hospital in a particular grade, a self prepared score card was used in MS EXCEL which included various parameters such as services delivered, physical infrastructure, Human Resources and Equipments etc in terms of qualitative as well as quantitative aspects. Hospitals were evaluated based on their score on the score card.

RESULTS AND DISCUSSION

As a part of study, an attempt to categorize hospitals have been made by preparing a guideline based on few parameters. According to the score of the Hospital/ Nursing Home included both in terms of Quantitative as well as Qualitative Parameters, these can be categorized in different categories. Hospital with a higher score (Quantitative and Qualitative) can be given as Higher Grade and those with lower score can be assigned with a lower grade.

TABLE OF CONTENTS

ABBREVIATIONS

- CII Confederation of Indian industry.
- CRISIL Credit Rating Information Services of India Limited.
- ICRA Investment Information and Credit Rating Agency of India Limited.
- ICU Intensive Care Unit.
- IRDA Insurance Regulatory and Development Authority.
- NHS National Health Service.
- SSH Single Specialty Hospital.
- TAT Turnaround Time.
- TPA Third Party Administrator.
- WHO World Health Organization.

PART I

INTERNSHIP REPORT

INSURANCE OVERVIEW

What is Insurance?

Insurance is defined as the equitable transfer of the risk of a potential loss, from one entity to another, in exchange for a premium. It is a mechanism that helps to reduce the effect of adverse situations.

For Example, In a community there are 1000 persons who all are healthy. It is expected that on an average 1% of persons or 10 persons may get hospitalized for different reasons in one year. If the economic value of loss suffered by the family of each person getting hospitalized is taken to be 20,000, the total loss would be 200,000. If each person is contributing 200, the common fund (Insurance Pool) would be 200,000. Thus the risks are shared by 1000 persons, although 990 of them did not suffer any loss.

The business of insurance is related to the protection of the economic values of assets. Every asset has a value. The asset would have been created through the efforts of the owner. The asset is valuable to the owner, because he expects to get some benefit from it. The benefit may be an income or something else. Insurance is a form of risk management primarily used to hedge against the risk of a contingent loss.

Purpose and Need of Insurance:

Assets are insured, because they are likely to be destroyed through accidental occurrences. Such possible occurrences are called perils. If such perils can cause damage to the asset, we say that the asset is exposed to that risk. Perils are the events. Risks are the consequential losses or damages. The risk only means that there is a possibility of loss or damage. The damage may or may not happen. Insurance is done against the contingency that it may happen. There has to be an uncertainty about the risk. Insurance is relevant only if there are uncertainties.

Insured does not protect the asset. It does not prevent its loss due to peril. The peril cannot be avoided through insurance. The peril can sometimes be avoided through better safety and damage control management. Insurance only tries to reduce the impact of the risk on the owner of the asset and those who depend on that asset. It only compensates the losses and

that too, not fully. Only economic consequences can be insured. If the loss is not financial, insurance may not be possible. Examples of Non-economic losses are love and affection of parents, leadership of managers, sentimental attachments to family heirlooms, innovative and creative abilities, etc.

How Insurance Works?

The mechanism of insurance is very simple. People who are exposed to the same risks come together and agree that, if any one of them suffers a loss, the others will share the loss and make good to the person who lost. Like this, different kinds of risks can be identified and separate groups made, including those exposed to such risks. By this method, the heavy loss that any one of them may suffer (all of them may not suffer such losses at the same time) is divided into bearable small losses by all. In other words, the risk is spread among the community and the likely big impact on one is reduced to smaller manageable impacts on all.

The insurer plays the role of an intermediary in the process of risk sharing. Insurance spreads losses of an individual over a group of individuals. This spread is considered equitable because those who share the risk are themselves exposed to similar risks

The business of insurance is to:

- Bring together persons with common insurance interests (sharing the same risks).
- Collect premium from all of them.
- Pay out compensation (claims) to those who suffer from the risks.

THE INSURANCE CONTRACT

Insurance is a contract whereby one party (insurer) agrees in consideration of money, called the premium paid to him by another party (insured or policyholder) to indemnify the latter against loss resulting to him in the event of a certain happening or to pay a specified sum of money in the event of a certain happening.

Insurance contracts are governed by:

- **Principle of Utmost Good Faith:** For a valid contract, the parties to the contract must be of the same mind. Both should be equally aware of the subject and the terms of the contract that they are entering into. Under it the policyholder is obliged to disclose all facts, which are material to the assessment of risk. Non disclosure of a material fact puts the insurer at a disadvantage. When the policyholder knowingly puts an insurer and the community of policyholders at a disadvantage, there is said to be "adverse selection".
- **Principle of Insurable Interest:** It means that the proposer must have a stake in the continuance of the subject matter insured and could suffer a loss, if the risk occurred. When a building is insured against fire damage, the continued existence of the building in its present form is not the issue. The issue is the interest of the insuring person in the continued existence of the building. The insured must be in a relationship with the subject matter of insurance, whereby he has an interest in its safety and well being. This relationship is recognized by law called as "insurable interest". Insurance assumes that the event insured against (peril) is not subject to the control of the insured.
- **Principle of Indemnity:** Insurance is meant to indemnify, which means , to compensate for losses. The amount paid by the insurer as a claim should not exceed the amount of loss incurred. Insurance should place the insured in the same financial position after a loss, as he enjoyed before it, not better. By implication the mechanism of insurance cannot be used to make a profit.

EVOLUTION OF THE INSURANCE SECTOR

EMERGENCE OF THE INDUSTRY

The Indian insurance industry emerged almost two hundred years ago. The first life insurance company started its operations as soon as 1818, while the first general insurance company was established in1850.

The industry demonstrated a rapid growth in both sectors. After independence by the year 1956, 154 Indian insurers and 16 non-Indian insurers were already operating in the life sector. At about the same time, 170 insurance companies, both Indian and foreign, were operating in the non-life sector.

NATIONALISATION OF THE INDUSTRY

The whole industry was taken over by the central government in two steps. In 1956, the life sector was nationalised and the Life Insurance Corporation of India (LIC) was established as the sole company to intervene in this sector.

In 1972, after amalgamating all non-life companies, four public companies were formed under the General Insurance Corporation in India (GIC) that similarly received the monopoly of conducting business in this sector.

While experiencing a regular growth both in coverage and volume, the public insurance companies did little to expand their activities into rural areas, where the majority of the population was to be found.

In 1993, in order to further develop the insurance industry, the government appointed a special committee to evaluate the sector, foresee its further developments and provide guidance for the necessary changes to be adopted.

After a comprehensive review of all insurance mechanisms and activities, the **Malhotra** committee came up with the following main recommendations:

- Private insurance companies to be allowed to enter the market
- The two sectors: life and non-life sectors to be kept strictly separate, no insurance company being allowed to simultaneously carry out activities in both sectors
- In order to avoid an excessive concentration on the urban market, a proportion of the activities conducted by the new entrants in rural non-traditional areas to be specified.

• In order to improve the performance of insurance companies and enable them to act as independent entities, it was proposed to set up an independent regulatory body.

OPENING OF THE MARKET

The issue of opening the insurance market to private players was hotly debated in India after the submission of the Malhotra report. The final acceptance of this recommendation went along with stiff regulations aiming to limit the fierce competition that could result from the intervention of new actors. Among these, the most significant was the minimum paid-up capital required from a new entrant which was established at Rs 1.000.000.000 (some 22,2 million US $).

The Insurance Regulatory and Development Authority was set up in 1996, in order to provide all necessary regulations and guidelines related to the opening of the insurance market to new private companies. With the passage of the IRDA Bill in Parliament in December 1999, the insurance market was opened to private companies .

THE INSURANCE BUSINESS

Insurance business is divided into:

1. Life Insurance
2. General insurance or Non Life insurance.

Life Insurers transact life insurance business. General Insurance deals with fire, marine, Miscellaneous (health, factories, cars etc.) Sickness and accidents to human beings are classified as non life insurance in India but as life insurance in many other countries. No composites are permitted as per law.

INSURANCE	
LIFE	GENERAL
• **Life**	• Health
	• Fire
	• Marine
	• Others

LIFE INSURERS:

PUBLIC INSURER

- Life Insurance Corporation of India (LIC).

PRIVATE INSURERS

- HDFC Standard Life Insurance Company Ltd.
- MAX NEW YORK Life Insurance Company Ltd.
- ICICI PRUDENTIAL Life Insurance Company Ltd.
- KOTAK MAHINDRA Life Insurance Company Ltd.
- BIRLA SUN Life Insurance Company Ltd.
- TATA AIG Life Insurance Company Ltd.
- SBI Life Insurance Company Ltd.
- ING VYASYA Life Insurance Company Private Ltd.
- BAJAJ ALLIANZ Life Insurance Company Ltd.
- METLIFE INDIA Insurance Company Private Ltd.
- AMP SANMAR Assurance Company Ltd.
- Aviva Life Insurance Company India Private Ltd.

GENERAL INSURERS:

PUBLIC INSURERS

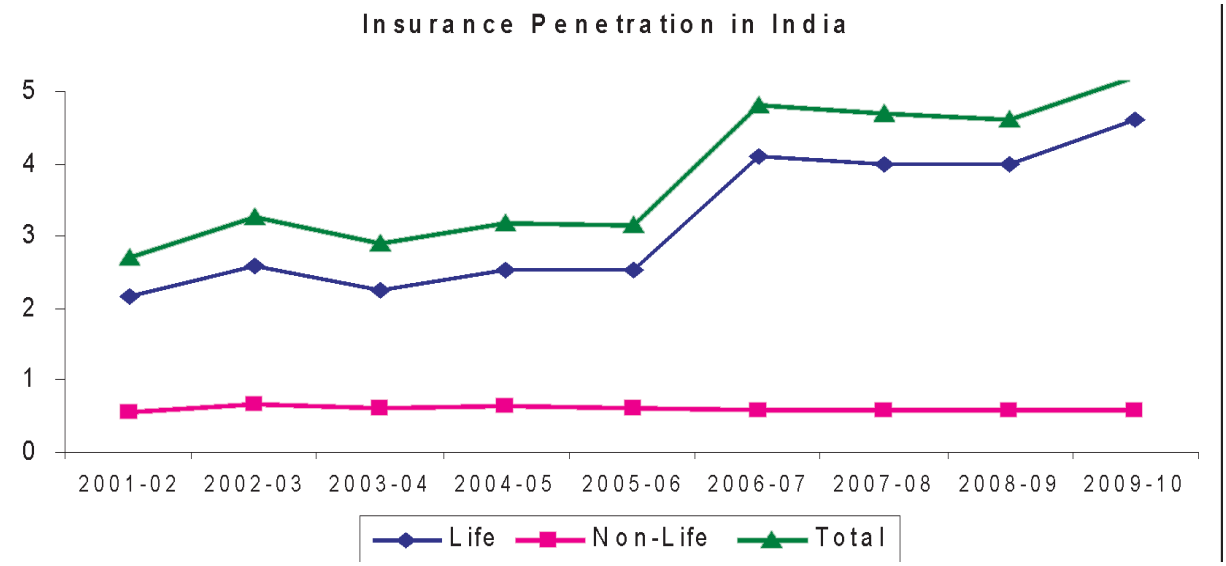
- THE ORIENTAL Insurance Company Ltd.
- NATIONAL Insurance Company Ltd.
- UNITED INDIA Insurance Company Ltd.
- THE NEW INDIA Assurance Company Ltd.
- AGRICULTURE Insurance Company of India.

PRIVATE INSURERS

- ICICI LOMBARD General Insurance Company Ltd.
- RELIANCE General Insurance Company Ltd.
- IFFCO TOKIO General Insurance Company Ltd.
- TATA AIG General Insurance Company Ltd.
- BAJAJ ALLIANZ General Insurance Company Ltd.
- ROYAL SUNDARAM Alliance Insurance Company Ltd.
- HDFC-ERGO General Insurance Company Ltd
- CHOLAMANDLAM MS General Insurance Company Ltd.
- STAR HEALTH AND ALLIED Insurance Company Ltd.
- APOLLO MUNICH Health Insurance Company Ltd.
- MAX BUPA Health Insurance Company Ltd.
- FUTURE GENERALI India Insurance Company Ltd.
- BHARTI AXA General Insurance Company Ltd.
- UNIVERSAL SAMPO General Insurance Company Ltd.

In addition to these insurers, The General Insurance corporation of India is the national reinsurer. All insurers are obliged to reinsure a certain proportion of their Indian business with G.I.C.

OVERVIEW OF THE CURRENT INSURANCE MARKET



INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (IRDA)

The Insurance act, 1938 provides for the Insurance Regulatory and Development Authority, which was constituted by an act of parliament in1999, to be the authority to administer the Insurance act and to regulate, promote and ensure the orderly growth of the insurance industry.

It has the authority to issue licences to insurers as well as intermediaries like agents, brokers, PA's etc and also to issue regulations relevant to proper functioning of the industry like adequacy of premium rates, limits on expenses, guidelines on investments, protection of policyholders rights, solvency limits. IRDA is a corporate body. The chairman and other members of IRDA are appointed by government of India.

A faster development and wider impact of the insurance industry were to be achieved through a process of insurance reforms resulting in the liberalization of the market and in the passage of the Insurance Regulatory and Development Authority (IRDA) Act, 1999. The reforms procedures recognized simultaneously the need for development of the sector in addition to the traditional concept of regulation and thus conferred on the Authority the obligation to develop the sector as well.

The entry of a large number of Indian and Foreign private companies in insurance business has to lead greater choice in terms of products and services. Increased consumer awareness of the benefits and importance of insurance and reinsurance has generated many more buyers; and new distribution channels among them brokers, bank assurance, the Internet, and corporate agents have provided additional ways of getting products and services to customers.

Private insurance companies have to date written a small percentage of business in this sector during the last three years, but they have ushered in a competitive environment that has accelerated market growth. State owned insurers still write the bulk of insurance business, and they have the net worth required to underwrite large corporate risks without depending almost entirely on reinsurance support. However, their focus on restructuring is beginning to put them at a disadvantage against private competitors. Over the next few years, the share of the market held by the public insurers is expected to drop substantially, with private companies assuming a growing percentage of the business written.

HEALTH INSURANCE

Insurance against loss by illness or bodily injury. Health insurance provides coverage for hospital stays and other medical expenses. Arrangements are made so that the policyholder does not have to pay bills of the hospital. The bills are paid by the insurer or its representative directly. These policies exclude treatment of diseases prevalent at the time of taking out the policy for the first time or contracted within 30 days of such commencement. These are generally short term policies, requiring renewal every year. These policies may be taken as individual (insured or policyholder), group policy to employers covering large number of employees or floater (family).

Group Mediclaim Policy

Group can be Employee-Employer, Association of Professionals Like Doctors, CA, Members of Cooperative Society, Banks , & Weaker sections of Society.

Benefits

- Premium under Group Mediclaim is less than Stand-alone personal mediclaim policy.
- Discount offers depend on the size of Group.
- Product can be customized to the size of the group.
- Group Insurance is more Flexible and provide more Benefits.

Floater Mediclaim Policy

Covers Entire Family

Benefits

- A single policy take care entire family.
- Single premium for entire family.
- The Sum insured floats over the entire family.
- No hassles of tracking renewals for different member.

THIRD PARTY ADMINISTRATOR(TPA):

A Third Party Administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. This can be viewed as "outsourcing" the administration of the claims processing.

