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THE UNQUALIFIED MEDICAL PRACTITIONERS

Methods of Practice and Nexus with the Qualified Doctors

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ABSTRACT

The private sector accounts for about 75 percent of outpatient as well as inpatient medical care in Andhra Pradesh. The presence of a large number of unqualified medical practitioners in the rural areas and urban slums indicate that they provide most of the outpatient services in the private sector. Given the huge quantum of services provided by the RMPs, the present study aims at identifying their number, characteristics and the nexus with the qualified doctors through a case study of one district in AP.

The RMPs have no professional qualification and no license to practice any system of medicine. They practice on the basis of work experience in hospitals and clinics. On average, there are 12 RMPs per 10,000 population. About 90 percent of the RMPs are from the deprived social groups. They are relatively young and a majority of them have more than 12 years of education. The RMPs are very popular in the rural areas and urban slums because they are the first contact in the medical emergencies. The RMPs are an organic part of the private medical care and have referral arrangement with the qualified doctors on the basis of kickbacks. It is not possible to ban the RMPs without providing alternative sources of medical care in the villages. In the short term, it is in the public interest to train the educated RMPs and regulate their services. As a long-term solution, there is a need for introducing short-term medical courses to provide a trained medical person in every habitation. Once the state is able to provide access to alternative sources of treatment, the RMPs will vanish on their own.

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Andhra Pradesh (A.P.) is one of the few states where the private sector has outgrown the size of public sector in the provision of outpatient as well as inpatient medical care. According to the 52nd round of the National Sample Survey, the private sector accounted for about 75 percent of inpatient and outpatient care in A.P[1]. In 1999-2000, the per capita household expenditure on medical care in A.P. was Rs.363 per annum[2], which was about two and half times more than the state government expenditure (Rs.149) in the same year. About 75 percent of the household expenditure on medical care was on outpatient services. In absolute terms, the total household expenditure on outpatient medical care was Rs.2036 crores per year in A.P. (Rs.1428 crores in rural areas and Rs.608 crores in urban areas). Given the volume of resources spent on the outpatient care, there is a need for identifying the sources and nature of outpatient medical care on which the households incur this expenditure. Since the major source of outpatient care in the rural areas and urban slums is the unqualified medical practitioners, the present study is aimed at identifying the relative size and characteristics of the unqualified medical practitioners and their nexus with the qualified doctors.

A large number of practitioners in the allopathic medicine have no professional qualification and no license to practice any system of medicine. They practice on the basis of the practical experience in the hospitals and clinics. The unqualified medical practitioners are popularly known as RMPs. In the past, the Board of Ayurvedic Medicine used to register the traditional Ayurveda practitioners on the basis of their family

[1] Central Statistical Organisation, Department of Statistics, Ministry of Planning, Government of India (1995-96): *NSS 50th Round*, CSO, New Delhi.

[2]Central Statistical Organisation, Department of Statistics, Ministry of Planning, Government of India (1999-2000): *NSS 55th Round,* CSO, New Delhi.

background and experience in the traditional medical practice. These "registered medical practitioners" or RMPs were supplied with the Ayurvedic medicines and paid monthly honorarium by the Board of Ayurvedic Medicine on the basis of average number of patients treated. However, they used to practice mainly the Allopathic medicine and the registration certificate provided a safeguard from the government agencies. That is how the term RMP became popular with the medical practitioners who move around in villages and poor localities in the urban areas and deliver medical care at nominal cost. Otherwise, there was never any certification to practice allopathic medicine on the basis of experience. However, there is widespread misunderstanding that until 1970s there was a recognised RMP certificate in allopathic medicine[3], issued on the basis of experience, but it is not true. Most of the present day RMPs do not have any certificate, not even the one given by the Board of Ayurvedic Medicine. Still they use this acronym for legitimacy in the eyes of public. It is used as an abbreviation for the Rural Medical Practitioners (RMPs). The other term used by the unqualified medical practitioners is the Private Medical Practitioners (PMPs), perhaps to save the unqualified medical practitioners in the urban areas from the embarrassment of calling themselves as Rural Medical Practitioners. In the present study, the unqualified medical practitioners are referred to as the RMPs.

1. Objectives and Methodology of Study

The study was conducted with the objective of identifying the following aspects:

1. The Socioeconomic Characteristics of RMPs and their number
2. The Nature of Medical Practice by the RMPs
3. The relations between the RMPs and Qualified Medical Practitioners (MBBS/MD/MS etc.) in Allopathy

Using questionnaire, data was collected from 209 RMPs in 5 towns and 91 Villages spread over 24 Blocks (Mandals) in Khammam District in AP (Table 1). It is basically a case study of a district but Khammam being in the middle range on many socio-economic indicators, it represents the typical situation in the state. The data is collected from about 7 percent of RMPs in the

[3] Berman, P. " Rethinking Health Care Systems: Private Health Care Provision in India." World Development, 26(8): 1463-1479, 1998, p.1473-74.

district on random basis. In addition, in-depth interviews were conducted with the Qualified Doctors, the RMPs, the associations of RMPs, Medical Stores and Diagnostic Centres to gain further insights into the phenomenon. The focus group discussions were also conducted in the rural and urban areas to understand the factors behind the popularity of RMPs and their methods of practice. However, the study was not aimed at probing the efficacy of treatment provided by the RMPs.

The study was confined to unqualified practitioners in the allopathic medicine only. It also does not cover the medical practitioners who are qualified in other systems of medicine like Homeopathy and Ayurveda but practice allopathic medicine i.e. cross-practice of non allopathic doctors. It also does not cover the paramedics in the government service (Auxiliary Nurse Midwives, Lady Health Visitors etc.), the traditional midwives etc. who may be occasionally delivering the allopathic medicines on the payment.

Table 1: Sample Size of Study

Place	Population Size				Sample Size			
	No.of Towns	No.of Mandals	No.of Villages	No. of RMPs	No.of Towns	No.of Mandals	No.of Villages	No. of RMPs
1.Rural	-	46	1092	2842	-	24 (52.2)	91 (8.3)	180 (6.3)
1.1 Tribal	-	31	796	1388	-	12 (38.7)	37 (4.7)	84 (6.05)
1.2 Non Tribal	-	15	296	1454	-	12 (80.0)	54 (18.2)	96 (6.6)
2.Urban	8	-	-	189	5 (62.5)	-	-	29 (15.3)
Total(1+2)	-	-	-	3031	-	-	-	209 (6.9)

Note: Figures in the parenthesis are the percentages

The number of RMPs and qualified doctors in the district and their distribution (rural-urban and public-private) is presented in the following section. The socioeconomic background of RMPs and the methods of their practice were presented in sections 3 and 4 respectively. In section 5, the formation of RMPs' associations and their functions were discussed. In sections 6 and 7, the factors behind the popularity of RMPs and their nexus with the qualified doctors were discussed. The summary of findings and broad conclusions were presented in the final section.