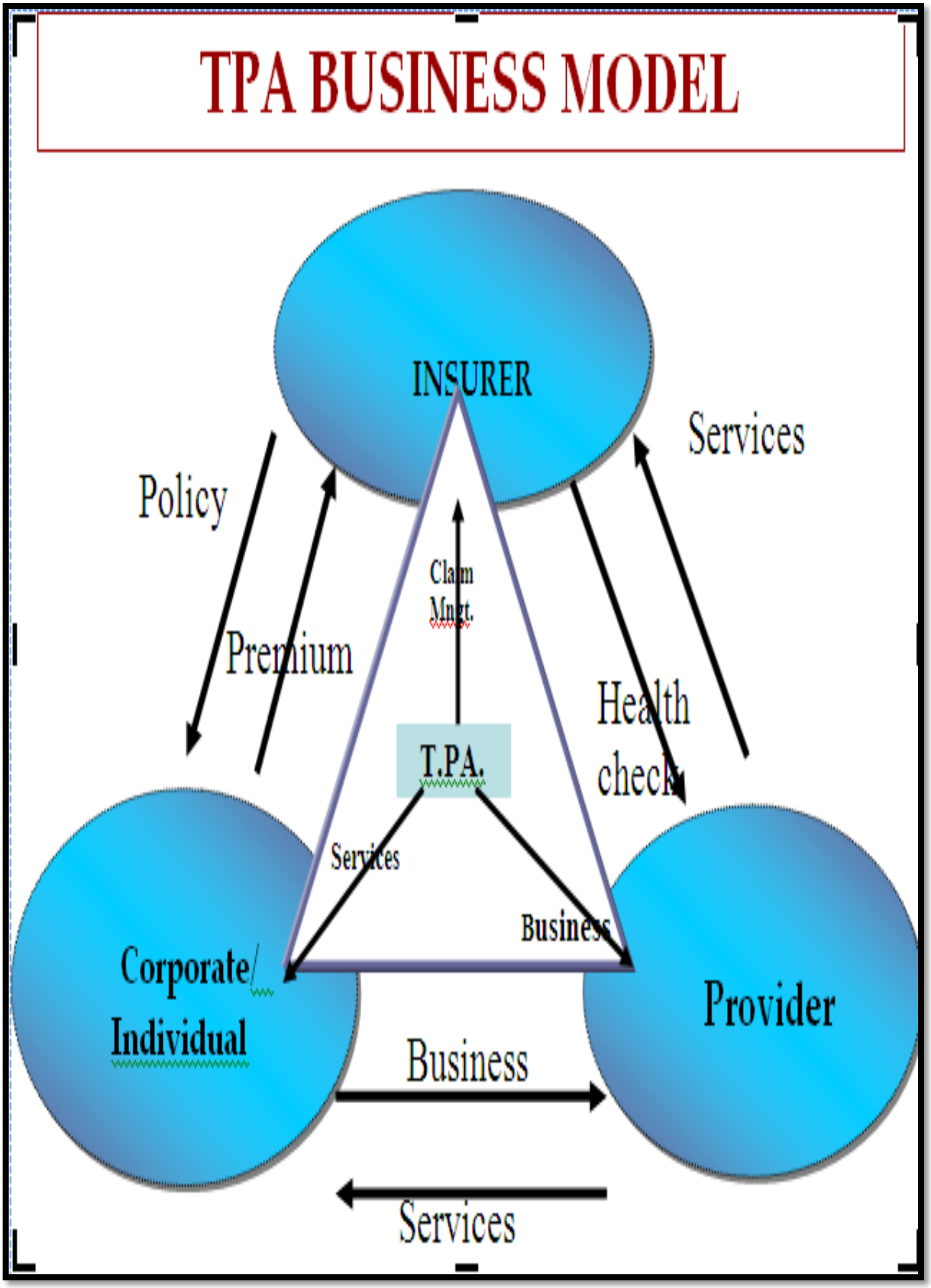
Third party administrators are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process.

TPAs concept were introduced by the IRDA in the year 2001. The concept of TPA was been introduced by IRDA for the benefit of both the insured and the insurer. While the insured is benefited by quicker & better service, insurers are benefited by reduction in their administrative costs, fraudulent claims and ultimately bringing down the claim ratios.

ROLE OF TPA:

- TPA functions as an intermediary between the insurer and the insured. The core service of a TPA is to ensure better services to policyholders**.**
- They are normally contracted by a health insurer or self-insuring companies to administer services, including claims administration, premium collection, no enrollment and other administrative activities.

TPA BUSINESS MODEL



ISSUES IN HEALTH INSURANCE

- ADVERSE SELECTION
- HIGH PAY OUTS
- PROVIDER MALPRACTICES
- ISSUES RELATING TO THIRD PARTY ADMINISTRATORS
- LACK OF INTEREST –BY INSURERS

OUT OF POCKET EXPENDITURE

Out-of-pocket expenses are direct outlays of cash which may or may not be later reimbursed. In the health care financing sector, this represents the share of the expenses that the patient or the family pay directly to the health care provider, without a third-party (insurer, or state). This usually means that the family has to bear the costs, without risk sharing or solidarity mechanisms involved, and without the possibility to spread the cost over time. Out of pocket expenditure is 70% in India.

MICRO INSURANCE

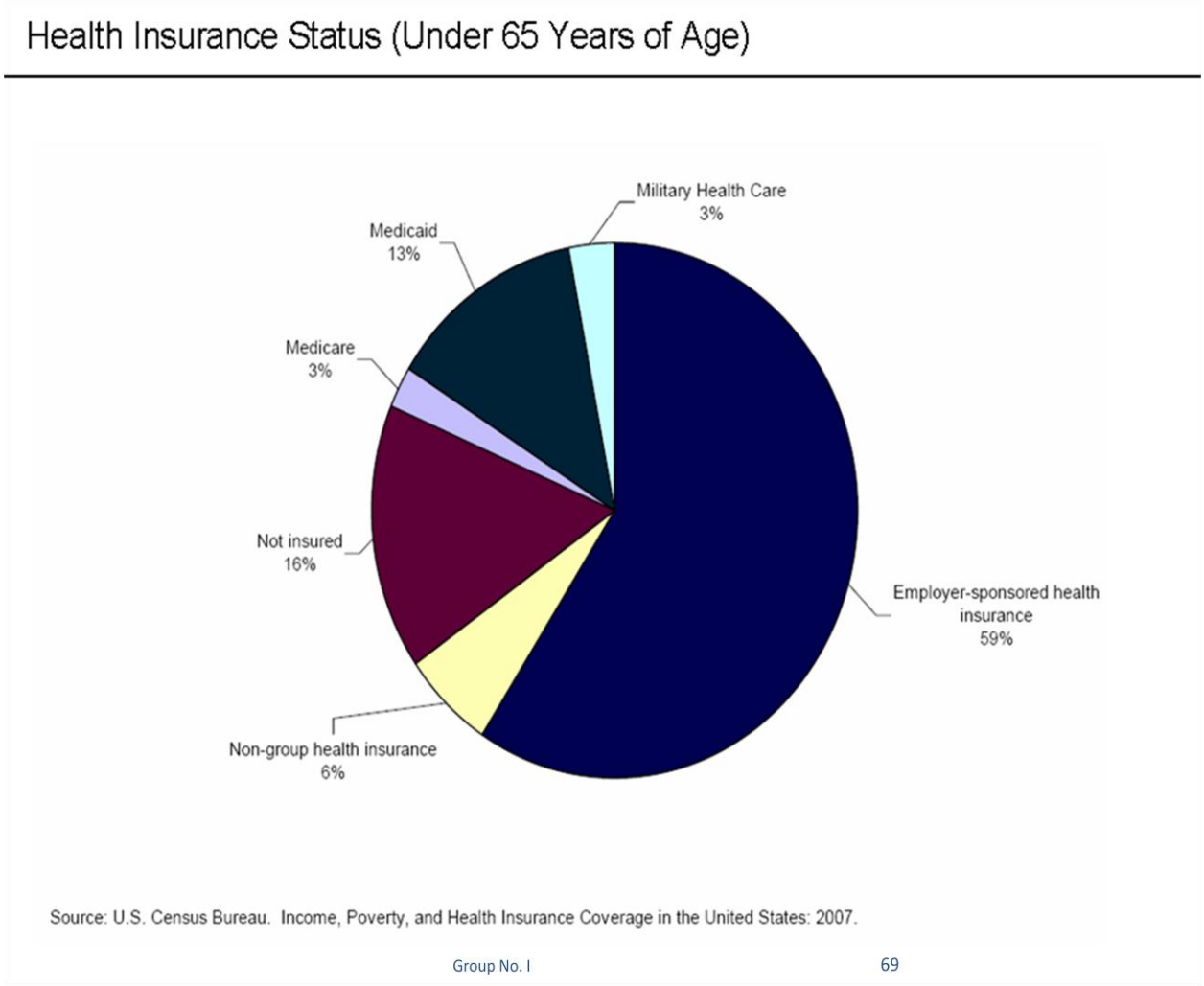
Microinsurance broadly means insurance for small Sum Assured like 5000 to 50000. Cater Lower Class. In India the IRDA has in 2005 issued regulations enabling micro-insurance For Example RSBY by ICICI LOMBARD, I PRU Micro insurance department.

In India, more than two-third of the population lives below poverty line and therefore importance of micro insurance is undeniable. Most of the people in this segment are not only illiterate, their level of awareness about insurance is also very low. In order to facilitate penetration of micro insurance to the lower income segments, IRDA has formulated the Micro Insurance regulations. Micro Insurance Regulations, 2005 provides a platform to distribute insurance products which are affordable to the rural and urban poor and to enable micro insurance to be an integral part of the country's wider insurance system.

The main thrust of micro insurance regulations is protection of low income people with affordable insurance products to help cope with and recover from common risks with standardised popular insurance products adhering to certain levels of cover, premium and benefit standards. These regulations have allowed Non Government Organisations (NGOs) and Self Help Groups (SHGs) to act as agents to insurance companies in marketing the micro insurance products and have also allowed both life and non-life insurers to promote combi micro insurance products.

INTERNATIONAL SCENARIO:

HEALTH INSURANCE IN USA



- Health insurance: primarily private sector.
- More than 80% population : insured
- 59.3% : through an employer under group coverage
- less than 9% purchases individual health insurance.

Government programs cover around 27% population. Include:

- Medicare: aged 65 and over, or who meet other special criteria
- Medicaid: families with low incomes and resources.
- Tricare

- Children's Health Insurance Program (CHIP)
- Veterans Health Administration.

HEALTH INSURANCE IN U.K

National Health Scheme was launched in 1948 in U.K. What the Government created was a comprehensive service based on the democratic principle that everyone should have access to the best available healthcare, delivered free at the point of need and funded from general taxation. exclusive provider of health services for over 90% of the population.

Over a period, a patient is seen by doctors, technicians and clerical staff with sympathy and responsiveness. Diagnostic and treatment are thoughtful and thorough, first class health care and there are no bills to pay. There is no need to even fill up a form or a claim to file.

NHS delivers healthcare through a network of clinics and hospitals.

NHS plan published in 2000, paved the way to a full-scale modernization programme designed to totally transform the NHS and the way it cares for patients. At its core, the Plan envisages the continuing commitment to the founding principles of NHS. These are:

Quality care that

- Meets the needs of everyone
- Its free at the point of need.
- And is based on a patient's clinical need and not their ability to pay.

HEALTH INSURANCE IN CANADA

Health care in Canada is delivered through a publicly funded health care system, which is mostly free at the point of use and has most services provided by private entities. It is guided by the provisions of the Canada Health Act. The government assures the quality of care through federal standards. The government does not participate in day-to-day care or collect any information about an individual's health, which remains confidential between a person and his or her physician. Canada's provincially based Medicare systems are cost-effective partly because of their administrative simplicity. In each province each doctor handles the

insurance claim against the provincial insurer. There is no need for the person who accesses health care to be involved in billing and reclaim. Private insurance is only a minimal part of the overall health care system. Competitive practices such as advertising are kept to a minimum, thus maximizing the percentage of revenues that go directly towards care. In general, costs are paid through funding from income taxes, although British Columbia is the only province to impose a fixed monthly premium which is waived or reduced for those on low incomes. There are no deductibles on basic health care and co-pays are extremely low or non-existent.

Hospital care is delivered by publicly funded hospitals in Canada. Most of the public hospitals, each of which are independent institutions incorporated under provincial Corporations Acts, are required by law to operate within their budget.

A health card is issued by the Provincial Ministry of Health to each individual who enrolls for the program and everyone receives the same level of care. There is no need for a variety of plans because virtually all essential basic care is covered, including maternity and infertility problems. Depending on the province, dental and vision care may not be covered but are often insured by employers through private companies. In some provinces, private supplemental plans are available for those who desire private rooms if they are hospitalized. Cosmetic surgery and some forms of elective surgery are not considered essential care and are generally not covered. These can be paid out-of-pocket or through private insurers. Health coverage is not affected by loss or change of jobs, as long as premiums are up to date, and there are no lifetime limits or exclusions for pre-existing conditions.

About 27.6% of Canadians' health care is paid for through the private sector. This mostly goes towards services not covered or only partially covered by Medicare, such as prescription drugs, dentistry and optometry. Some 75% of Canadians have some form of supplementary private health insurance; many of them receive it through their employers.

HEALTH INSURANCE IN SINGAPORE

Singapore has a modified universal healthcare system where the government ensures affordability of healthcare within the public health system, largely through a system of compulsory savings, subsidies and price controls. Singapore's system uses a combination of compulsory savings from payroll deductions (funded by both employers and workers) to provide subsidies within a nationalized health insurance plan known as **Medisave**. Within Medisave, each citizen accumulates funds that are individually tracked, and such funds can be pooled within and across an entire extended family. The vast majority of Singapore citizens have substantial savings in this scheme.

A key principle of Singapore's national health scheme is that no medical service is provided free of charge, regardless of the level of subsidy, even within the public healthcare system. This mechanism is intended to reduce the overutilisation of healthcare services, a phenomenon sometimes seen in fully subsidised universal health insurance systems.

Medishield is the national catastrophic Singapore health insurance program, which provides Singaporeans a low cost method of pooling risk. It is designed to help protect against the costs of lengthy hospitalizations and serious illnesses, including selected out-patient treatments such as kidney dialysis or chemotherapy. Singaporean residents may also avail themselves of Medisheild plus, which offers increased coverage options, or Integrated Shield Plans which Singapore health insurance plans run by private medical insurance companies, both of which can be paid for through Medisave Accounts.

Medisave

Every working individual (Singapore citizen or Singapore Permanent Resident) including the self-employed, is required by law to contribute to the Medisave portion of his CPF account. Medisave funds can be used to pay for hospitalisation expenses for himself or his dependants. Dependants are defined as one’s spouse, children, parents and grandparents who must be Singapore citizens or Permanent Residents.

Medisave can be used to buy Medishield, a medical insurance scheme, for himself and his dependants. It can also be used to buy a non-CPF medical insurance such as Incomeshield but you cannot have both Medishield and another non-CPF medical insurance.

Medishield & Medishield Plus

This is a low-cost medical insurance giving you and your family financial protection against the expenses of medical treatment in the event of prolonged or serious illnesses. The premiums can be paid from Medisave. Members purchasing Medishield Plus get a higher insurance coverage

ICICI LOMBARD

ICICI Lombard GIC Ltd. is a 74:26 joint venture between ICICI Bank Limited, India's second largest bank with consolidated total assets of over USD 91 billion at March 31, 2011 and Fairfax Financial Holdings Limited, a Canada based USD 30 billion diversified financial services company engaged in general insurance, reinsurance, insurance claims management and investment management.

ICICI Lombard GIC Ltd. is the largest private sector general insurance company in India with a Gross Written Premium (GWP) of Rs. 4,734.89 crore for the year ended March 31, 2011.