2. Relative Size of Qualified and Unqualified Medical Practitioners

The number of RMPs and qualified allopathic doctors in the district was estimated from different sources. The number of doctors in the government service is arrived at from sources like the District Medical and Health Officer and the District Coordinator of Health Services. The number of doctors in the private sector is gathered from district chapter of the Indian Medical Association (IMA). The number of RMPs is estimated from the lists provided by the associations of RMPs, the diagnostic centres, private hospitals and pharmaceutical stores. Further, these sources are verified and supplemented by the field surveys. There are about 3030 RMPs and about 487 qualified doctors in the district (Table2). Still there could be some underestimation in the number of RMPs in the district because they are ubiquitous even in the remote tribal areas and some of them might have not figured in our sources. In the case of qualified doctors, the number is more reliable because they are concentrated mainly in the urban areas and Mandal/block head quarters (HQs).

Table 2 : RMPs and Qualified doctors (QDs) in Khammam District

Place	RMPs	Qualified Doctors (QDs)			RMPs per QD	Per 10,000 Population	
		Govt	Private	Total		RMPs	QDs
1. Rural	2842	109 *(82.0)*	24 *(18.0)*	133 *(100)*	21	14	0.6
1.1 Tribal	1388	81 *(88.0)*	11 *(12.0)*	92 *(100)*	15	11	0.7
1.2 Non-Tribal	1454	28 *(68.3)*	13 *(31.7)*	41 *(100)*	35	17	0.5
2. Urban	189	76 *(21.5)*	278 *(78.5)*	354 *(100)*	0.5	4	7.4
Total(1+2)	3031	185 *(38.0)*	302 *(62.0)*	487 *(100)*	6	12	1.9

Note: Figures in the parenthesis are the percentages

The presence of RMPs is inversely related to the per capita availability of qualified doctors. On average, there are 14 RMPs and less than 2 qualified doctors per 10,000 population in the district. The RMPs are very widespread in the non-tribal areas (17 RMPs per 10,000 population) where the per capita availability of qualified doctors is lowest (0.5 per doctors per 10,000 popula-

tion). In contrast, there were only 4 RMPs per 10,000 population in the urban areas where there are more than 7 qualified doctors per 10,000 population.

The ratio of RMPs to the qualified doctors indicates that most of the outpatient care in the rural areas is provided by the RMPs. There are six RMPs per a qualified allopathic doctor in the district. In the urban areas, however, the number of RMPs is only half the number of qualified doctors. In contrast, there are 21 RMPs per a qualified doctor in the rural areas. Within the rural areas, the number of RMPs per a qualified doctor was more in the non-tribal areas (31 RMPs per a qualified doctor).

The rural-urban distribution of RMPs and qualified doctors shows similar pattern. About 94 percent of RMPs in the district are practicing in the rural areas. In contrast, only 27 percent of the qualified doctors are in the rural areas. While a majority (59 percent) of the qualified doctors in the government service are posted in the rural areas, only 8 percent of the qualified private doctors are practicing in the rural areas.

Together, the RMPs and qualified private doctors account for more than 95 percent of medical practitioners in the district. In addition, the private sector includes the private practice of the government doctors. All the RMPs and 62 percent of qualified doctors were in the private sector. However, the percent of qualified doctors in the private sector is relatively very high (about 79 percent) in the urban areas and very low i.e. 18 percent (12 percent in the tribal areas and 32 percent in the non tribal areas) in the rural areas.

3. Socio-Economic Background of RMPs

The socioeconomic background of RMPs is analysed in terms of the caste, age, education, family occupation etc.

3.1 Social Background

Nearly 90 percent of RMPs were from the deprived social groups (SCs, STs, OBCs and minorities) (Table3). The OCs account for only 11.5 percent of the total RMPs in the district but in the towns they constitute about 20 percent of RMPs. The OBCs account for nearly 60 percent of RMPs and a majority of them belong to artisan castes (weavers, goldsmiths, carpenters, etc.). The percent of Muslims is also quite high. They account for about 15 percent of RMPs.

Table 3: Social Background of RMPs

Caste / Place	SC	ST	OBC	Muslim	OC	Total
Village	20	3	81	27	16	147
	(13.6)	*2*	*(55.1)*	*(18.4)*	*(10.9)*	*(100)*
Mandal HQ	5	--	22	4	2	33
	(15.2	*--*	*(66.7)*	*(12.1)*	*(6.1)*	*(100)*
Towns	4	--	19	--	6	29
	(13.8)	*--*	*(65.5)*	*--*	*(20.7)*	*(100)*
Total	29	3	122	31	24	209
	(13.9)	*1.4*	*(58.4)*	*(14.8)*	*(11.5)*	*(100)*

Note: Figures in the parenthesis are the percentages

3.2 Age

About 75 percent of RMPs were in the age group of 20-40 years and those aged above 50 years were less than 10 percent (Table 4A). When compared to towns and Mandal Head Quarters (HQs), the villages have higher percent of RMPs in the younger age groups (20-30 years). It implies that the less experienced RMPs tend to practice in the villages. Similarly, the percent of younger age group was very high among the RMPs from the deprived social groups, particularly the SCs (Table 4B). In contrast, it was only about 13 percent among the upper castes.

Table 4: Age Levels of RMPs

A

Age / Place	20-30	31-40	41-50	51-60	60+	Total
Village	71	46	18	6	6	147
	(48.3)	*(31.3)*	*(12.2)*	*(4.1)*	*(4.1)*	*(100)*
Mandal HQ	9	13	7	4		33
	(27.3)	*(39.4)*	*(21.2)*	*(12.1)*		*(100)*
Town	6	13	6	3	1	29
	(20.7)	*(44.8)*	*(20.7)*	*(10.3)*	*(3.4)*	*(100)*
Total	86	72	31	13	7	209
	(41.1)	*(34.4)*	*(14.8)*	*(6.2)*	*(3.3)*	*(100)*

B

Age / Caste	20-30	31-40	41-50	51-60	60+	Total
SC	15	11	2	1	0	29
	(51.7)	*(37.9)*	*(6.9)*	*(3.4)*	*(0)*	*(100)*
ST	1	2	0	0	0	3
	(33.3)	*(66.7)*	*(0)*	*(0)*	*(0)*	*(100)*
BC	53	40	16	8	5	122
	(43.4)	*(32.8)*	*(13.1)*	*(6.6)*	*(4.1)*	*(100)*
Mus-lim	14	9	4	3	1	31
	(45.2)	*(29)*	*(12.9)*	*(9.7)*	*(3.2)*	*(100)*
OC	3	10	9	1	1	24
	(12.5)	*(41.7)*	*(37.5)*	*(4.2)*	*(4.2)*	*(100)*
Total	86	72	31	13	7	209
	(41.1)	*(34.4)*	*(14.8)*	*(6.2)*	*(3.3)*	*(100)*

Note: Figures in the parenthesis are the percentages

3.3 Education

The educational background of the RMPs is higher than the expected levels. About 22 percent of RMPs were with degree or above qualifications and 40 percent were with 12 years of education (intermediate) (Table 5A). Only 4 percent of them had less than secondary school education. The high level of education among the RMPs is mainly due to part-time working of a good number of poor students in the hospitals and clinics while in the junior and degree colleges. After the completion of studies they are taking up this profession due to lack of other employment opportunities. A majority of the graduate RMPs tend to practice either in the towns or Mandal HQs. As a result about 40 percent of RMPs in the towns and Mandal HQs were graduates. In contrast only about 14 percent of RMPs were graduates in the villages.

Table 5 : Educational Levels

Edu. / Place	VI-VIII	VIII-X	Inter	Degree+	Total
Village	7	53	67	20	147
	(4.8)	*(36.1)*	*(45.6)*	*(13.6)*	*(100)*
Mandal HQ	--	11	8	14	33
	--	*(33.3)*	*(24.2)*	*(42.4)*	*(100)*
Towns	1	8	9	11	29
	(3.4)	*(27.6)*	*(31.0)*	*(37.9)*	*(100)*
Total	8	72	84	45	209
	(3.8)	*(34.4)*	*(40.2)*	*(21.5)*	*(100)*

Note: Figures in the parenthesis are the percentages

It may also be noted that, over a period of time, there was gradual increase in the educational levels of RMPs (Table 5B). Among the RMPs who started the practice in 1980s and 1990s, there were about 23 percent with degree and above qualifications when compared to 14 percent among those who entered this profession in 1970s. Similarly, the percent of RMPs with 12 years of education had increased from 29 percent among those joined in 1980s to 43 percent among those joined during 1990s.

Educational Levels

Table 5B

Edu. / Year	VI-VIII	VIII-X	Inter	Deg -ree+	Total
1960s	1 *(16.7)*	4 *(66.7)*	1 *(17.0)*	0 *(0)*	6 *(100)*
1970s	4 *(19)*	8 *(38.1)*	6 *(29.0)*	3 *(14.3)*	21 *(100)*
1980s	0 *(0)*	16 *(35.6)*	18 *(40.0)*	11 *(24.4)*	45 *(100)*
1990s	3 *(2.2)*	44 *(32.1)*	59 *(43.0)*	31 *(22.6)*	137 *(100)*
Total	8 *(3.8)*	72 *(34.4)*	84 *(40.0)*	45 *(21.5)*	209 *(100)*

Table 5C

Edu. / Caste	VI-VIII	VIII-X	Inter	Deg -ree+	Total
SC		5 *(17.2)*	15 *(52.0)*	9 *(31.0)*	29 *(100)*
ST		3 *(100.0)*			3 *(100)*
BC	6 *(4.9)*	41 *(33.6)*	50 *(41.0)*	25 *(20.5)*	122 *(100)*
Muslim	2 *(6.5)*	11 *(35.5)*	12 *(39.0)*	6 *19.4)*	31 *(100)*
OC		12 *(50.0)*	7 *(29.0)*	5 *(20.8)*	24 *(100)*
Total	8 *(3.8)*	72 *(34.4)*	84 *(40.0)*	45 *(21.5)*	209 *(100)*

Note: Figures in the parenthesis are the percentages

The educational levels were relatively higher among the RMPs from the deprived social groups. For instance, among the RMPs from the SCs, 31 percent had degree and above level of qualification (Table 5C). Among the other social groups including the upper castes, only 20 percent of them were graduates. Similarly, the percent of RMPs with 12 years of education among the SCs was higher than all other social groups. When compared to other social groups, the percent of educated among the upper caste RMPs was lowest. In other words, only less educated from the upper castes is opting for this profession. The higher levels of education among the RMPs from the less advanced social groups could be due to lack of adequate employment opportunities in other sectors, particularly in the recent decades.

3.4 Family Occupation

About 85 percent of the RMPs have no family background in the medical practice (Table 6). Of the 16 percent RMPs who claimed family background in the medical practice, 2.5 percent of them were the second generation RMPs. The remaining 13.5 percent were from families with background in the traditional medical practice (TMP). The percent of RMPs with the family background in the traditional medical practice was more among those practicing in the towns and Mandal HQs. The poor economic background of the RMPs is reflected in their family background. About 20 percent of the RMPs were from the daily wageworkers' families.

Table 6 : Occupational Background of RMP Families

Occu. / Place	Self Employed	Salaried	Wage Labour	TMP	RMP	Total
Village	77	12	39	16	3	147
	(52.4)	*(8.2)*	*(26.5)*	*(10.9)*	*(2.0)*	*(100)*
Mandal HQ	18	6	2	6	1	33
	(54.5)	*(18.2)*	*(6.1)*	*(18.2)*	*(3.0)*	*(100)*
Towns	14	5	3	6	1	29
	(48.3)	*(17.2)*	*(10.3)*	*(20.7)*	*(3.4)*	*(100)*
Total	109	23	44	28	5	209
	(52.2)	*(11.0)*	*(21.1)*	*(13.4)*	*(2.4)*	*(100)*

Note: TMP: Traditional Medical Practitioners;
Figures in the parenthesis are the percentages

3.5 Native Place

About 58 percent of RMPs do not belong to the place of their present practice (Table 7). The percent of non-local RMPs was highest in the Mandal HQs (64 per cent) and lowest in the urban areas (48 percent). Apart from the limited scope for practice, there are several other factors for not practicing in their native places. They migrate to new places mainly because it is difficult to establish themselves as doctors in their native places. In addition, the collection of fee is also a problem in the native place because of the close family and personal relations.

Table 7 : Native Place of RMPs

Native / Place	Local	Non Local	Total
Village	61	86	147
	(41.5)	*(58.5)*	*(100)*
Mandal HQ	12	21	33
	(36.4)	*(63.6)*	*(100)*
Towns	15	14	29
	(51.7)	*(48.3)*	*(100)*
Total	88	121	209
	(42.1)	*(57.9)*	*(100)*

Note: Figures in the parenthesis are the percentages

3.6 Number of Places Practiced

An important aspect of RMPs is shifting the practice from one place to other. About 33 percent of RMPs have shifted from their first place of practice (Table

8). About 5 percent of the RMPs had shifted from more than two places. Some of the factors responsible for shifting from one place to other are deaths and other complications due to their treatment, misbehavior with women patients etc.

Table 8 : Number of Places Practiced

Place	1	2	>2	Total
Village	98	43	6	147
	(66.7)	*(29.3)*	*(4.1)*	*(100.0)*
Mandal HQ	23	8	2	33
	(69.7)	*(24.2)*	*(6.1)*	*(100.0)*
Towns	18	9	2	29
	(62.1)	*(31.0)*	*(6.9)*	*(100.0)*
Total	139	60	10	209
	(66.5)	*(28.7)*	*(4.8)*	*(100.0)*

Note: Figures in the parenthesis are the percentages

3.7 Growth in Number of RMPs

The growth in the number of RMPs took place mostly during the last two decades. About 65 percent of the existing RMPs began their practice in 1990s (Table 9). The growth in the number of RMPs was mainly from the deprived social groups. More than 80 percent of existing RMPs from SCs and STs entered this profession in 1990s. In contrast, only 25 percent of the existing RMPs from the OCs began their practice in 1990s. And about 70 percent of the RMPs with intermediate and above levels of education entered this profession in1990s (Table 16B).