The headquarters of ICICI Lombard is based in Mumbai. As an alliance, ICICI Lombard combines the forte of these two trusted names in the financial sector. It leverages ICICI Bank's strong brand equity, extensive distribution network and sound technological infrastructure to serve customer needs. This joins force with Lombard's domain knowledge, product innovation and business processes based on international best practices in the insurance business. To the Indian consumer this means the security of strong parentage with access to a range of customized and innovative insurance solutions that is supported by internationally benchmarked service levels.

PRODUCT RANGE

1. **Business Solutions**
    - Burglary Insurance
    - Industrial All Risk
    - All Risk Insurance
    - Consequential Loss(Fire) Insurance
    - Electronic Equipment Insurance
    - Fidelity Insurance
    - Fire and Special Perils
    - Tea Corp Insurance
    - Marine export import
    - Machinery

- Boiler Insurance
- Inland Transit Insurance

2. **Project Solutions**
    - Contractors' All Risk
    - Contractors' Plant & Machinery
    - Erection All Risk
    - Performance Guarantee

3. **Liability Solutions**
    - Director's & Officers Liability
    - Event Insurance
    - Product Liability
    - Public Liability
    - Workmen's Compensation
    - Professional Indemnity

4. **Export Solutions**
    - Export Import Transit
    - Export Credit

5. **Rural Solutions**
    - Weather Insurance
    - Janata Personal Accident
    - Tractor
    - Farmer's Package

6. **Personal Solutions**
    - Health Insurance
    - Health
    - Personal Accident
    - Group Personal Accident
    - Group Health

7. **Travel Insurance**
    - Domestic Travel
    - Individual Overseas Travel
    - Student Overseas Travel
    - Senior Citizen Overseas Travel
    - Corporate Overseas Travel
    - Pravasi Bhartiya Bima Yojana

8. **Motor Insurance**
    - Two Wheeler
    - Four Wheeler

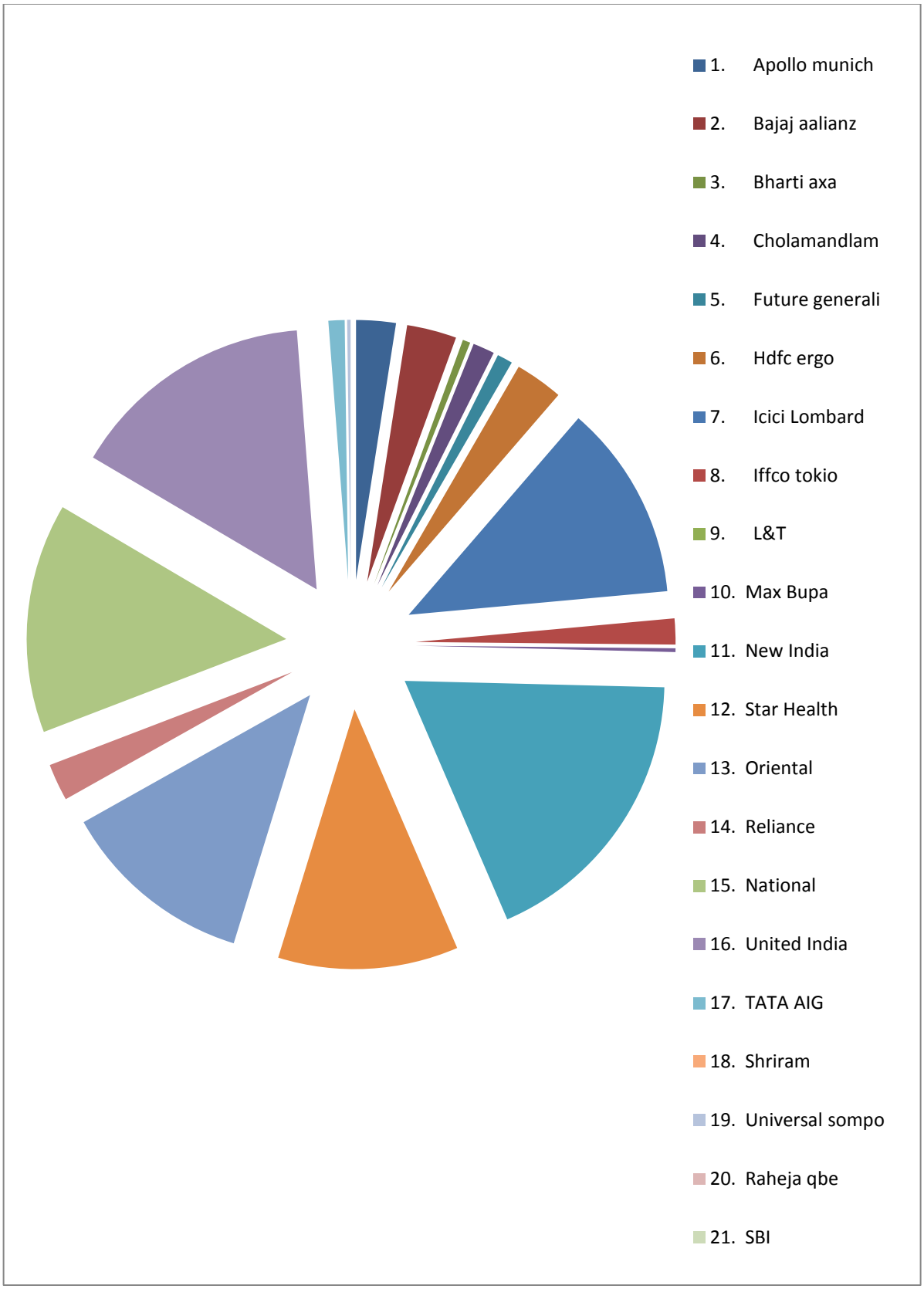
9. **Home Insurance**

According to a recent report by Towers Watson **ICICI Lombard General Insurance** Company is said to have chalked up an aggressive plan to promote online sales from which it gets approximately 5 per cent of its total sales. In terms of new business, travel insurance is the largest online selling product, while if renewals are also counted, travel, motor and health insurance contributed equally to the online premium collections for the company.

Meanwhile, the company has introduced new online tracking features for customers including a facility to keep track of all the policies bought from the company held under a single account.

MARKET SHARE

COMPANY	MARKET SHARE
1. APOLLO MUNICH	2.43%
2. BAJAJ AALIANZ	3.05%
3. BHARTI AXA	0.47%
4. CHOLAMANDLAM	1.33%
5. FUTURE GENERALI	0.95%
6. HDFC ERGO	2.95%
7. ICICI LOMBARD	12.04%
8. IFFCO TOKIO	1.59%
9. L&T	0.00%
10. MAX BUPA	0.23%
11. NEW INDIA	17.89%
12. STAR HEALTH	11.06%
13. ORIENTAL	11.94%
14. RELIANCE	2.28%
15. NATIONAL	14.11%
16. UNITED INDIA	15.09%
17. TATA AIG	0.99%
18. SHRIRAM	0.00%
19. UNIVERSAL SOMPO	0.21%
20. RAHEJA	0.00%
21. SBI GENERAL INSURANCE	0.00%


1. Apollo munich
2. Bajaj aalianz
3. Bharti axa
4. Cholamandlam
5. Future generali
6. Hdfc ergo
7. Icici Lombard
8. Iffco tokio
9. L&T
10. Max Bupa
11. New India
12. Star Health
13. Oriental
14. Reliance
15. National
16. United India
17. TATA AIG
18. Shriram
19. Universal sompo
20. Raheja qbe
21. SBI

PART II

DISSERTATION REPORT

A PROCESS OF DEFINING THE PARAMETERS FOR CATEGORISING THE HOSPITALS

INTRODUCTION:

Health care (or **healthcare**) is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments. It includes the promotion, maintenance and restoration of health. Health care service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions (WHO).

Health care is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other care providers. It refers to the work done in providing **Primary care, Secondary care and Tertiary care.**

PRIMARY LEVEL OF CARE

Primary care is the care a patient receives at first contact with the health care system, usually involving coordination of care and continuity over time (WHO).

Primary care is the term for the health care services which play a role in the local community. It refers to the work of health care professionals who act as a first point of consultation for all patients within the health care system. Such a professional would usually be a primary care physician, such as a general practitioner or family physician, or a non-physician primary care provider, such as a physician assistant or nurse practitioner. Depending on the locality, health system organization, and sometimes at the patient's discretion, they may see another health care professional first, such as a pharmacist, a nurse, or an Ayurvedic or other traditional medicine professional. Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care (Bhat et al 2001).

In Primary health care settings Laboratory facilities are minimal and include routine blood examination, microscopy, urine, stools, X-ray chest etc. These facilities have trained staff but there are no specialists.

Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Consequently, a primary care practitioner must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem (MOHFW 2000).

The ultimate goal of primary health care is better **Health for all**. WHO has identified five key elements to achieving that goal:

- Reducing exclusion and social disparities in health (universal coverage reforms);
- Organizing health services around people's needs and expectations (service delivery reforms);
- Integrating health into all sectors (public policy reforms);
- Pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.

SECONDARY LEVEL OF CARE:

Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients (WHO). Secondary care is generally a community hospital, capable of providing the majority of hospital based services, both general medical and surgical, but limited with regards to specialist access. Their range of services includes diagnostics, treatment, care, counseling, and rehabilitation. District hospitals may also provide health information, training, and administrative and logistical support to primary and community health care programmes. It concentrates skills and resources in one place for the delivery of interventions for conditions that are either

uncommon or difficult to treat. It is also a repository of knowledge and diagnostic tools for assessing whether referral to an even more specialized facility is indicated (Gupta et al 2000).

It includes acute care which is the necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services. In these hospitals trained doctors, nurses and some specialists are available. Round-the-clock monitoring of patients is possible. Laboratory facilities include routine blood, urine and stool examination, biochemical tests, radiology and microbiology. Pathology services may be available but are not advanced.

The "secondary care" is sometimes used synonymously with "hospital care". However many secondary care providers do not necessarily work in hospitals, such as psychiatrists or physiotherapists, and some primary care services are delivered within hospitals. Depending on the organization and policies of the national health system, patients may be required to see a primary care provider for a referral before they can access secondary care (Indrani et al 2001).

TERTIARY LEVEL OF CARE

Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital (WHO). It includes medical and nursing schools, large city hospitals, regional hospitals, some infectious disease hospitals, research institutions and large private hospitals, mostly in the cities. Round-the-clock services are available. These hospitals are able to do specialized tests, undertake dialysis for acute renal failure, provide ventilation to patients with respiratory failure, and render intensive care to critically ill patients. These hospitals undertake some research and have adequate library facilities.

Tertiary care is Managed care. The most specialized health care, administered to patients with complex diseases who may require high-risk pharmacologic regimens, surgical

procedures, or high-cost high-tech resources; Tertiary care requires sophisticated technology, multiple specialists and subspecialists, a diagnostic support group, and intensive care facilities Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions(MOHFW).

Tertiary Hospitals can further be divided into two types:

- **Multi-specialty hospitals:** These are institutions that offer comprehensive treatment across a wide array of specialties, and are centers of excellence for in-patient surgical procedures.

- **Single Specialty Hospitals :** These are the Hospitals that are centers of excellence in a focused single discipline. They may or may not offer care across more than one discipline, however a majority of their patients seek treatment for their core specialty.

Single Specialty hospitals (SSH) provide care for a specific specialty (e.g., cardiac, oncology, ophthalmology, orthopedic, or psychiatric) or type of patient (e.g., children or women) or type of process (e.g., minimal invasive surgeries). Specialty hospitals tailor their care and facilities to fit the chosen type of condition, patient or procedure on which they focus. SSH chains have evolved from hospitals looking to leverage the credibility generated by offering "best in class" treatment in certain defined therapy areas; thereby positioning themselves as centres of excellence in those therapies. As SSHs are focused on one field, they can offer end to end services and personalised care in that core area

RATIONALE OF THE STUDY

The main aim of the study was to set up Guidelines for Categorization of Hospitals in different categories. It will help in determining value i.e service provided versus price charged by the Hospital, so that neither the payer (Insurance Companies) nor the Provider (Hospitals) is at loss.

With the current insurance model being practiced it can be seen that there is no regulatory framework for the Hospitals which can determine the price charged by them in comparison

to the services offered. It often results in mismatching i.e Insurance companies paying higher amounts of hospitals which have lesser costs sometimes and sometimes hospitals getting reduced prices for their services provided. Hence there is a derth need for uniform Grading system to be followed across the industry by the providers and the payers.

OBJECTIVES OF THE STUDY:

General objective of the study:

To undertake Parameters of Health Services at Primary, Secondary and Tertiary care settings for evolving benefit packages to determine the premium to be levied and subsidies to be given.

Specific objectives of the study:

1. Reduce claim disputes substantially by providing a reference framework for payers (Insurance Companies) to process medical claims for the conditions and thus reducing the needs for queries moving back and forth between payers and providers (Hospitals).

2. Help in setting appropriate grades/ levels of payout for different types of surgeries and setting scientific and reasonable sub-limits for different procedures during cashless or reimbursement plans.

3. Provide a framework for costing and for development of appropriate price range for different conditions in different location and different providers.

TYPE OF STUDY:

Descriptive study based on my personal visit to different hospitals in Delhi & NCR.

Sampling method- Non Random Convenience Sampling method was used for the choice of hospitals due to financial and time constraints.

TOOLS:

For the purpose of classifying a Hospital in a particular grade, a self prepared score card was used in MS EXCEL which included various parameters such as services delivered, physical

infrastructure, Human Resources and Equipments etc in terms of qualitative as well as quantitative aspects. Hospitals were evaluated based on their score on the score card. Higher the score in the score card would mean that the hospital has higher facilities and infrastructure, hence would be classified as a Higher Grade Hospital.

LITERATURE REVIEW:

HEALTH INSURANCE IN INDIA

1. **GOVERNMENT BASED:**

   CGHS, ESIS

2. **MARKET BASED:**

   Insurance companies schemes : LIC Jeevan Asha, Ashadeep, GIC Mediclaim.

3. **EMPLOYER BASED:**

   - Railway health scheme
   - Defense medical services

4. **NGO BASED:**

   - SEWA(Gujarat),
   - ACCORD(Tamil Nadu)
   - BAIF(Maharashtra).

Central Government Health Scheme

The Central Government Health Scheme (CGHS) was introduced in 1954 as a Contributory health scheme to provide comprehensive medical care to the central government employees and their families. It was basically designed to replace the cumbersome and expensive system of reimbursements. Premiums ranging from Rs 15 to Rs 150 per month based on salary scales. Beneficiaries at this moment are around 432 000, spread across 22 cities.

Separate dispensaries are maintained for the exclusive use of central government workers. There are also central government run hospitals where the CGHS beneficiaries are treated. Over the years, the coverage has grown spatially and also in terms of beneficiaries. Besides providing medical services, the CGHS provides reimbursement for out-of-pocket expenditure for availing treatment in government hospitals and approved private facilities.

The Central Govt. Health Scheme in India is comprehensive health care to the CGHS

Beneficiaries. The Central Govt. Health Scheme is applicable to the following categories of people residing in CGHS covered cities:

- All Central Govt. Servants paid from Civil Estimates (other than those employed in Railway Services and those employed under Delhi Administration except members of Delhi Police Force).
- Pensioners drawing pension from Civil Estimates and their family members –

(Pensioner residing in non- CGHS areas also may obtain CGHS Card from nearest CGHS covered City).

- Hon'ble Members of Parliament
- Hon'ble Judges of Supreme Court of India
- Ex- Members of Parliament
- Employees & Pensioners of Autonomous Bodies covered under CGHS (Delhi)
- Ex- Governors and Ex-Vice Presidents
- Former Prime Ministers
- Former Judges of Hon'ble Supreme Court of India and Hon'ble High Courts
- Freedom Fighters

It provides service through following categories of systems:-

- Allopathic
- Homeopathic
- Indian System of Medicines e.g. Ayurveda, Unani, Yoga, Sidha System.

Employees' State Insurance Scheme

The Employee State Insurance Corporation (ESIC) runs the ESIS, which provides both cash and medical benefits. The scheme (launched in 1948) is essentially a compulsory social security benefit to workers in the industrial sector. The original legislation required it to cover only factories using power and employing 10 or more employees, and was later extended to cover factories not using power and employing 20 or more persons. Persons working in mines and plantations are specifically excluded from the ESIS coverage The

monthly wage limit for enrolment in the ESIS has been raised from Rs. 3500 to Rs. 6500. The contribution is paid in the form of a payroll tax Prepayment contribution in the form of a payroll tax of 1.75% by employees, 4.75% of employees' wages paid by the employers, 12.5% of the total expenses are borne by the state governments. The beneficiaries are over 50 million (as of march 2009) spread over 620 ESI centres across states. Medical benefits comprise cash payment for sickness, maternity, temporary or permanent disablement, survivorship and funeral expenses. Expenditure for medical benefits constitutes 70 per cent of the total benefits paid under the ESIS. These medical benefits are provided primarily through hospitals and dispensaries.

CURRENT INSURANCE MODEL

India with about 200 million middle class household shows a huge untapped potential for players in the insurance industry. Saturation of markets in many developed economies has made the Indian market even more attractive for global insurance majors. The insurance sector in India has come to a position of very high potential and competitiveness in the market. Indians, have always seen life insurance as a tax saving device, are now suddenly turning to the private sector that are providing them new products and variety for their choice.

Consumers remain the most important centre of the insurance sector. After the entry of the foreign players the industry is seeing a lot of competition and thus improvement of the customer service in the industry. Computerisation of operations and updating of technology has become imperative in the current scenario. Foreign players are bringing in international best practices in service through use of latest technologies

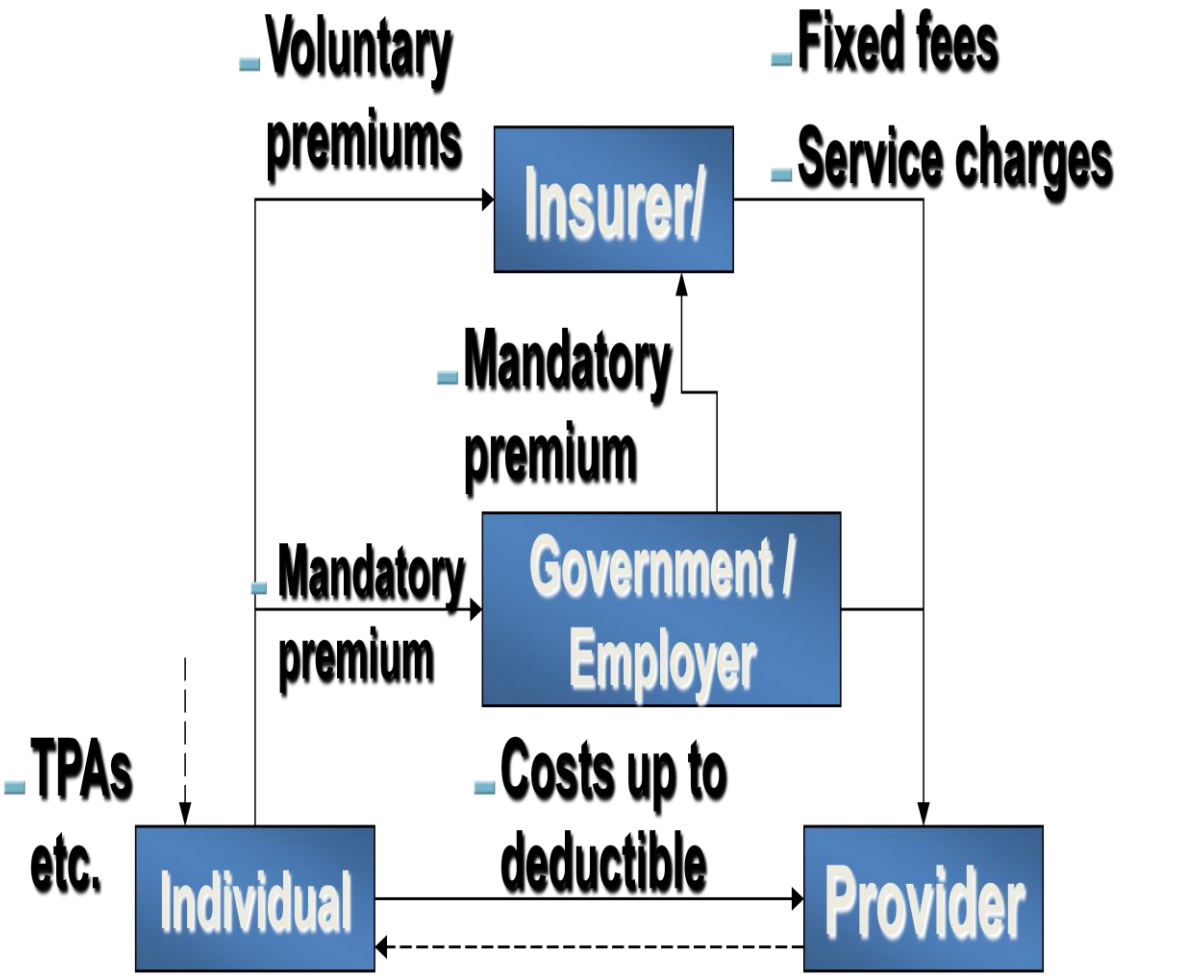
The insurance agents still remain the main source through which insurance products are sold. The concept is very well established in the country like India but still the increasing use of other sources is imperative. At present the distribution channels that are available in the market are listed below.

- Direct selling
- Corporate agents

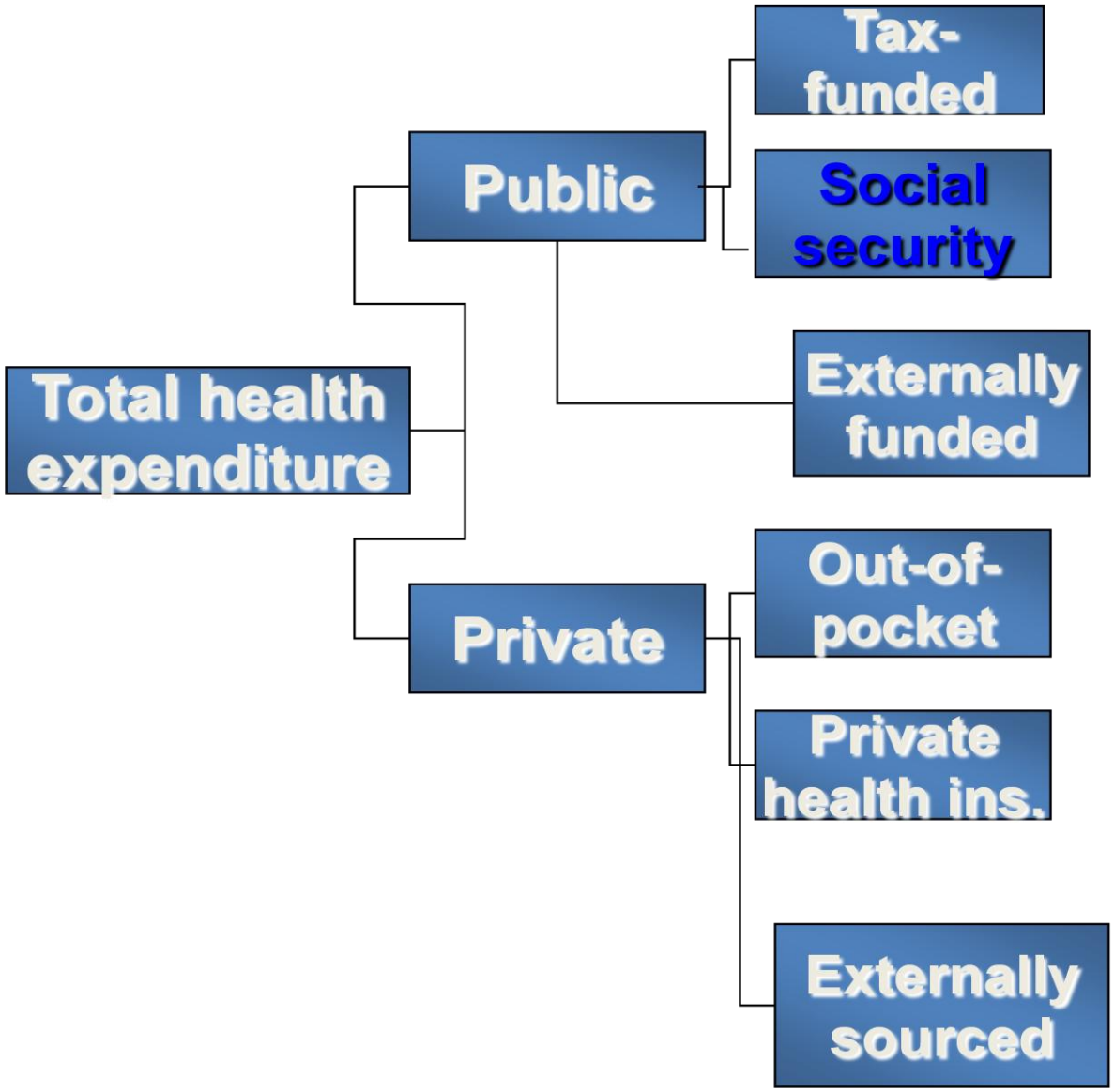
- Group selling
- Brokers and cooperative societies
- Bancassurance

Customers have tremendous choice from a large variety of products from pure term (risk) insurance to unit-linked investment products. Customers are offered unbundled products with a variety of benefits as riders from which they can choose. More customers are buying products and services based on their true needs and not just traditional moneyback policies, which is not considered very appropriate for long-term protection and savings. There is lots of saving and investment plans in the market. However, there are still some key new products yet to be introduced - e.g. health products.

Given below is the current insurance model which primarily focuses on the insurer or the intermediaries working on the employed only at the front end


Voluntary premiums
Fixed fees
Insurer/
Service charges
Mandatory premium
Mandatory premium
Government / Employer
TPAs etc.
Costs up to deductible
Individual
Provider
Financial flows
Service flows
Could be allied to insurer or be a government approved provider

POSSIBLE APPROACH TO INSURANCE



Health insurance providers may need to align themselves to overall health care including financing, preventive health care and health outreach in order to grow coverage. Regulations and policy must be designed to encourage this.

HOSPITAL GRADING

What is Grading?

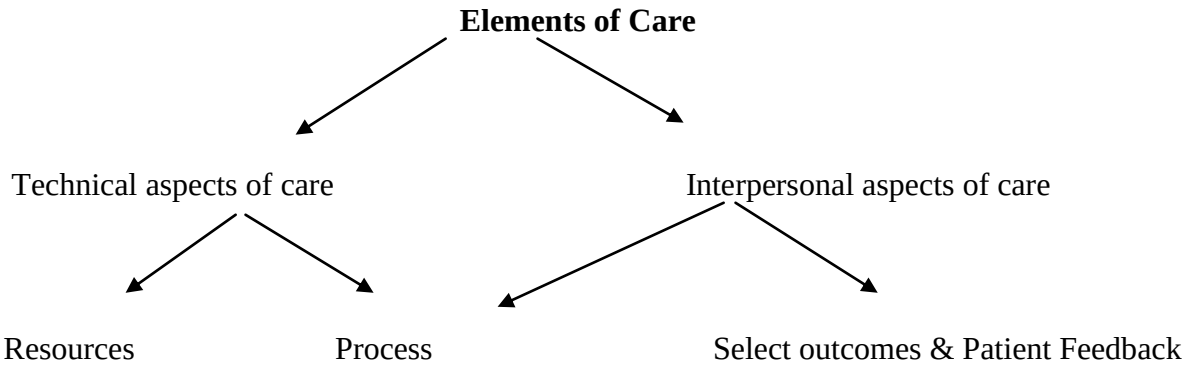
Grading is an Independent Opinion on Quality of Care a Provider is Capable of Delivering.

It evaluates capability to deliver quality of care from the user's (patient's) perspective. It is initiated by independent third party agencies in response to societal needs for an objective hospital quality evaluation mechanism. It Grades the capability to deliver care and recognises excellence beyond standards.

What it is not?

It's not an opinion on the correctness of diagnosis or the probability of outcome of any therapy or surgery.

Concept of Grading:



Benefits of Grading:

1. Consumers:

- It Indicates scope of service i.e.Value given versus Price charged. It also facilitates comparison between different service providers. This will help consumers in making a choice between different Hospitals for their treatment.
- Reliable, Dynamic and Accessible
- .Simple yet composite and robust indicator

2. **Medical Service Providers:**
    - Transparent, Provides feedback- It will be a transparent system which will be based on different parameters and will provide feedback for the services rendered. It will maintain patient's privacy and confidentiality.
    - Fosters commitment and compliance- It will be accepted by all the providers which will help in delivering the commitment made by the Hospitals as their performance will affect their image in the competitive market.
    - Focus on functionality, not a system.

3. **Healthcare Institutions:**
    - Build patient perception- Grading will act as a positioning tool to build patient's perception about the hospital/ Nursing Home. Today Patients are aware as well as Quality conscious so grading will help in attracting these patients.
    - Improve credibility
    - Benchmark services against other hospitals,

4. **Healthcare Regulators:**
    - Provides an indication of the healthcare system's capability and performance.

5. **Payors:**

Public Sector Units

- Grading will act as an Objective tool for selecting preferred providers based on their performance.

Health Insurers and TPAs: objective input for:

- Categorisation will act as an objective input for Provider Empanellment and Contracts Negotiation.

Lenders and Investors .

- Grading will act as a key input for Business Risk Assessment for Lenders and Investors. They will be able to know their risk and will invest in those institutions who score more.

Patrick et al concluded that one of the most important consideration in Indian Health Insurance is **minimizing operational costs and reducing fraudulent activities**. The current scenario is the outcome of an unregulated healthcare market. Whether it is cashless service or reimbursement made directly to policy-holders, medical billing has been a topic of debate which can only be settled with uniform practices across the industry.

According to a survey conducted by a TPA, the estimated number of false claims in the industry is estimated at around 10-15 per cent of total claims. The total premium collection for medical insurance firms in the country is about Rs 4,000 crore, while total claims amount to about Rs 4,300 crore in a year. This means that the healthcare insurance industry is recording an annual loss of around Rs 300 crore.

Presently there are no standard procedures to be followed by all the hospitals. The hospitals have the independence for framing the charges for the treatments done. This leads to different hospitals charging differently. This often gives way for unethical practices where the doctors and patients collaborate in issuing fake medical certificates and bills leading to losses for insurers. Standardizing procedures and hospital charges has emerged as one of the strategies for achieving the same (Mahal A 2005).

(Rao et al 2000) With costs of medical treatment and hospital room tariffs varying from institution to institution, mediclaim service providers are all set to send a list of proposals to the Health Ministry, asking for the standardisation and grading of medical services.

The Association of Third Party Administrators, whose membership covers 18 of India's 24 TPAs in the mediclaim sector - is working on a host of proposals for the Health Ministry to standardise billing and grading hospitals in the country. **The main demand is to create a regulator for health providers.** There has to be somebody to monitor quality and cost offered by the various health providers.
It may be noted that there is a regulator for health insurance in the form of the Insurance

Regulatory and Development Authority (IRDA), but no regulator for health providers.