Table 9: Growth in Number of RMPs

A						B					
Year / Caste	1960s	1970s	1980s	1990s	Total	Year / Edu.	1960s	1970s	1980s	1990s	Total
SC	0	1	3	25	29	I-VII	1	4	0	3	8
	(0.0)	*(3.4)*	*(10.3)*	*(86.2)*	*(100)*		*(12.5)*	*(50.0)*	*(0.0)*	*(37.5)*	*(100)*
ST	0	0	0	3	3	VIII-X	4	8	16	44	72
	(0.0)	*(0.0)*	*(0.0)*	*(100)*	*(100)*		*(5.6)*	*(11.1)*	*(22.2)*	*(61.1)*	*(100)*
BC	3	14	24	81	122	Inter	1	6	18	59	84
	(2.5)	*(11.5)*	*(19.7)*	*(66.4)*	*(100)*		*(1.2)*	*(7.1)*	*(21.4)*	*(70.2)*	*(100)*
Muslim	1	5	3	22	31	Degree	0	3	11	31	45
	(3.2)	*(16.1)*	*(9.7)*	*(71.0)*	*(100)*		*(0.0)*	*(6.7)*	*(24.4)*	*(68.9)*	*(100)*
OC	2	1	15	6	24	Total	6	21	45	137	209
	(8.3)	*(4.2)*	*(62.5)*	*(25.0)*	*(100)*		*(2.9)*	*(10.0)*	*(21.5)*	*(65.6)*	*(100)*
Total	6	21	45	137	209						
	(2.9)	*(10.0)*	*(21.5)*	*(65.6)*	*(100)*						

Note: Figures in the parenthesis are the percentages

3.8 Standard of Living of RMPs

The standard of living of RMPs does not seem to be high. While 17 percent of them have colour TVs, 27 percent of them don't have even black & White TV (Table 10A). About 60 percent of them move on bicycles for their practice while 35 percent of them have motor cycles/scooters (Table 10B). About 45 percent of them have no telephones (Table 10C). The percent of RMPs with colour TVs, motorcycles and telephones was relatively high among the upper caste RMPs. However, there is no evidence to show whether it is due to difference in the current income from the profession or due to other economic background of their families.

Table 10 : Standard of Living

	A. Television				B. Vehicle			C. Telephone			
Caste	No TV	Color TV	B&W TV	Total	No Vehicle	Bicycle	Motor Cycle	Total	Yes	No	Total
SC	11 (37.9)	1 (3.4)	17 (58.6)	29 (100)	-- --	24 (82.8)	5 (17.2)	29 (100)	8 (27.6)	21 (72.4)	29 (100)
ST	3 (100)	-- --	-- (100)	3 --	-- --	2 (66.7)	1 (33.3)	3 (100)	-- --	3 (100)	3 (100)
OBC	26 (21.3)	25 (20.5)	71 (58.2)	122 (100)	6 (4.9)	69 (56.6)	47 (38.5)	122 (100)	48 (39.3)	74 (60.7)	122 (100)
Muslim	14 (45.2)	4 (12.9)	13 (41.9)	31 (100)	5 (16.1)	18 (58.1)	8 (25.8)	31 (100)	13 (54.2)	11 (45.8)	24 (100)
OC	3 (12.5)	6 (25)	15 (62.5)	24 (100)	2 (8.3)	11 (45.8)	11 (45.8)	24 (100)	6 (19.4)	25 (80.6)	31 (100)
Total	57 (27.3)	36 (17.2)	116 (55.5)	209 (100)	13 (6.2)	124 (59.3)	72 (34.4)	209 (100)	75 (35.9)	134 (64.1)	209 (100)

Note: Figures in the parenthesis are the percentages

About 75 percent of RMPs reported Rs.12,000 to Rs.24,000 income per annum (Table 11). The percent of RMPs with higher levels of income was more in the towns and Mandal HQs. None of them claimed income above one lakh rupees per year.

4. Methods of Medical Practice

The nature of RMPs' medical practice is discussed in terms of their work experience, place of practice, range of services etc.

Table 11: Average Annual Income of the RMPs

Income / Place	12000-24,000	24000-36,000	36000-48,000	48000-60,000	60,000-100,000	Total
Villages	41 *(39.4)*	45 *(43.3)*	9 *(8.7)*	6 *(5.8)*	3 *(2.9)*	104 *(100)*
Mandal HQ	5 *(15.2)*	15 *(45.5)*	8 *(24.2)*	3 *(9.1)*	2 *(6.1)*	33 *(100)*
Towns	2 *(14.3)*	5 *(35.7)*	2 *(14.3)*	3 *(21.4)*	2 *(14.3)*	14 *(100)*
Total	48 *(31.8)*	65 *(43.0)*	19 *(12.6)*	12 *(7.9)*	7 *(4.6)*	151 *(100)*

Note: Figures in the parenthesis are the percentages

4.1 Work Experience

The RMPs practice on the basis of their work experience at a hospital or clinic. Nearly 90 percent of RMPs claimed work experience with qualified medical practitioners (MBBS/MD/MS), while the remaining 10 percent were trained under other RMPs (Table 12A). About 70 percent of RMPs claimed 1 to 5 years of apprenticeship while 27 percent of them claimed 6 to 10 year of practical experience (Table 12B). A small percent of them claimed more than 10 years of work experience before their practice.

Table 12: Work Experience

A. Years of Experience					B. Trainer's Qualification			
Exp. / Place	1 to 5	6 to 10	11 to 16	Total	Qlf. / Place	MBBS/	RMP MD etc	Total
Village	110 *(74.8)*	35 *(23.8)*	2 *(1.4)*	147 *(100.0)*	Village	132 *(89.8)*	7 *(10.2)*	147 *(100.0)*
Mandal *HQ*	17 *(51.5)*	14 *(42.4)*	2 *(6.1)*	33 *(100.0)*	Mandal *HQ*	27 *(81.8)*	6 *(18.2)*	33 *(100.0)*
Towns	17 *(58.6)*	8 *(27.6)*	4 *(13.8)*	29 *(100.0)*	Towns	26 *(89.7)*	3 *(10.3)*	29 *(100.0)*
Total	144 *(68.9)*	57 *(27.3)*	8 *(3.8)*	209 *(100.0)*	Total	185 *(88.5)*	24 *(11.5)*	209 *(100.0)*

Note: Figures in the parenthesis are the percentages

4.2 Other Systems of Medicine

About 85 percent of RMPs practice only allopathic medicine (Table 13). Among the other systems of medicine, Ayurveda is more popular and was practiced along with the allopathic medicine by about 10 percent of RMPs. The percent

of RMPs practicing Ayurveda or Homeopathy along with the allopathic medicine was highest in the Mandal HQs. Despite a high percent of Muslim RMPs, only one RMP reported practicing Unani along with the allopathic medicine.