GRADING OF HOSPITALS BY ICRA:

Currently, India faces a wide gap between the demand for, and supply of, healthcare services. With private/voluntary sector participation in healthcare increasing and health insurance gaining in popularity, the healthcare industry in the country is undergoing a transformation. This transformation is likely to usher in a healthcare market that is starkly different from what we see today. The emerging picture calls for enhancements in quality and productivity, among other things. Keeping such changes in view, ICRA has developed a unique methodology for Grading Healthcare Institutions. ICRA's Healthcare Grading serves as an objective indicator, and is a symbolic representation, of an institution's capability to deliver quality care.

A healthcare institution with a higher Grading would have relatively better care infrastructure and processes than those Graded lower. While evaluating a healthcare institution ICRA looks into a host of factors such as availability of infrastructure, equipment, manpower, systems and clinical algorithms, all from the user's point of view. The evaluation of these core factors involves a review of the institution's resources, processes and outcome to determine its capability to deliver care. The focus of the evaluation is on the quantitative adequacy (number), technical adequacy (type) and availability (distribution) of core resources.

Benefits of ICRA's Healthcare Grading :

- It can be used as a positioning and assessment tool by the healthcare facility.
- It can be used to define the complexity and intensity of care provided.
- It can be used to bridge the knowledge gap between the healthcare facility and the patient's expectations.

The ICRA Healthcare Grading Scale is as follows:

H1- Institution has resources and processes consistent with those required for delivering highest quality of care.

H2- Institution has resources and processes consistent with those required for delivering high quality of care.

H3-Institution has resources and processes that can deliver moderate quality of care.

H4- Institution has resources and processes that can deliver low quality of care.

Ram et al graded Hospitals and Nursing homes into three categories based on different parameters like Availability of I.C.U, Ambulance, In House Laboratory, Sonography and X-Ray machines. This would help Insurance companies curb inflated bills and abnormal claims by patients as they can easily estimate expenditure based on the grading.

Susan Thomas (E- Health Magazine) , a research associate said that the grading would have two effects:

1. It will help policyholders to get some idea about the type of healthcare they can expect.

2. It will bring down the premium rates on Health Insurance Policies as the claim ratios goes down.

Crisil in conjunction with CII graded Hospitals into four categories based on various parameters.

Grade A- Institution has enough facilities, manpower, equipments and the service quality levels are highest in the industry.

Grade B- Institution has good quality of healthcare but lesser than Grade A.

Grade C- Institution has average quality of healthcare.

Grade D- Institution has poor quality of healthcare.

In an attempt to encourage transparency in the health care sector, the government is planning to grade all health care institutes across the state based on various parameters. The medical

and health department will work out the modalities based on **number of beds, medical equipment, location, staff strength and other facilities** provided by nursing homes and hospitals.

According to medical and health minister K Rosaiah, grading will be of immense help to people on various fronts. "For instance, hotels are being classified ”such as three star, five star, etc” which has been helping customers know their standards. In a similar way, if hospitals and nursing homes are graded, people will approach their choice of health care institutes. Besides, the move will bring a healthy competition among the hospital managements which, in the long run, could help improve the standard of health care.

With the evolution of Hospital Accreditation, there has emerged a corresponding necessity for grading of Hospitals. While Accreditation will ensure a seal of quality for Hospitals, Grading will enable distinction among the accredited Hospitals and can offer value versus price analysis. CII on Accreditation of Hospitals has given some recommendations:

- **Grading**: The necessity of grading of hospitals cannot be underscored. With the spread of accreditation, grading will become a necessity. It will eventually determine hospital tariffs. However, grading will need to be backed by strong regulatory support in order to gain due acceptability.

- **Packaged programmes for accreditation**: It would also be extremely useful to small healthcare providers if packaged programmes for accreditation could be offered to them in terms of the budget to be allotted for the purpose, and the provision of advisory/technical services through a panel of consultants.

- **Raising awareness:** An essential prerequisite to popularizing accreditation is raising awareness of the concept among stakeholders to sensitize them of the potential benefits so that they can be induced to embrace the process. .

OBJECTIVES OF THE STUDY:

General objective of the study:

- To undertake costing of Health Services at Primary, Secondary and Tertiary care settings for evolving benefit packages to determine the premium to be levied and subsidies to be given.

Specific objectives of the study:

1. Reduce claim disputes substantially by providing a reference framework for payers (Insurance Companies) to process medical claims for the conditions and thus reducing the needs for queries moving back and forth between payers and providers (Hospitals).

2. Enable increased automation of claims handling resulting in faster claim processing and reduction of Turn Around Time (TAT) for a significant proportion of claims.

3. Help in setting appropriate grades/ levels of payout for different types of surgeries and setting scientific and reasonable sub-limits for different procedures during cashless or reimbursement plans.

4. Provide a framework for costing and for development of appropriate price range for different conditions in different location and different providers.

METHODOLOGY

TYPE OF STUDY:

Descriptive study based on my personal visit to different hospitals like Aashlok hospital in New Delhi , R.K hospital in Faridabad and various other hospitals in Delhi & NCR.

Sampling method- Non Random Convenience Sampling method was used for the choice of hospitals due to financial and time constraints.

TOOLS:

For the purpose of classifying a Hospital in a particular grade, a self prepared score card was used in MS EXCEL which included various parameters such as services delivered, physical infrastructure, Human Resources and Equipments etc in terms of qualitative as well as quantitative aspects. Hospitals were evaluated based on their score on the score card. Higher the score in the score card would mean that the hospital has higher facilities and infrastructure, hence would be classified as a Higher Grade Hospital.

RESULTS AND DISCUSSION:

HOSPITAL PARAMETER SHEET: Score card consisting of different parameters based on which hospitals can be graded.

PARAMETERS FOR GRADING OF MULTISPECIALITY HOSPITAL

SIZE OF THE HOSPITAL (BED STRENGTH).

- LESS THAN 100 BEDS.
- 101-200 BEDS.
- 201-300 BEDS.
- 301-500 BEDS.
- MORE THAN 500 BEDS.

SERVICES

OPD

- MEDICAL
- SURGICAL
- OBSETETRIC AND GYNAECOLOGY
- PAEDIATRICS AND NEONATOLOGY.
- ORTHOPAEDICS.
- OPTHALMIC(EYE).
- ENT
- DENTAL
- DERMATOLOGY AND VENEREOLOGY

  PSYCHIATRY
- IMMUNIZATION.

SPECIALTIES

- CARDIOLOGY
- CARDIO-THORACIC AND VASCULAR SURGERY
- GASTRO-ENTEROLOGY
- SURGICAL GASTRO-ENTEROLOGY
- PLASTIC SURGERY
- ELECTROPHYSIOLOGY
- NEPHROLOGY
- UROLOGY
- NEUROLOGY
- NEUROSURGERY
- ONCOLOGY
- ENDOCRINOLOGY/METABOLISM
- MEDICAL ONCOLOGY
- SURGICAL ONCOLOGY
- RADIATION ONCOLOGY
- NUCLEAR MEDICINE

MATERNAL AND CHILD HEALTH CARE

ANTE-NATAL CARE ·

RADIATION ONCOLOGY

INTRANATAL CARE (24 - HOUR DELIVERY SERVICES BOTH NORMAL AND ASSISTED)

POST-NATAL CARE

NEW BORN CARE

EMERGENCY SERVICES

- 24X 7 OPERATIONAL EMERGENCY WITH TRIAGE
- DISTINCT ENTRY
- MOBILE X-RAY/ LABORATORY, SIDE LABS/PLASTER ROOM/AND

MINOR OT FACILITIES.

· TYPE OF INTERVENTION- FULL TREATMENT OR REFERED AFTER STABILIZATION.

IN PATIENT SERVICES

- GENERAL WARDS.
- PRIVATE WARDS.
- SPECIAL WARDS.

GENERAL WARDS AVAILABLE

- MALE MEDICAL WARD
- MALE SURGICAL WARD
- FEMALE MEDICAL WARD
- FEMALE SURGICAL WARD
- MATERNITY WARD
- PAEDIATRIC WARD
- NURSERY
- ISOLATION WARD

PRIVATE WARDS AVAILABLE:

- AC SINGLE.
- AC SHAIRING.
- NON AC SINGLE.
- NON AC SHARING.

SPECIAL WARDS AVAILABLE:

- EMERGENCY WARD/TRAUMA WARD
- BURN WARD

- ORTHOPAEDIC WARD
- POST OPERATIVE WARD
- INFECTIOUS DISEASE WARD

OTHER SERVICES

- HEALTH PROMOTION AND COUNSELING SERVICES.
- TOBACCO CESSATION SERVICES.
- DIALYSIS SERVICES
- DOT CENTRE
- DESIGNATED MICROSCOPY CENTRE
- AYUSH
- INTEGRATED COUNSELING AND TESTING CENTRE; STI CLINIC;

INTENSIVE CARE UNIT WITH NO OF BEDS IN EACH

- ICU
- ICCU.
- NICU
- MICU.
- SICU.

- NURSING STATION.
- EQUIPMENT ROOM.
- HIGHLY SPECIALIZED STAFF AND EQUIPMENT.

DETAILS OF BED STRENGTHS

AC SINGLE

AC SHARING

NON AC SINGLE

NON AC SHARING

GENERAL

DAY CARE

LABOUR CARE

DIALYSIS

ICU

PHARMACY

- IN-HOUSE PHARMACY OR OUTSOURCED.

- 24 HOUR AVAILABILITY.

OPERATION THEATRE

· NO. OF OT'S.

· ZONING.

CONSTANT SPECIALIZED SERVICES

· PIPED SUCTION.

· MEDICAL GASES.

· ELECTRIC SUPPLY.

· LAMINAR FLOW OF AIR.

· AIR-CONDITIONING.

· VENTILATOR.

· BOYLE'S APPARATUS.

· PORTABLE X-RAY,ECG,CARDIAC MONITOR.

· C- ARM.

SEPARATE ROOMS:

- PREPARATION ROOM,
- PRE-OPERATIVE ROOM
- POST OPERATIVE RESTING ROOM.

- SCRUB-UP ROOM.

HOSPITAL SERVICES:

MANAGEMENT INFORMATION SYSTEM (MIS)

IS THE ADMINISTRATION / BILLING / MEDICAL RECORDS SYSTEM COMPUTERIZED?

DO YOU HAVE INTERNET ACCESS?

DO YOU HAVE A HOSPITAL MANAGEMENT SYSTEM THAT LINKS ALL DEPARTMENTS TO BILLING AND MEDICAL RECORDS?

HOSPITAL KITCHEN (DIETARY SERVICE)

- DIETICIAN.

CENTRAL STERILE AND SUPPLY DEPARTMENT (CSSD)

- LABELLING
- CALIBRATION AND MAINTENANCE OF INSTRUMENTS.

HOSPITAL LAUNDRY

- FACILITIES FOR DRYING, PRESSING AND STORAGE OF SOILED AND CLEANED LINENS.

MEDICAL AND GENERAL STORES

- VEHICULAR ACCESSIBILITY AND VENTILATION.
- SECURITY AND FIRE FIGHTING ARRANGEMENTS.

MORTUARY

- FACILITY FOR AUTOPSY.

ENGINEERING SERVICES

EMERGENCY LIGHTING

- SHADOW LESS LIGHT IN OPERATION THEATRE AND DELIVERY ROOMS .
- EMERGENCY PORTABLE LIGHT IN WARDS AND DEPARTMENTS.
- UPS AVAILABILITY IN ALL CRITICAL AREAS

CALL BELLS

CALL BELLS WITH SWITCHES FOR ALL BEDS IN ALL TYPES OF WARDS

· INDICATOR LIGHTS AND LOCATION INDICATOR IN NURSES DUTY ROOM OF THE WARDS.

VENTILATION

· EITHER BY NATURAL SUPPLY OR BY MECHANICAL EXHAUST OF AIR.

MECHANICAL ENGINEERING

· AIR-CONDITIONING AND ROOM HEATING IN OPERATION THEATRE AND NEO-NATAL UNITS

· WATER COOLERS AND REFRIGERATOR IN WARDS AND DEPARTMENTS.

DRAINAGE AND SANITATION

WASTE DISPOSAL SYSTEM

HOUSEKEEPING SERVICES

· CLEANING TECHNIQUES

· PEST CONTROL

MEDICAL GAS SUPPLY

ANNUAL MAINTENANCE CONTRACT (AMC)

RECORD MAINTENANCE (MEDICAL RECORD DEPARTMENT)

HOSPITAL TRANSPORTATION- TYPE WITH NUMBERS.

- LIFTS/ ELEVATORS- BIG FOR TRANSPORTATION OF PATIENTS OR SMALL.

QUALITY CONTROL:

DO YOU FOLLOW PATIENT SAFETY GUIDELINES?

DO YOU FOLLOW ANY SET CLINICAL PROTOCOLS?

DO YOU ADHERE TO WASTE DISPOSAL GUIDELINES?

DO YOU HAVE A HOSPITAL INFECTION COMMITTEE?

IS THE FACILITY ACCREDITED/ASSESSED BY ANY RECOGNIZED ACCREDITATION BODIES?

IF YES, WHICH ARE THEY?

EQUIPMENTS WITH TYPE AND NUMBERS

IMAGING EQUIPMENT:

- X-RAY.
- CT-SCAN.
- MRI

ULTRASOUND.

OTHER SPECIAL EQUIPMENT LIKE BONE DENSITOMETRY

CARDIAC EQUIPMENT:

- ECG
- VENTILATORS.

- PULSE OXYMETERS.
- INFUSION PUMP.
- B.P APPARATUS.
- STETHOSCOPE.
- OTHER LIKE CARDIAC DEFIBRILLATOR.

LABOUR ROOM & NEONATAL EQUIPMENT:

- BABY INCUBATOR.
- PHOTOTHERAPY UNIT.
- EMERGENCY KIT.
- EPISIOTOMY KIT.
- FOETAL DOPPLER.
- FORCEPS DELIVERY KIT.
- VACUUM EXTRACTOR METAL.

- NEBULIZER.
- WEIGHING MACHINE.
- CARDIAC MONITOR.

EYE EQUIPMENT:

- CRYOSURGERY UNIT.
- OPHTHALMOSCOPE.
- SLIT LAMP.
- RETINOSCOPE.
- IOL OPERATION SET.

E.N.T EQUIPMENT:

- AUDIOMETER.
- MASTOID SET.

- OPERATING MICROSCOPE.

- STAPEDOTOMY SET.
- LARYNGOSCOPE.
- OTOSCOPE.
- OESOPHAGOSCOPE.
- OTHERS.

DENTAL

- DENTAL CHAIR- MOTOTRIZED OR MANUAL

- OTHERS.

O.T EQUIPMENT:

- AUTOCLAVE.
- O.T TABLE.
- DIATHERMY.
- STERLIZER.
- SUCTION APPARATUS.

PHYSICAL INFRASTRUCTURE

PARKING FACILITY WITHIN HOSPITAL PREMISES

ACCESSIBILITY TO THE HOSPITAL IN ALL WEATHERS

ELECTRICAL ENGINEERING

- ELECTRICITY SUPPLY - 24 HOURS

- FACILITIES FOR SUB STATION AND GENERATION.

WATER SUPPLY-24 HOUR SUPPLY.

HOSPITAL COMMUNICATION.

§ INTERNAL TELEPHONE EXCHANGE

§ LANDLINE PHONES

§ MOBILES/CELLULAR PHONES IN CLOSED USER GROUP

§ PRIVATE MOBILE/CELLULAR PHONES

§ LOUDSPEAKERS/PUBLIC ADDRESS SYSTEMS

§ WIRELESS SETS FOR SECURITY AND AMBULANCE PERSONNEL

§ THE COMMUNICATION ROOM

§ 24X7 WORKING TELEPHONE AVAILABLE FOR HOSPITAL.

§ COMPETENT PERSON AVAILABLE FOR ANSWERING THE ENQUIRIES

RECEPTION AND ENQUIRY

· ENQUIRY/ MAY I HELP DESK AVAILABLE WITH COMPETENT STAFF FLUENT IN LOCAL LANGUAGE.

· SERVICES AVAILABLE AT THE HOSPITAL DISPLAYED AT THE ENQUIRY.

WAITING SPACES

· WAITING AREA WITH SEATING ARRANGEMENT.

· GENERAL WAITING AND SUBSIDIARY WAITING SPACES ADJACENT TO EACH CONSULTATION AND TREATMENT ROOM IN ALL THE CLINICS.

PATIENT AMENITIES

· POTABLE DRINKING WATER

· FUNCTIONAL AND CLEAN TOILETS WITH RUNNING WATER AND FLUSH

· SEPARATE ROOM FOR DOCTORS/CONSULTANTS

· ROOMS FOR REPORTING
· SPACE FOR TECHNICIANS
· STORAGE /RECORDS AREAS

· AIR-COOLING
· PATIENT CALLING SYSTEM WITH ELECTRONIC DISPLAY.

· SPECIMEN COLLECTION CENTRE

· TELEVISION IN WAITING AREA

· COMPUTERIZED REGISTRATION

· PUBLIC TELEPHONE BOOTH

IMAGING AREA

- CHANGING ROOM FACILITY.
- FILM DEVELOPING AND PROCESSING (DARK ROOM).
- LEAD APRONS AND THERMO LUMINESCENT DOSIMETERS (TLD)
- BADGES AVAILABLE WITH ALL THE STAFF WORKING IN X-RAY ROOM.

CLINICAL LABORATORY:

- SPECIMEN COLLECTION CENTRE.
- SPECIAL ROOM FOR DOCTORS.

HUMAN RESOURCES WITH QUALIFICATION AND EXPERIENCE AND NUMBERS

DOCTORS:

- HOSPITAL SUPERINTENDENT
- MEDICAL SPECIALIST
- SURGERY SPECIALIST
- O&G SPECIALIST
- DERMATOLOGIST
- PAEDIATRICIAN
- ANESTHETIST
- OPTHALMOLOGIST
- ORTHOPEDICIAN
- RADIOLOGIST
- CASUALTY DOCTORS
- DENTAL SURGEON

- FORENSIC SPECIALIST
- E.N.T SURGEON

PARAMEDICAL STAFF:

- STAFF NURSE
- HOSPITAL WORKER (OP/WARD +OT+ BLOOD STORAGE UNIT+ COLD CHAIN HANDLER)
- SANITARY WORKER
- OPHTHALMIC ASSISTANT / REFRACTIONIST
- ECG TECHNICIAN
- LABORATORY TECHNICIAN (LAB + BLOOD STORAGE UNIT)
- LABORATORY ATTENDANT
- RADIOGRAPHER
- PHARMACIST
- DIETICIAN
- DENTAL TECHNICIAN/ ASSISTANT/ HYGIENIST
- ASSISTANT NURSING SUPERINTENDENT
- MEDICAL RECORDS OFFICER / TECHNICIAN
- COLD CHAIN & VACCINE LOGISTICS ASSISTANT
- ELECTRICIAN
- PLUMBER

PARAMETERS FOR GRADING OF SINGLE SPECIALITY EYE HOSPITAL

BED STRENGTH-

SERVICES:

REFRACTIVE SURGERY

- CUSTOM VUE INDIVIDUALIZED LASIK
- ILASIK (CUSTOM VUE WITH INTRALASE)
- EPI LASIK
- PHAKIC IOL (ICL) IMPLANTATION
- REFRACTIVE LENS EXCHANGE

CATARACT SURGERY

- PHACOEMULSIFICATION CATARACT SURGERY
- MICS
- SICS AND CONVENTIONAL CATARACT EXTRACTION

RETINAL SURGERY

- PARS PLANA VITRECTOMY
- SCLERAL BUCKLING
- DIABETIC VITRECTOMY
- VITREO RETINAL SURGERY WITH SILICON OIL
- INTRAVITREAL INJECTIONS
- SILICON OIL REMOVAL
- BUCKLE REMOVAL
- SCLERAL FIXATION OF INTRAOCULAR LENS (SECONDARY IOL)

GLAUCOMA SURGERY

- TRABECULECTOMY WITH/WITHOUT MITOMYCIN C
- PHACOEMULSIFICATION WITH IOL + TRABECULECTOMY
- GLAUCOMA DRAINAGE DEVICES

· TRABECULOTOMY

SQUINT SURGERY

OCULOPLASTY PROCEDURES

· SYRINGING & PROBING
· CHALAZION
· ELECTROEOPILATION
· DACRYOCYSTORHINOSTOMY (DCR)
· PTOSIS SURGERY
· ENTROPION SURGERY
· ECTROPION SURGERY
· EVISCERATION WITH/WITHOUT IMPLANT
· MUCOUS MEMBRANE GRAFTING
· FORNIX FORMATION
· TARSORRHAPHY
· ORBITOTOMY
· DERMOID CYST EXCISION
· LID REPAIR
· LID RECONSTRUCTION
· CANALICULAR REPAIR
· BOTOX INJECTION

CORNEAL TRANSPLANTATION

· PENETRATING KERATOPLASTY (PK) + CATARACT EXTRACTION WITH IOL
· THERAPEUTIC KERATOPLASTY
· LAMELLAR KERATOPLASTY
· DESCEMET'S STRIPPING AUTOMATED ENDOTHELIAL KERATOPLASTY

· ANTERIOR STROMAL PUNCTURE (ASP) + BCL

- TISSUE ADHESIVE + BCL
- EDTA CHELATION
- INTACS
- COLLAGEN CROSSLINKING (C3R/CXL)
- PTK – PHOTOTHERAPEUTIC KERATOPLASTY
- PTERYGIUM EXCISION + CONJUCTIVAL AUTOGRAFT
- OCULAR SURFACE NEOPLASIA EXCISION WITH/ WITHOUT GRAFT

DIAGNOSTIC & THERAPEUTIC PROCEDURES

- SCHIRMER'S TEST
- APPLANATION TONOMETRY
- REFRACTION
- FLUORESCEIN STAINING
- PUNCTAL PLUGS INSERTION
- CORNEAL TOPOGRAPHY & PACHYMETRY (PENTACAM & ORBSCAN)
- VISUAL FIELDS
- SQUINT WORK UP
- FUNDUS FLUORESCEIN ANGIOGRAPHY
- ICG
- EXAMINATION UNDER ANAESTHESIA
- FUNDUS PHOTOGRAPHY
- CCT (PACHYMETRY)
- ULTRASOUND B – SCAN
- DIURNAL VARIATION
- ECG

EYE BANK.

RESEARCH CENTRE.

EMERGENCY SERVICES

- 24X 7 OPERATIONAL EMERGENCY WITH TRIAGE
- DISTINCT ENTRY
- MOBILE X-RAY/ LABORATORY, SIDE LABS/PLASTER ROOM/AND MINOR OT FACILITIES.
- TYPE OF INTERVENTION- FULL TREATMENT OR REFERED AFTER STABILIZATION.

PRIVATE WARDS AVAILABLE:

- AC SINGLE.
- AC SHAIRING.
- NON AC SINGLE.
- NON AC SHARING.

DETAILS OF BED STRENGTHS

AC SINGLE

AC SHARING

NON AC SINGLE

NON AC SHARING

GENERAL

DAY CARE

ICU

PHARMACY

IN-HOUSE PHARMACY OR OUTSOURCED

24 HOUR AVAILABILITY.

OPERATION THEATRE

- NO. OF OT'S.

CONSTANT SPECIALIZED SERVICES

- PIPED SUCTION.
- MEDICAL GASES.
- ELECTRIC SUPPLY.
- LAMINAR FLOW OF AIR.
- AIR-CONDITIONING.
- VENTILATOR.
- BOYLE'S APPARATUS.
- PORTABLE X-RAY,ECG,CARDIAC MONITOR.
- C- ARM.

SEPARATE ROOMS:

- PREPARATION ROOM,
- PRE-OPERATIVE ROOM
- POST OPERATIVE RESTING ROOM.
- SCRUB-UP ROOM.

HOSPITAL SERVICES:

MANAGEMENT INFORMATION SYSTEM (MIS)

IS THE ADMINISTRATION / BILLING / MEDICAL RECORDS SYSTEM COMPUTERIZED?

DO YOU HAVE INTERNET ACCESS?

DO YOU HAVE A HOSPITAL MANAGEMENT SYSTEM THAT LINKS ALL DEPARTMENTS TO BILLING AND MEDICAL RECORDS?

HOSPITAL KITCHEN (DIETARY SERVICE)

- DIETICIAN.

CENTRAL STERILE AND SUPPLY DEPARTMENT (CSSD)

- LABELLING
- CALIBRATION AND MAINTENANCE OF INSTRUMENTS.

HOSPITAL LAUNDRY

· FACILITIES FOR DRYING, PRESSING AND STORAGE OF SOILED AND CLEANED LINENS.

MEDICAL AND GENERAL STORES

· VEHICULAR ACCESSIBILITY AND VENTILATION.

· SECURITY AND FIRE FIGHTING ARRANGEMENTS.

ENGINEERING SERVICES

EMERGENCY LIGHTING

· SHADOW LESS LIGHT IN OPERATION THEATRE AND DELIVERY ROOMS .

· EMERGENCY PORTABLE LIGHT IN WARDS AND DEPARTMENTS.

· UPS AVAILABILITY IN ALL CRITICAL AREAS

CALL BELLS

· CALL BELLS WITH SWITCHES FOR ALL BEDS IN ALL TYPES OF WARDS

· INDICATOR LIGHTS AND LOCATION INDICATOR IN NURSES DUTY ROOM OF THE WARDS.

VENTILATION

· EITHER BY NATURAL SUPPLY OR BY MECHANICAL EXHAUST OF AIR.

MECHANICAL ENGINEERING

· AIR-CONDITIONING AND ROOM HEATING IN OPERATION THEATRE AND NEO-NATAL UNITS

· WATER COOLERS AND REFRIGERATOR IN WARDS AND DEPARTMENTS.

DRAINAGE AND SANITATION

WASTE DISPOSAL SYSTEM

HOUSEKEEPING SERVICES

- CLEANING TECHNIQUES
- PEST CONTROL

MEDICAL GAS SUPPLY

ANNUAL MAINTENANCE CONTRACT (AMC)

RECORD MAINTENANCE (MEDICAL RECORD DEPARTMENT)

HOSPITAL TRANSPORTATION- TYPE WITH NUMBERS.

- LIFTS/ ELEVATORS- BIG FOR TRANSPORTATION OF PATIENTS OR SMALL.

QUALITY CONTROL:

DO YOU FOLLOW PATIENT SAFETY GUIDELINES?

DO YOU FOLLOW ANY SET CLINICAL PROTOCOLS?

DO YOU ADHERE TO WASTE DISPOSAL GUIDELINES?

DO YOU HAVE A HOSPITAL INFECTION COMMITTEE?

IS THE FACILITY ACCREDITED/ASSESSED BY ANY RECOGNIZED ACCREDITATION BODIES?

IF YES, WHICH ARE THEY?

PHYSICAL INFRASTRUCTURE

PARKING FACILITY WITHIN HOSPITAL PREMISES

ACCESSIBILITY TO THE HOSPITAL IN ALL WEATHERS

ELECTRICAL ENGINEERING

- ELECTRICITY SUPPLY - 24 HOURS
- FACILITIES FOR SUB STATION AND GENERATION.

WATER SUPPLY-24 HOUR SUPPLY.

HOSPITAL COMMUNICATION.

- § INTERNAL TELEPHONE EXCHANGE
- § LANDLINE PHONES
- § MOBILES/CELLULAR PHONES IN CLOSED USER GROUP
- § PRIVATE MOBILE/CELLULAR PHONES
- § LOUDSPEAKERS/PUBLIC ADDRESS SYSTEMS
- § WIRELESS SETS FOR SECURITY AND AMBULANCE PERSONNEL
- § THE COMMUNICATION ROOM
- § 24X7 WORKING TELEPHONE AVAILABLE FOR HOSPITAL.
- § COMPETENT PERSON AVAILABLE FOR ANSWERING THE ENQUIRIES

RECEPTION AND ENQUIRY

- ENQUIRY/ MAY I HELP DESK AVAILABLE WITH COMPETENT STAFF FLUENT IN LOCAL LANGUAGE.
- SERVICES AVAILABLE AT THE HOSPITAL DISPLAYED AT THE ENQUIRY.

WAITING SPACES

- WAITING AREA WITH SEATING ARRANGEMENT.
- GENERAL WAITING AND SUBSIDIARY WAITING SPACES ADJACENT TO EACH CONSULTATION AND TREATMENT ROOM IN ALL THE CLINICS.

PATIENT AMENITIES

- POTABLE DRINKING WATER

- FUNCTIONAL AND CLEAN TOILETS WITH RUNNING WATER AND FLUSH

- SEPARATE ROOM FOR DOCTORS/CONSULTANTS
- ROOMS FOR REPORTING
- SPACE FOR TECHNICIANS
- STORAGE /RECORDS AREAS
- AIR-COOLING
- PATIENT CALLING SYSTEM WITH ELECTRONIC DISPLAY.
- SPECIMEN COLLECTION CENTRE
- TELEVISION IN WAITING AREA
- COMPUTERIZED REGISTRATION
- PUBLIC TELEPHONE BOOTH

CLINICAL LABORATORY:

- SPECIMEN COLLECTION CENTRE.
- SPECIAL ROOM FOR DOCTORS.

HUMAN RESOURCES WITH QUALIFICATION AND EXPERIENCE AND NUMBERS

DOCTORS:

- HOSPITAL SUPERINTENDENT
- MEDICAL SPECIALISTS
- SURGERY SPECIALISTS

PARAMEDICAL STAFF:

- STAFF NURSE
- HOSPITAL WORKER (OP/WARD +OT+ BLOOD STORAGE UNIT+ COLD CHAIN HANDLER)
- SANITARY WORKER
- OPHTHALMIC ASSISTANT / REFRACTIONIST
- ECG TECHNICIAN

- LABORATORY TECHNICIAN (LAB + BLOOD STORAGE UNIT)
- LABORATORY ATTENDANT
- RADIOGRAPHER
- PHARMACIST
- DIETICIAN
- DENTAL TECHNICIAN/ ASSISTANT/ HYGIENIST
- ASSISTANT NURSING SUPERINTENDENT
- MEDICAL RECORDS OFFICER / TECHNICIAN
- COLD CHAIN & VACCINE LOGISTICS ASSISTANT
- ELECTRICIAN
- PLUMBER

PARAMETERS FOR GRADING OF SINGLE SPECIALITY ONCOLOGY HOSPITAL

BED STRENGTH-

TREATMENT AVAILABLE FOR:

- HEAD AND NECK CANCER
- ORAL CANCER
- LUNG CANCER
- BREAST CANCER
- CERVICAL CANCER
- OVARIAN CANCER
- UTERINE CANCER
- PROSTATE CANCER
- PANCREATIC CANCER
- COLORECTAL CANCER
- STOMACH CANCER
- GALL BLADDER CANCER
- LYMPHOMA CANCER

- LEUKEMIA CANCER
- BRAIN CANCER
- BONE CANCER
- ESOPHAGEAL CANCER

MEDICAL ONCOLOGY

- HEMATO-ONCOLOGY
- PEDIATRICS ONCOLOGY
- TREATEMENT FOR BREAST HEALTH
- PREVENTIVE ONCOLOGY
- DAYCARE CHEMOTHERAPY
- PATIENT COUNSELING

SURGICAL ONCOLOGY

- HEAD & NECK UNIT.
- BREAST & THORACIC UNIT.
- GASTRO INTESTINAL & HEPATOBILLIARY.
- GENITOURINARY SERVICES.
- RECONSTRUCTIVE SERVICES
- NEURO ONCO SURGERY SERVICES
- MUSCULOSKELETAL SERVICES
- PAEDIATRIC SURGICAL ONCOLOGY

RADIATION ONCOLOGY

- BRACHYTHERAPY
- CYBERKNIFE-ROBOTIC RADIOSURGERY.
- EXTERNAL BEAM RADIOTHERAPY (EBRT) OR TELETHERAPY
- LINEAR ACCELERATOR (LINAC)
- TRUE BEAM
- SIMULATOR.