Table 13 : System of Medicine

Sys. / Place	Only Allopathy	Allopathy & Ayurveda	Allopathy & Homeopathy	Allopathy & Unani	Mixed	Total
Village	132	11	---	1	3	147
	(89.8)	*(7.5)*	---	*(0.7)*	*(2.0)*	*100)*
Mandal HQ	20	6	6	---	1	33
	(60.6)	*(18.2)*	*(18.2)*	---	*(3.0)*	*(100)*
Towns	26	2	---	---	1	29
	(89.7)	*(6.9)*	---	---	*(3.4)*	*(100)*
Total	178	19	6	1	5	209
	(85.2)	*(9.1)*	*(2.9)*	*(0.5)*	*(2.4)*	*100)*

Note: Figures in the parenthesis are the percentages

4.3 Practice in Multiple Places

About 47 percent of RMPs have their practice in more than one village (Table 14). The Mandal HQs tend to have a large number of RMPs practicing locally and also in surrounding villages through daily visits. About 70 percent of RMPs staying at Mandal HQs visit surrounding villages for their practice. About half of the RMPs living in the villages practice in more than one village. The percent of RMPs visiting neighboring villages is relatively less among those living in the towns. However, some of the very successful RMPs live in the towns and make daily visits to their clinics in Mandal HQs and roadside villages. Often the rent-free space is provided for these clinics by the medical shops for the sake of their business.

Table 14 : Number of Villages Covered

Place	1	2	3	4	5	5+	Total
Villages	79	19	19	15	13	2	147
	(53.7)	*(12.9)*	*(12.9)*	*(10.2)*	*(8.8)*	*(1.4)*	*(100)*
Mandal HQ	10	7	6	4	3	3	33
	(30.3)	*(21.2)*	*(18.2)*	*(12.1)*	*(9.1)*	*(9.1)*	*(100)*
Towns	22	4		2	1	0	29
	(75.9)	*(13.8)*	*(0)*	*(6.9)*	*(3.4)*	*(0)*	*(100)*
Total	111	30	25	21	17	5	209
	(53.1)	*(14.4)*	*(12)*	*(10)*	*(8.1)*	*(2.4)*	*(100)*

Note: Figures in the parenthesis are the percentages

4.4 Place of Practice, Home Visits and Practice Hours

Nearly 85 percent of RMPs have no separate clinics. They practice from their residences (Table 15). In fact, most of the RMPs do not sit at any one place and practice. They tend to move around the villages, most of them on bicycle. The percent of RMPs with the separate clinics was lowest in the villages (10 percent) and highest in the towns (38 percent). In villages, most of the RMPs visit the patients' homes and have no fixed hours of practice. They are available round the clock. It provides easy access to the RMPs, which could be one of the factors responsible for their popularity. Only 15 percent of RMPs in the towns and 10 percent in the Mandal HQs do not visit the patients' home and have fixed hours of practice.

Table 15: Methods of Practice

A. Practice Place				B. Fixed Hours				C. Home Visits			
Place	**Clinic**	**Home**	**Total**	**Place**	**Yes**	**No**	**Total**	**Place**	**Yes**	**No**	**Total**
Village	15 (10.2)	132 (89.8)	147 (100)	Village	7 (4.8)	140 (95.2)	147 (100)	Village	146 (99.3)	1 (0.7)	147 (100)
Mandal HQ	7 (21.2)	26 (78.8)	33 (100)	Mandal HQ	3 (9.1)	30 (90.9)	33 (100)	Mandal HQ	30 (90.9)	3 (9.1)	33 (100)
Towns	11 (37.9)	18 (62.1)	29 (100)	Towns	5 (17.2)	24 (82.8)	29 (100)	Towns	25 (86.2)	4 (13.8)	29 (100)
Total	33 (15.8)	176 (84.20	209 (100)	Total	15 (7.2)	194 (92.8)	209 (100)	Total	201 (96.2)	8 (3.8)	209 (100)

Note: Figures in the parenthesis are the percentages

4.5 Sign Board

About 40 percent of the RMPs don't display any signboard at the place of their practice i.e. clinic or residence (Table 16). The percent of RMPs without signboards increased from 10 percent in towns to 15 percent in the Mandal HQs and 50 percent in the Villages. In the villages where the RMPs visiting patients' homes is most common, the signboard may not have special advantage. Often, they use very neutral signboards like "First Aid Centre" and "People's Clinic" (Praja Viadysala). The RMPs Association also advises its members to keep the signboard only as First Aid Centre.

Table 16 : Sign Board at the Place of Practice

SignBoard / Place	No Board	Board with Dr. Name	Board without Dr. Name	Total
Village	75	1	71	147
	(51.0)	*(0.7)*	*(48.3)*	*(100)*
Mandal HQ	5	3	25	33
	(15.2)	*(9.1)*	*(75.8)*	*(100)*
Towns	3	2	24	29
	(10.3)	*(6.9)*	*(82.8)*	*(100)*
Total	83	6	120	209
	(39.7)	*(2.9)*	*(57.4)*	*(100)*

Note: Figures in the parenthesis are the percentages

The main reason for not keeping the name of the RMP on the signboard is the fear of police and other government agencies. Sometimes they mention the name of a qualified doctor and his/her visiting hours, mainly to ward off the harassment by the police.

4.6 Range of Facilities

All the RMPs have stethoscope and thermometer irrespective of the place of practice and educational qualification. About 96 percent of the RMPs had the BP apparatus but possession of apparatus for checking the blood pressure (BP) was correlated with the educational levels of RMPs (Table 17). While all the RMPs with intermediate and above levels of education had BP instrument, about 25 percent of RMPs with primary schooling and 7 percent with secondary level education had no BP instrument.

Table 17 : BP Apparatus

Education	Yes	No	Total
Primary	6	2	8
	(75.0)	*(25.0)*	*(100)*
Secondary	67	5	72
	(93.1)	*(6.9)*	*(100)*
Inter	84	0	84
	(100.0)	*(0.0)*	*(100)*
Degree+	45	0	45
	(100.0)	*(0.0)*	*(100)*
Total	201	8	209
	(96.2)	*(3.8)*	*(100)*

Note: Figures in the parenthesis are the percentages

4.7 Quantum of Services

On average, the RMPs had 20 patients per day (Table 18). The number of patients per RMP was marginally high in Mandal HQs and low in the towns. On average, fifty five percent of patients were given injections but its incidence was relatively high in the villages. Similarly, about 3.3 percent of patients were given IV fluids. The incidence of IV fluids was marginally high in the towns and Mandal HQs. The main causes for injecting IV fluids was general weakness, diarrhea, pesticide consumption (poisoning) and pregnancy.