EXTERNAL RADIOTHERAPY

- VOLUMETRIC MODULATED ARC THERAPY (VMAT).
- IMAGE GUIDED RADIOTHERAPY (IGRT)
- INTENSITY MODULATED RADIOTHERAPY (IMRT)
- STEREOTACTIC RADIATION THERAPY(SRT)
- STEREOTACTIC RADIO SURGERY(SRS)
- STEREOTACTIC BODY RADIATION THERAPY(SBRT)
- THREE-DIMENSIONAL CONFORMAL RADIATION THERAPY(3-D CRT)
- RESPIRATORY GATING.

INTERNAL RADIOTHERAPY

- REMOTE AFTER LOADING HIGH DOSE RATE BRACHYTHERAPY (HDR BRACHYTHERAPY).

UROLOGY AND GYNAECOLOGICAL ONCOLOGY

- RADICAL NEPHRECTOMY.
- EXTENDED RADICAL NEPHRECTOMY.
- RADICAL PROSTATECTOMY.
- RADICAL CYSTOPROSTATECTOMY.
- TREATMENT FOR CANCER CERVIX.
- TREATMENT FOR CANCER OF OVARIES AND FALLOPIAN TUBE.
- TREATMENT FOR CANCER OF UTERINE CAVITY.
- TREATMENT FOR CANCER VULVA.
- TREATMENT FOR CANCER VAGINA.

PAEDIATRIC HAEMATOLOGY AND ONCOLOGY

- BONE MARROW TRANSPLANTATION.
- PAEDIATRIC ONCOSURGERY.

DIAGNOSTIC AND INTERVENTIONAL GASTROENTEROLOGY

· UPPER GI ENDOSCOPY AND BIOPSY – FOR OESOPHAGUS OR STOMACH LESIONS

· LOWER GI ENDOSCOPY AND BIOPSY – FOR LESIONS OF LARGE INTESTINE

· ERCP (ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY)

· OESOPHAGEAL STENT – DILATATION FOR IMPASSABLE MALIGNANT STRICTURES OF OESOPHAGUS.

· COLONIC STENTS

· ERCP STENTS FOR MALIGNANT JAUNDICE

· PTBD (PERCUTANEOUS TRANSHEPTIC BILIARY DRAINAGE) UNDER GUIDANCE

· PEG (PERCUTANEOUS ENDOSCOPIC GASTROSTOMY) FOR PURPOSE OF FEEDING

· DUODENAL STENTS IN CASES OF UNRESECTABLE PANCREATIC TUMORS WITH GASTRIC OUTLET OBSTRUCTION.

· SCLEROTHERAPY FOR VARICEAL BLEED

· TACE (TRANS ARTERIAL CHEMOEMBOLIZATION)

NUCLEAR MEDICINE.

· CONVENTIONAL STUDIES.

· RADIONUCLIDE THERAPY.

· POSITRON EMISSION TOMOGRAPHY.

IMAGING

· X-RAY

· ULTRASOUND

· MRI.

· FUNCTIONAL MRI.

· WHOLE BODY MRI.

· 2D & 3D SPECTROSCOPY.

· MRI GUIDED BIOPSY.

- DIGITAL MAMMOGRAM.
- DOPPLER
- DOTANOC SCAN
- ECHO
- ENDOSCOPY
- MAGNETOM SKYRA 3 TESLA MRI
- NUCLEAR MEDICINE – DUAL HEAD GAMMA CAMERA
- PET MR
- COLONOSCOPY
- 16 SLICE PET CT.
- 128 SLICE PET CT.
- 128 – SLICE CT

CLINICAL LABORATORY

- BIOCHEMISTRY
- CLINICAL PATHOLOGY
- HAEMATOLOGY
- HISTOPATHOLOGY
- MICROBIOLOGY
- MOLECULAR BIOLOGY
- SEROLOGY
- TRANSFUSION MEDICINE.

PREVENTIVE ONCOLOGY

SUPPORT SERVICES

- ONCO-PSYCHOTHERAPY
- PHYSIOTHERAPY
- YOGA THERAPY
- PHARMACY

RESEARCH CENTRE.

EMERGENCY SERVICES

- 24X 7 OPERATIONAL EMERGENCY WITH TRIAGE
- DISTINCT ENTRY
- MOBILE X-RAY/ LABORATORY, SIDE LABS/PLASTER ROOM/AND MINOR OT FACILITIES.
- TYPE OF INTERVENTION- FULL TREATMENT OR REFERED AFTER STABILIZATION.

PRIVATE WARDS AVAILABLE:

- AC SINGLE.
- AC SHAIRING.
- NON AC SINGLE.
- NON AC SHARING.

DETAILS OF BED STRENGTHS

AC SINGLE

AC SHARING

NON AC SINGLE

NON AC SHARING

GENERAL

DAY CARE

ICU

PHARMACY

IN-HOUSE PHARMACY OR OUTSOURCED

24 HOUR AVAILABILITY.

OPERATION THEATRE

- NO. OF OT'S.

CONSTANT SPECIALIZED SERVICES

- PIPED SUCTION.
- MEDICAL GASES.
- ELECTRIC SUPPLY.
- LAMINAR FLOW OF AIR.
- AIR-CONDITIONING.
- VENTILATOR.
- BOYLE'S APPARATUS.
- PORTABLE X-RAY,ECG,CARDIAC MONITOR.

SEPARATE ROOMS:

- PREPARATION ROOM,
- PRE-OPERATIVE ROOM
- POST OPERATIVE RESTING ROOM.
- SCRUB-UP ROOM.

HOSPITAL SERVICES:

MANAGEMENT INFORMATION SYSTEM (MIS)

IS THE ADMINISTRATION / BILLING / MEDICAL RECORDS SYSTEM COMPUTERIZED?

DO YOU HAVE INTERNET ACCESS?

DO YOU HAVE A HOSPITAL MANAGEMENT SYSTEM THAT LINKS ALL DEPARTMENTS TO BILLING AND MEDICAL RECORDS?

HOSPITAL KITCHEN (DIETARY SERVICE)

- DIETICIAN.

CENTRAL STERILE AND SUPPLY DEPARTMENT (CSSD)

- LABELLING
- CALIBRATION AND MAINTENANCE OF INSTRUMENTS.

HOSPITAL LAUNDRY

- FACILITIES FOR DRYING, PRESSING AND STORAGE OF SOILED AND CLEANED LINENS.

MEDICAL AND GENERAL STORES

- VEHICULAR ACCESSIBILITY AND VENTILATION.
- SECURITY AND FIRE FIGHTING ARRANGEMENTS.

ENGINEERING SERVICES

EMERGENCY LIGHTING

- SHADOW LESS LIGHT IN OPERATION THEATRE AND DELIVERY ROOMS .
- EMERGENCY PORTABLE LIGHT IN WARDS AND DEPARTMENTS.
- UPS AVAILABILITY IN ALL CRITICAL AREAS

CALL BELLS

- CALL BELLS WITH SWITCHES FOR ALL BEDS IN ALL TYPES OF WARDS
- INDICATOR LIGHTS AND LOCATION INDICATOR IN NURSES DUTY ROOM OF THE WARDS.

VENTILATION

- EITHER BY NATURAL SUPPLY OR BY MECHANICAL EXHAUST OF AIR.

MECHANICAL ENGINEERING

· AIR-CONDITIONING AND ROOM HEATING IN OPERATION THEATRE AND NEO-NATAL UNITS

· WATER COOLERS AND REFRIGERATOR IN WARDS AND DEPARTMENTS.

DRAINAGE AND SANITATION

WASTE DISPOSAL SYSTEM

HOUSEKEEPING SERVICES

· CLEANING TECHNIQUES

· PEST CONTROL

MEDICAL GAS SUPPLY

ANNUAL MAINTENANCE CONTRACT (AMC)

RECORD MAINTENANCE (MEDICAL RECORD DEPARTMENT)

HOSPITAL TRANSPORTATION- TYPE WITH NUMBERS.

· LIFTS/ ELEVATORS- BIG FOR TRANSPORTATION OF PATIENTS OR SMALL.

QUALITY CONTROL:

DO YOU FOLLOW PATIENT SAFETY GUIDELINES?

DO YOU FOLLOW ANY SET CLINICAL PROTOCOLS?

DO YOU ADHERE TO WASTE DISPOSAL GUIDELINES?

DO YOU HAVE A HOSPITAL INFECTION COMMITTEE?

IS THE FACILITY ACCREDITED/ASSESSED BY ANY RECOGNIZED ACCREDITATION BODIES?

IF YES, WHICH ARE THEY?

PHYSICAL INFRASTRUCTURE

PARKING FACILITY WITHIN HOSPITAL PREMISES

ACCESSIBILITY TO THE HOSPITAL IN ALL WEATHERS

ELECTRICAL ENGINEERING

- ELECTRICITY SUPPLY - 24 HOURS
- FACILITIES FOR SUB STATION AND GENERATION.

WATER SUPPLY-24 HOUR SUPPLY.

HOSPITAL COMMUNICATION.

- § INTERNAL TELEPHONE EXCHANGE
- § LANDLINE PHONES
- § MOBILES/CELLULAR PHONES IN CLOSED USER GROUP
- § PRIVATE MOBILE/CELLULAR PHONES
- § LOUDSPEAKERS/PUBLIC ADDRESS SYSTEMS
- § WIRELESS SETS FOR SECURITY AND AMBULANCE PERSONNEL
- § THE COMMUNICATION ROOM
- § 24X7 WORKING TELEPHONE AVAILABLE FOR HOSPITAL.
- § COMPETENT PERSON AVAILABLE FOR ANSWERING THE ENQUIRIES

RECEPTION AND ENQUIRY

- ENQUIRY/ MAY I HELP DESK AVAILABLE WITH COMPETENT STAFF FLUENT IN LOCAL LANGUAGE.
- SERVICES AVAILABLE AT THE HOSPITAL DISPLAYED AT THE ENQUIRY.

WAITING SPACES

- WAITING AREA WITH SEATING ARRANGEMENT.

· GENERAL WAITING AND SUBSIDIARY WAITING SPACES ADJACENT TO EACH CONSULTATION AND TREATMENT ROOM IN ALL THE CLINICS.

PATIENT AMENITIES

· POTABLE DRINKING WATER
· FUNCTIONAL AND CLEAN TOILETS WITH RUNNING WATER AND FLUSH

· SEPARATE ROOM FOR DOCTORS/CONSULTANTS
· ROOMS FOR REPORTING
· SPACE FOR TECHNICIANS
· STORAGE /RECORDS AREAS
· AIR-COOLING
· PATIENT CALLING SYSTEM WITH ELECTRONIC DISPLAY.
· SPECIMEN COLLECTION CENTRE
· TELEVISION IN WAITING AREA
· COMPUTERIZED REGISTRATION
· PUBLIC TELEPHONE BOOTH

CLINICAL LABORATORY:

· SPECIMEN COLLECTION CENTRE.
· SPECIAL ROOM FOR DOCTORS.

HUMAN RESOURCES WITH QUALIFICATION AND EXPERIENCE AND NUMBERS

DOCTORS:

· HOSPITAL SUPERINTENDENT
· MEDICAL SPECIALISTS
· SURGERY SPECIALISTS

PARAMEDICAL STAFF:

· STAFF NURSE

· HOSPITAL WORKER (OP/WARD +OT+ BLOOD STORAGE UNIT+ COLD CHAIN HANDLER)
· SANITARY WORKER
· OPHTHALMIC ASSISTANT / REFRACTIONIST
· ECG TECHNICIAN
· LABORATORY TECHNICIAN (LAB + BLOOD STORAGE UNIT)
· LABORATORY ATTENDANT
· RADIOGRAPHER
· PHARMACIST
· DIETICIAN
· DENTAL TECHNICIAN/ ASSISTANT/ HYGIENIST
· ASSISTANT NURSING SUPERINTENDENT
· MEDICAL RECORDS OFFICER / TECHNICIAN
· COLD CHAIN & VACCINE LOGISTICS ASSISTANT
· ELECTRICIAN
· PLUMBER

PARAMETERS FOR GRADING OF SINGLE SPECIALITY UROLOGY HOSPITAL

BED STRENGTH-

SERVICES: TECHNOLOGY USED:

UROLOGY SERVICES:

· URETERIC STRICTURE
· URETHRAL STRICTURE
· ERECTILE DYSFUNCTION
· MALE INFERTILITY
· FEMALE URINARY INCONTINENCE.
· TREATMENT OF KIDNEY CANCER .
· TREATMENT OF URINARY BLADDER CANCER .

· IMPLANTS

URINARY STONE SERVICES:

· PERCUTANEOUS NEPHROSTOLITHOTOMY (PCNL).
· LITHOTRIPSY .
· URETEROSCOPIC LITHOTRIPSY (UCS) .

LAPAROSCOPIC SERVICES:

· GALL BLADDER STONE
· HERNIA REPAIR.
· UTERINE FIBROIDS
· UTERINE PROLAPSE.
· INFERTILITY
· PILES.
· APPENDICITIS.

PROSTATE SERVICES:

· LASER .
· ENUCLEATION OF PROSTATE .
· TREATMENT OF PROSTATE ENLARGEMENT .
· TREATMENT OF PROSTATE CANCER .

RESEARCH CENTRE.

EMERGENCY SERVICES

· 24X 7 OPERATIONAL EMERGENCY WITH TRIAGE
· DISTINCT ENTRY
· MOBILE X-RAY/ LABORATORY, SIDE LABS/PLASTER ROOM/AND MINOR OT FACILITIES.
· TYPE OF INTERVENTION- FULL TREATMENT OR REFERED AFTER STABILIZATION.

PRIVATE WARDS AVAILABLE:

- AC SINGLE.
- AC SHAIRING.
- NON AC SINGLE.
- NON AC SHARING.

DETAILS OF BED STRENGTHS

AC SINGLE

AC SHARING

NON AC SINGLE

NON AC SHARING

GENERAL

DAY CARE

ICU

PHARMACY

IN-HOUSE PHARMACY OR OUTSOURCED

24 HOUR AVAILABILITY.

OPERATION THEATRE

- NO. OF OT'S.

CONSTANT SPECIALIZED SERVICES

- PIPED SUCTION.
- MEDICAL GASES.
- ELECTRIC SUPPLY.
- LAMINAR FLOW OF AIR.
- AIR-CONDITIONING.
- VENTILATOR.

- BOYLE'S APPARATUS.
- PORTABLE X-RAY,ECG,CARDIAC MONITOR.

SEPARATE ROOMS:

- PREPARATION ROOM,
- PRE-OPERATIVE ROOM
- POST OPERATIVE RESTING ROOM.
- SCRUB-UP ROOM.

HOSPITAL SERVICES:

MANAGEMENT INFORMATION SYSTEM (MIS)

IS THE ADMINISTRATION / BILLING / MEDICAL RECORDS SYSTEM COMPUTERIZED?

DO YOU HAVE INTERNET ACCESS?

DO YOU HAVE A HOSPITAL MANAGEMENT SYSTEM THAT LINKS ALL DEPARTMENTS TO BILLING AND MEDICAL RECORDS?