Table 18 : Quantum of Services

Service \ Place	Villages	Mandal HQs	Towns	Total
Average No. of Patients per Month	605	670	546	614
Average No. of Injections per Month	337	373	257	338
Percent of Patients Receiving Injections	55.8	55.7	47.1	55.0
Average No. of IV Fluids per Month	20	23	19	21
Percent of Patients Receiving IV Fluids	3.3	3.5	3.5	3.3

Note: Figures in the parenthesis are the percentages

4.8 Other Occupations

While 69 percent of RMPs were full time medical practitioners, 12 percent of them have agriculture as the supplementary occupation (Table 19). The remaining 19 percent of RMPs have non-agriculture activities like grocery stores, life insurance agency, etc.

Table 19 : Other Occupations

Place \ Occu.	None	Agriculture	Others	Total
Village	103 *(70.1)*	19 *(12.9)*	25 *(17.0)*	147 *(100)*
Mandal HQ	21 *(63.6)*	6 *(18.2)*	6 *(18.2)*	33 *(100)*
Towns	20 *(69.0)*	1 *(3.4)*	8 *(27.6)*	29 *(100)*
Total	144 *(68.9)*	26 *(12.4)*	39 *(18.7)*	209 *(100)*

Note: Figures in the parenthesis are the percentages

5. Associations of RMPs

Like the qualified allopathic medical practitioners, the RMPs have very active professional associations at the state and district levels. There are two parallel associations in the district. While the "RMP Association" is affiliated to the Communist Party of India (M), the "RMP Welfare Association" maintains contacts with the CPI and Congress. A good number of qualified medical practitioners in the district were actively associated with the Marxist and other political parties. As a result, the RMPs who worked at the hospitals of these doctors tend to be associated with these parties.

The RMPs' associations claim that the membership and identification card are given on the basis of prescribed qualifications like 5 years experience as a compounder in a hospital, 3 to 5 years of practice experience in a village without problems and minimum educational qualification like the 10th class. The members are given practice guidelines like not to claim any degree or specialisation, not to treat medico-legal cases and not to undertake or arrange surgeries at their place of practice. However, the members are allowed to designate themselves as ' Doctors'. They maintain that this is an honorary designation given to them by the people out of love and affection. The associations also advise the members against displaying signboards as nursing homes. They are advised to display neutral signboards like First Aid Centre and Health Care Centre. There are no formal elections in these associations at the district level. The office bearers are always unanimously elected. Following are the major functions of the associations.

1. Cultivating Relations with the political parties, the police and other government agencies to protect RMPs from official harassment,
2. Establishing referral arrangements with the qualified doctors in the towns, and
3. Settlement of problems in the villagers in case of death or other com plications due to the treatment of RMPs.

Widespread fear of harassment by the police and revenue officials seems to be the main motivation for forming the associations. Though the individual RMPs claim very cordial relations with the officials, they are very conscious about illegality of their profession and live under constant fear. For instance, during the fieldwork of this study, the RMPs from some of villages ran out to

nearby towns thinking that the field investigators are the police in civil dress. The RMPs' Association maintains close liaison with the district health administration. They cultivate relations with the District Medical and Health Officer and the programme specific officers for diseases like AIDS and Malaria to involve themselves in the public health campaigns against these diseases and in the family welfare programmes. In return they seek some certificate like participation in the Family Planning and AIDS awareness campaigns. The RMPs are really desperate for legitimacy with the government agencies and eager to take any certificate from official agencies.

The revenue officials and police officers are also regularly invited to the periodic meetings conducted by the RMP Associations. Overall, there are no active official attempts at curbing the practice of RMPs. Only in the case of medical complications and misbehavior of RMPs, there is some official involvement.

The Associations are publishing monthly magazines like "Vidya Jyothi" and "Vidya Deepika" with the proclaimed objective to protect their rights, self respect and the profession. They repeatedly appeal to their members to unite and fight against the police harassment and fight for recognition of their profession.

The RMPs' associations are active in cultivating the relations with the leaders of various political parties at the state level. The political parties are very obliged to the RMPs' associations because the RMPs are considered very influential in shaping the public opinion in the villages. The politicians try to cultivate relations with them for mobilizing the public opinion and the voters in their favour.The main demand of RMPs is for the recognition of their profession. It has not been materialized mainly because of opposition from the Indian Medical Association (IMA). Every year, one or other minister at the state or central level attend the state level conferences and promise them the recognition of their profession. However, the very next day the IMA condemns the concerned minister for attending the meeting of quacks and encouraging them.

The other main function of the associations is to cultivate relations with the qualified doctors. There is a dichotomy in the relations between the RMPs

and qualified doctors. The IMA at the state level fights politically and legally for the ban on RMPs but in towns and cities the individual doctors and hospitals compete with each other in wooing the RMPs for mobilising the patients. The private hospitals and doctors organise and finance periodic "training camps" for the RMPs at the block level ostensibly to teach them basic medical care but the real intention is to establish referral mechanisms with appropriate financial incentives. The RMPs' Associations play key role in organizing these training camps in the rural areas.

Given the large number of RMPs in the villages, there are frequent instances of disputes with the villagers due to complications from treatment, drunkenness, gambling and misbehavior with women patients. The Associations are actively involved in pacifying such situations.

6. The Factors behind the Popularity of RMPs

The RMPs are not confined to places where there are no qualified doctors. They are widespread even in the Block headquarters and other urban centres where there are qualified doctors. For instance, in Khammam town itself with a population of two lakhs, there are about 65 RMPs along with 160 qualified doctors in the public and private sectors. There are a large number of RMPs in the Mandal HQs even if there is a Primary Health Centre and a qualified private practitioner. For instance, in Tallada, a Mandal HQ which has a PHC and a private MBBS doctor, there are about 10 RMPs. It indicates that the lack of spatial access to qualified doctors is not the only reason for the existence of RMPs. There are a number of other factors which make the RMPs very popular in the rural areas and urban slums. Social contacts, door to door visit of RMPs on routine basis, easy payment methods, ignorance, caste loyalties etc. seem to work in favour of RMPs. According to a qualified doctor practicing at a Mandal HQ, only 20 percent of people in the rural areas avoid going to the RMPs.

6.1 First Aid in Medical Emergencies

The basic reason for the existence of RMPs is the non-availability of any trained person to provide medical relief to day to day problems like fever, stomach upset, head ache and minor injuries. In most of the villages and urban slums, there is no doctor or trained/qualified paramedic either in the

public or private sector to provide first aid in medical emergencies and to attend routine health problems. The vacuum in the organized medical system is filled by the RMPs. Because of time and financial constraints, it is not possible to visit nearby town/urban centre for every minor problem. Hence, the villagers, including the rich and educated, first try with the locally available RMP for immediate relief from the sufferings and if there was no relief, they would go to a qualified doctor in the town.

6.2 Referral and Escort Services

The RMPs are considered the pillars of the private sector in the medical care. The RMPs provide a very effective referral mechanism for hospitals and clinics in the private sector. The RMPs refer the patients from the rural areas to appropriate specialists in the towns. The private hospitals and doctors distribute their visiting cards with the provision for the name of referring RMP and his village and when the patients come with this card, they are allowed to bypass the queue. Even the well to do and the educated people in the rural areas depend on the RMPs in visiting hospitals and diagnostic centres in the towns.

Apart from providing referral services, the RMPs also accompany the patients to the towns in the case of serious problems. Lack of familiarity with the towns and lack of knowledge about the specialists compel the villagers to depend on the RMPs for referral and escort services. The role of guiding and accompanying the patients to the specialists in the towns is a crucial function of the RMPs. The referral and escort services are the other main reasons for the popularity of RMPs in villages.

6.3 Supervising the Follow-up Treatment

Another main strength of RMPs is that they provide the follow up mechanism for the treatment prescribed by the doctors in towns. Often, the villagers depend on the RMPs to administer the prescriptions from the qualified doctors. For instance, when a patient from a village is prescribed a course of injections, it would be difficult for the patient to go to the hospital in the town every day. Instead he/she would take the help of local RMPs for completing the course.

6.4 Convenience of Payment

The convenience of payment system is another reason for the popularity of RMPs. The RMPs charge per visit, which usually includes injection and tablets as well as consultation fee. It is a system of paying for treatment. The RMPs use unlabelled generic medicines which are cheaper than the labeled medicines because the companies avoid taxes on them. The RMPs also use cheap medicines supplied by the unknown companies. Hence the RMPs are able to give one injection and some tablets for fee of Rs.10. In the case of a qualified doctor, he/she charges consultation fee of Rs.20 and gives prescription for the full course of treatment (medicines and/or injections) which is often beyond the capacity of the poor patients to buy at a time. Convenience of daily home visits and paying in small amounts for daily doses make the RMPs very popular with the poor.

6.5 Social Contacts

The qualified doctors in the towns as well as Mandal HQs think that the main strength of RMPs is their close social relations with the local community. The RMPs visit the families on routine basis, whether somebody is sick or not, and maintain close rapport with the families. As a result, the local community develops greater faith in the RMPs than in the qualified doctors. A qualified doctor at a Mandal HQ reported that it is difficult to compete with the RMPs because of their strong public relations. A senior doctor in the district town complained that the people have so much confidence in the RMPs that even if there are deaths during the treatment of RMPs, there is no hue and cry against the RMPs. But if there is any death in the hospitals of qualified doctors, there is a growing trend of attacking the doctors and ransacking the hospitals.

To protect themselves from these frequent attacks, the hospitals have started renting out a part of the hospital premises for the diagnostic centres and medical shops that can come to their rescue in case of such situations. Preference is given to those who own a chain of diagnostic centres and medical shops and have required "strength" to protect the hospitals. There are a few instances where the diagnostic centres have started their own hospitals and employed doctors who are otherwise not willing to take the risk of own private practice.

6.6 Participation in the Public Health Programmes

The informal participation of RMPs in the public health programmes gives legitimacy to them in the public. The services of RMPs are used informally by the district health administration in implementing the family planning and other public health programmes. For instance in Khammam district, the DMHO utilized the services of RMPs in the family planning and malaria services. Under Sukha Parivar scheme sponsored by the Hindustan Liver, contraceptives, pills etc. kits were distributed through the RMPs. The meetings of RMPs were organized to educate them in family planning. They are considered the first contact in the villages and family planning message was spread through them. The ANMs also use the goodwill of RMPs in convincing the women for sterilization. In the case of malaria epidemic outbreak, the medicines were distributed through the RMPs. The RMPs are also used in the AIDS awareness campaigns.

6.7 Political Patronage

Political patronage is another source of strength for the RMPs. The village leaders support RMPs because they usually receive free treatment from them. The RMPs are not politically active at the village level but they are considered very influential in shaping the public opinion. However, there are a few instances where the RMPs are village/Mandal presidents. The qualified doctors blame the political parties for the patronage to the RMPs' associations at the district and state levels.

7. Nexus between the RMPs and the Qualified Doctors

However, the role of RMPs has taken a very negative turn with the growing competition and unscrupulous practices in the private medical sector. The RMPs are employed by the qualified doctors to mobilize patients for surgeries (hysterectomy, caesarean, appendicitis, etc) and diagnostic tests on the basis of commissions. Mobilization of women from the villages for the hysterectomy (with one or two symptoms) by the gynecologists has become particularly notorious in recent years. For instance, the hospitals in Khammam town pay about 30 percent of surgery charges in the case of hysterectomy and caesarean to the RMPs as commission. The hospitals charge Rs.3,000 for hysterectomy and Caesarian and pay Rs.1,000 as commission to the RMPs. After paying for the operation theatre, anesthetist etc., the surgeon is sometimes left with less amount than the commission paid to the RMP. The

diagnostic centres pay about 50 percent of charges for scanning and lab tests and 30 percent for X-Ray tests. The commissions are paid not only for the surgeries and tests but also from the consultation fee. In addition, the private hospitals sometimes pay Rs. 10,000 to 15,000 as business advance to the RMPs. With the growing competition, there is gradual increase in the commissions. The wooing of RMPs is not confined to the small hospitals in towns. Even the super specialists from the corporate hospitals are resorting to payment of commissions to RMPs for the surgeries and tests.

Apart from the commissions, the RMPs sometimes receive what is popularly known as "addings" on surgeries, tests and medicines. At the instance of the RMPs, the hospitals, diagnostic centers and medical shops charge extra from the well-to-do and ignorant patients and pass on the amount to the RMPs. The "addings" are in addition to the commissions on regular charges. The level of "addings" is in proportion to the ignorance of patients. The RMPs also impose addings on influential people in the village who otherwise don't pay to RMPs for the treatment.

The strong nexus between the RMPs and qualified doctors is very open. For instance, a corporate diagnostic centre in the district town provides free office space and clerical assistance to one of the RMPs' associations in the district. The private hospitals and Diagnostic Centres maintain the lists of names and addresses of RMPs in the district. One of the main sources of information on the number of RMPs in the district was the RMPs' list supplied by them.

In the day-to-day transactions, most of the qualified doctors have no complaints against the RMPs. In fact, most of them have active referral arrangements based on commissions and consider the RMPs the pillars of private sector providing first aid in medical emergencies, referral and escort services and supervising the follow-up treatment. Only the well-established senior doctors and a few new doctors don't have arrangements with the RMPs. Most of the qualified doctors think that the payment of commissions is a normal part of their business. Even among themselves, the qualified doctors demand commissions for referring cases to each other for specialist services, surgeries etc. Most of the doctors think that medicine is like any other business and consider the commissions as legitimate part of their profession.

The Indian Medical Association (IMA) seems to be more worried about the "cross-practice" of allopathic medicine by the doctors qualified in other systems of medicine, particularly homeopathic doctors, some of whom have flourishing practice in towns and are a major competition to the allopathic practitioners. The RMPs are no threat to most of the qualified doctors. In fact, they are useful in expanding their market/practice. Most of the qualified doctors have referral arrangements with the RMPs and are not at all hostile towards them. The RMPs also have no specific complaint against the qualified doctors with whom they have client-patron relationship. It is a business relationship that is mutually beneficial but very harmful to the interests of public.