HOSPITAL KITCHEN (DIETARY SERVICE)

- DIETICIAN.

CENTRAL STERILE AND SUPPLY DEPARTMENT (CSSD)

- LABELLING
- CALIBRATION AND MAINTENANCE OF INSTRUMENTS.

HOSPITAL LAUNDRY

- FACILITIES FOR DRYING, PRESSING AND STORAGE OF SOILED AND CLEANED LINENS.

MEDICAL AND GENERAL STORES

· VEHICULAR ACCESSIBILITY AND VENTILATION.

· SECURITY AND FIRE FIGHTING ARRANGEMENTS.

ENGINEERING SERVICES

EMERGENCY LIGHTING

· SHADOW LESS LIGHT IN OPERATION THEATRE AND DELIVERY ROOMS .

· EMERGENCY PORTABLE LIGHT IN WARDS AND DEPARTMENTS.

· UPS AVAILABILITY IN ALL CRITICAL AREAS

CALL BELLS

· CALL BELLS WITH SWITCHES FOR ALL BEDS IN ALL TYPES OF WARDS

· INDICATOR LIGHTS AND LOCATION INDICATOR IN NURSES DUTY ROOM OF THE WARDS.

VENTILATION

· EITHER BY NATURAL SUPPLY OR BY MECHANICAL EXHAUST OF AIR.

MECHANICAL ENGINEERING

· AIR-CONDITIONING AND ROOM HEATING IN OPERATION THEATRE AND NEO-NATAL UNITS

· WATER COOLERS AND REFRIGERATOR IN WARDS AND DEPARTMENTS.

DRAINAGE AND SANITATION

WASTE DISPOSAL SYSTEM

HOUSEKEEPING SERVICES

- CLEANING TECHNIQUES
- PEST CONTROL

MEDICAL GAS SUPPLY

ANNUAL MAINTENANCE CONTRACT (AMC)

RECORD MAINTENANCE (MEDICAL RECORD DEPARTMENT)

HOSPITAL TRANSPORTATION- TYPE WITH NUMBERS.

- LIFTS/ ELEVATORS- BIG FOR TRANSPORTATION OF PATIENTS OR SMALL.

QUALITY CONTROL:

DO YOU FOLLOW PATIENT SAFETY GUIDELINES?

DO YOU FOLLOW ANY SET CLINICAL PROTOCOLS?

DO YOU ADHERE TO WASTE DISPOSAL GUIDELINES?

DO YOU HAVE A HOSPITAL INFECTION COMMITTEE?

IS THE FACILITY ACCREDITED/ASSESSED BY ANY RECOGNIZED ACCREDITATION BODIES?

IF YES, WHICH ARE THEY?

PHYSICAL INFRASTRUCTURE

PARKING FACILITY WITHIN HOSPITAL PREMISES

ACCESSIBILITY TO THE HOSPITAL IN ALL WEATHERS

ELECTRICAL ENGINEERING

- ELECTRICITY SUPPLY - 24 HOURS
- FACILITIES FOR SUB STATION AND GENERATION.

WATER SUPPLY-24 HOUR SUPPLY.

HOSPITAL COMMUNICATION.

§ INTERNAL TELEPHONE EXCHANGE

§ LANDLINE PHONES

§ MOBILES/CELLULAR PHONES IN CLOSED USER GROUP

§ PRIVATE MOBILE/CELLULAR PHONES

§ LOUDSPEAKERS/PUBLIC ADDRESS SYSTEMS

§ WIRELESS SETS FOR SECURITY AND AMBULANCE PERSONNEL

§ THE COMMUNICATION ROOM

§ 24X7 WORKING TELEPHONE AVAILABLE FOR HOSPITAL.

§ COMPETENT PERSON AVAILABLE FOR ANSWERING THE ENQUIRIES

RECEPTION AND ENQUIRY

· ENQUIRY/ MAY I HELP DESK AVAILABLE WITH COMPETENT STAFF FLUENT IN LOCAL LANGUAGE.

· SERVICES AVAILABLE AT THE HOSPITAL DISPLAYED AT THE ENQUIRY.

WAITING SPACES

· WAITING AREA WITH SEATING ARRANGEMENT.

· GENERAL WAITING AND SUBSIDIARY WAITING SPACES ADJACENT TO EACH CONSULTATION AND TREATMENT ROOM IN ALL THE CLINICS.

PATIENT AMENITIES

· POTABLE DRINKING WATER

· FUNCTIONAL AND CLEAN TOILETS WITH RUNNING WATER AND FLUSH

· SEPARATE ROOM FOR DOCTORS/CONSULTANTS

· ROOMS FOR REPORTING

· SPACE FOR TECHNICIANS

· STORAGE /RECORDS AREAS

· AIR-COOLING

- PATIENT CALLING SYSTEM WITH ELECTRONIC DISPLAY.
- SPECIMEN COLLECTION CENTRE
- TELEVISION IN WAITING AREA
- COMPUTERIZED REGISTRATION
- PUBLIC TELEPHONE BOOTH

CLINICAL LABORATORY:

- SPECIMEN COLLECTION CENTRE.
- SPECIAL ROOM FOR DOCTORS.

HUMAN RESOURCES WITH QUALIFICATION AND EXPERIENCE AND NUMBERS

DOCTORS:

- HOSPITAL SUPERINTENDENT
- MEDICAL SPECIALISTS
- SURGERY SPECIALISTS

PARAMEDICAL STAFF:

- STAFF NURSE
- HOSPITAL WORKER (OP/WARD +OT+ BLOOD STORAGE UNIT+ COLD CHAIN HANDLER)
- SANITARY WORKER
- OPHTHALMIC ASSISTANT / REFRACTIONIST
- ECG TECHNICIAN
- LABORATORY TECHNICIAN (LAB + BLOOD STORAGE UNIT)
- LABORATORY ATTENDANT
- RADIOGRAPHER
- PHARMACIST
- DIETICIAN
- DENTAL TECHNICIAN/ ASSISTANT/ HYGIENIST
- ASSISTANT NURSING SUPERINTENDENT

- MEDICAL RECORDS OFFICER / TECHNICIAN
- COLD CHAIN & VACCINE LOGISTICS ASSISTANT
- ELECTRICIAN
- PLUMBER

CONCLUSION:

Health Insurance companies (Payors) are hurt by the inflated bills produced by hospitals. They are trying to resolve the potential issues of excess usage of health facilities, increase in inappropriate care, adverse selection and risk selection that go with the availability of health insurance.

In an effort to curb that the public sector units(PSU's) have decided to work on the Preferred Provider Rates (PPR). In order to work it out, Hospitals have to be categorized into different categories.

According to the score of the Hospital/ Nursing Home included both in terms of Quantitative as well as Qualitative Parameters, these can be categorized in different categories. Hospital with a higher score (Quantitative and Qualitative) can be given as Higher Grade and those with lower score can be assigned with a lower grade.

RECOMMENDATIONS:

1. Categorization of Hospitals is a standardized procedure which should be done by Government.

2. Government should create common standards and norms for coding of diseases and treatment procedures.

3. IRDA should implement strict licensing and categorization of health service providers along with formalization and monitoring of fees structure.

4. IRDA should review and reform the existing CGHS and ESIS schemes including withdrawl from those who can pay for healthcare.

REFERENCES

1. Anurag Prasad . Conquest IIM Shilong. Health insurance in India- opportunities, challenges and way ahead; January 2011
2. Bhat Ramesh & Mavlankar Dileep (2000), 'Health Insurance in India: Opportunities,Challenges and Concerns', Indian Institute of Management, Ahmedabad.
3. Bhat Ramesh (1999), 'A note on policy initiatives to protect the poor from high medical

   costs', Indian Institute of Management, Ahmedabad.Social Health Insurance.
4. Bhat R, Reuben E. Analysis of claims and reimbursements made under Mediclaim Policy of GIC, W.P.No. 2001-08-09. Ahmedabad: IIM; 2001.
5. Bhat R. Public private partnerships in the health sector: Issues and prospects, May 1999, W.P No. 99 – 05-06 Ahmedabad: IIM.
6. Bhat R. Public private partnerships in health sector: Issues andpolicy options, January 2000, Paper prepared for DFID, Delhi.
7. Ellis Randall P, Moneer Alam, Indrani Gupta, Health Insurance in India : Prognosis and Prospects, EPW, Jan 22, 2000.
8. Garg C. Implications of current experiences of health insurance in India. In: Private health Insurance and Public health goals in India: Report on a National Seminar, New Delhi: World Bank;2000.
9. Garg C. Is health insurance feasible in India: Issues in private and social health insurance? Health security in India (unpublished).
10. Government of India. Private Health Insurance And Public Health Goals In India – Report on a National Seminar, GOI, 2000.
11. Gupta Indrani, Private Health Insurance and Health Costs: Results from a Delhi Study, EPW, vol XXXVII July, 2002.
12. Mahal A. Assessing private health insurance in India: Potential impacts and regulatory issues. Economic and Political Weekly 2002:559–71.
13. Rao S. Health insurance: Concepts, issues and challenges. EPW, August 2004

14. Sekhrie N, Savedoff W. Private health insurance: Implications for developing countries; policy and practice. Bulletin of the World Health Organization 2005;85:127—34.
15. Susan Thomas Reasearch Associate E- Health, Scope of Health Insurance in India,2006.
16. Confederation of Indian Industry, newsletter 2010.
17. Mrityunjay Ram, Times of India, Government pill to heal Hospitals, 2005.
18. Crisil Ratings for healthcare institutions
19. ICRA ratings for healthcare institutions.
20. Annual Health Report 2010,MOHFW
21. Government of India, (2010), "India in Business: Industries & Services: Infrastructure,
    Health " I T P division, Ministry of External Affairs, Government of India cited on April
    10, 2009.
22. Ministry of Health and Family Welfare, Government of India.
23. Mavalankar D, Bhatt R. **Health Insurance in India Opportunities, Challenges and Concerns.** Indian Institute of Management, Ahmedabad; 2000.
24. Ranson Kent & Jowett Matthew (2003), 'Developing Health Insurance in India: Background Paper', Prepared for Govt. of India Workshop on Health Insurance, 3- 4 January, New Delhi.

Excel Sheet

1. Indian public health standards-Guidelines for 500 bedded hospital, Revised draft.
2. Indian Standard Basic Requirement for Hospital Planning; Part 2 Upto 100 Beded Hospital, Bureau of Indian Standards, New Delhi, January, 2001
3. Rationalisation of Service Norms for Secondary Care Hospitals, Health & Family Welfare Department, Govt. of Tamil Nadu. (Unpublished)
4. District Health Facilities, Guidelines for Development and Operations; WHO; 1998.
5. Indian Public Health Standards (IPHS) for Community Health Centres; Directorate General of Health Services, Ministry of Health & Family Welfare, Govt. of India.

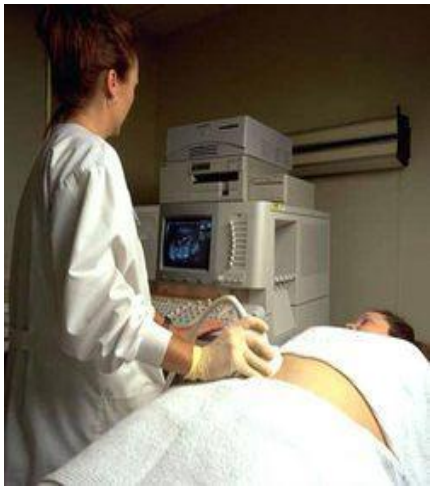
6. Population Census of India, 2001; Office of the Registrar General, India.
7. Prof. Anand S.Arya, under the GOI- Disaster Risk Management Programme, National Disaster Management Division, MHA, New Delhi.

LIST OF FIGURES

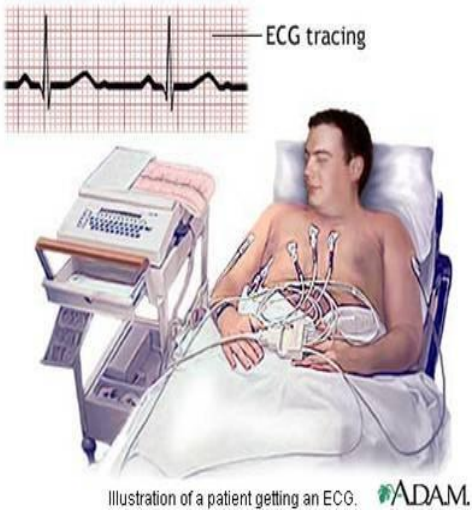
1. CATH LAB

2. MRI MACHINE

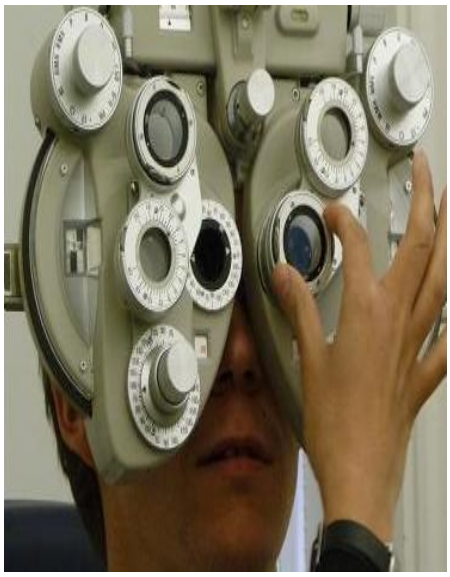
3. ULTRSOUND



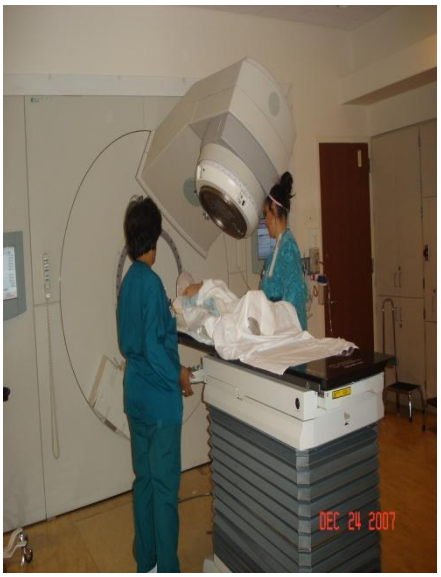
4. ECG



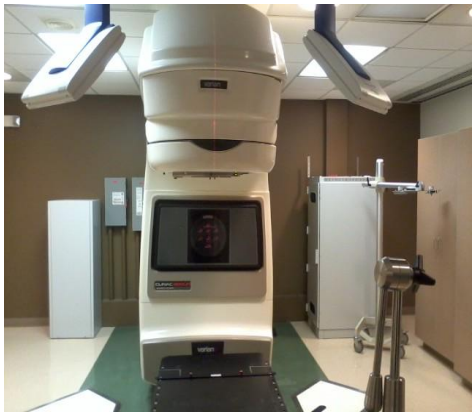
5. CUSTOM VUI INDIVIDULIZED LASIK



6.DAYCARE CHEMOTHERAPY

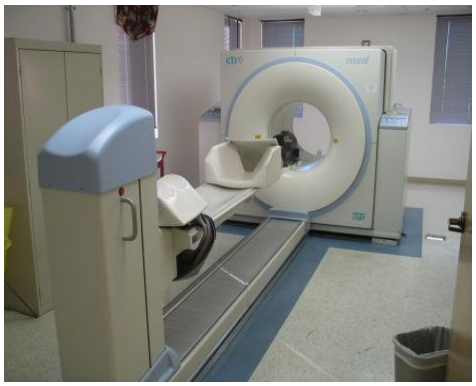


7. LINAC



8. IMRT

9. POSITRON EMISSION TOMOGRAPHY



10. LITHOTRIPSY