The main responsibility for the degeneration in the private medical system lies with the qualified doctors. The senior doctors complained that because of severe competition and lack of unity among the qualified doctors, the newly established doctors are desperate to attract patients and are indulging in payment of commissions to the RMPs. Even before setting up practice in towns and block headquarters, the newly qualified doctors go around the villages and establish contacts with the RMPs. It is considered necessary to have referral arrangement with at least 10 RMPs to sustain private practice by a new doctor. To begin with, the RMPs tend to have contacts with the doctors with whom they were working before starting independent practice. Once established, the RMPs send patients to doctors who pay highest commission.

For some of the RMPs in the surroundings of towns, the main source of income is "Referral and Escort Services" i.e. commissions from the diagnostic centres and hospitals. The income from the practice is considered nominal and hardly enough for subsistence. Because of commissions, many people are entering into this profession. Some RMPs complained that because of commissions, many individuals without any practical experience also entering into this profession. The RMPs have become touts for the qualified doctors in the towns. It is reported that in some villages, the village elders have begun taking patients to the towns for the sake of commission. The practice of commission has become so rampant that there are touts who pickup patients from the bus stand and railway station and bring them to hospitals and diagnostic centres who pay them fixed reward per patient.

The payment of commissions is not restricted to individual doctors and RMPs. Even the corporate entities are collecting monthly commission simply by lending their name to diagnostic centres, hospitals, medical shops etc. Usually the franchise arrangement involves provision for quality control, manpower supply and business expansion plans in return for the share in the gross income. However, in practice the corporate hospitals and diagnostic centres are lending their names to smaller hospitals, diagnostic centers, medical shops and collect fixed monthly charges without any franchise obligations. A corporate diagnostic centre and polyclinic in Hyderabad has this kind of arrangement with a diagnostic centre in Khammam.

The payment of commissions is a two way process. While paying commissions to the RMPs and other qualified doctors, the hospitals and doctors in turn receive commissions from the diagnostic centres and medical shops. Ultimately it is patient who bears the burden of all commissions.

The senior doctors have no hope of improving the system except through the public awareness in the long run. They say it is impossible to stop the qualified doctors from paying the commissions because of competition and lack of unity. In contrast, the RMPs are alleged to have strong unity and patronage from the vote-seeking politicians. They think it is also not possible to ban RMPs because there is no alternative source of medical care in the villages.

The nexus between the RMPs and qualified doctors has serious consequences to the cost and quality of medical care in the private sector.

7.1 Impact on the Cost of Medical Care

The unnecessary referrals, commissions, "addings", and additional costs due to delay in the treatment and/or wrong treatment are the main reasons for the additional burden on the patients. There are instances of a section of qualified doctors openly criticizing their colleagues through pamphlets for encouraging the RMPs and adding to the costs of medical care. At the instance of qualified doctors, the RMPs encourage unnecessary surgeries and tests for the sake of commissions. Even the simple cases that can be treated by the local MBBS doctor are taken to the specialists in the towns because they get commissions. According to a qualified doctor in rural areas, about 50 percent of cases need no referral to the specialists.

The financial burden due to wrong treatment of RMPs and delay in the treatment is very widespread. The villagers tend to go to RMPs first and when there is no relief in a day or two, they go to the qualified doctor in the towns. Sometimes because of delay in going to the qualified doctors, the problem is aggravated and patient is hospitalized. The qualified doctors reported that some RMPs undertake even serious medical problems like abortions and deliveries. Sometimes, the wrong treatment given by the RMPs result in serious complications and huge financial burden, apart from damage to their health.

It is widely believed that the RMPs provide basic medical care to the poor at a cheaper rate. According to a qualified doctor at a Mandal HQ, it is not always true. The RMPs charge about Rs.10 for each visit which usually includes injection and some tablets. The qualified doctors at the Mandal HQs charge Rs.20 as consultation fee and prescribe necessary medicines. Except in the case of chronic diseases, the qualified doctors do not charge any fee for the subsequent visits. It is alleged that often a patient visits the RMP a number of times for the same illness and end up paying greater amount.

7.2 Impact on the availability of Qualified Doctors in the Rural Areas

Most of the villages do not have any qualified medical practitioner. At present, the MBBS doctors are spread up to the level of Mandal HQs for the private practice. Some of the Mandal HQs are small urban centres and have more than one MBBS doctor in the private sector. However, most of the Mandal HQs in the backward areas do not have any qualified private medical practitioner. In Khammam district, there is no qualified medical practitioner in the private sector in 30 out of 46 Mandals.

There is a PHC in every Mandal HQ and as per the norms every PHC is supposed to have one or more doctors along with other staff. However, in most of the PHCs either the doctor posts are vacant or the doctors do not attend their duties regularly. As a result, most of the Mandals have no qualified doctor either in the public or private sector.

In a way the RMPs are partly responsible for non-availability of the qualified doctors in the rural areas. The scope for the private practice is considerably reduced by the presence of RMPs. According to a qualified doctor from a Mandal HQ, most of the people are not aware that RMPs are not qualified to

give any treatment and the villagers have enormous confidence in them. It reduces the market for the qualified doctors in the rural areas.

The referral arrangement between the RMPs and the qualified doctors in the towns further reduces the scope for private practice in the rural areas. Some of the MBBS doctors in the Mandal HQs complained that they are crushed between the RMPs in the villages and specialists in the towns. The specialists from the towns organize periodical meetings with the RMPs and distribute gifts to establish referral arrangements. The specialists are not interested in cultivating relations with local MBBS doctors because the scope for referrals from them is limited. The RMPs refer even the simple cases which could be treated by the local MBBS doctors.

The most negative aspect that scares away the qualified doctors from the rural areas is the hostile attitude of RMPs. In the rural areas where there is only one qualified doctor in a village/Mandal HQ, often there is friction with the RMPs. It is reported that the RMPs indulge in adverse campaign in the villages against the qualified doctors who have no referral arrangements with them. They indulge in the character assassination of qualified doctors by spreading rumors like misbehavior with the women patients and by creating doubt about the efficacy of their treatment.

The RMPs refuse to treat the villagers in emergency if they go to the qualified doctors who have no referral arrangements with them. The RMPs also refuse the supervision of follow-up treatment if the prescription is by the doctor who has no referral arrangements with them. It is to put pressure on the qualified doctors to have referral arrangements with them.

7.3 Impact on the Quality of Care

The nexus between the qualified doctors and the RMPs has adverse impact on the quality of private medical care. It is resulting in unnecessary tests, surgeries and treatment. In addition, the linkages with the qualified doctors encourage the RMPs in undertaking the serious problems like abortions and deliveries. It is widely reported by the qualified doctors that the RMPs often use the broad-spectrum antibiotics for quick results and tend to give injections and IV fluids on routine basis to impress the patients. The qualified doctors in rural area reported that sometimes they feel compelled to indulge in similar

practices to retain their patients. In fact, a qualified doctor at the Mandal HQ reported that in 90 percent of cases the treatment given by the qualified doctors and the RMPs is similar. Whether the treatment provided by the RMPs is positively contributing to the well being of the people or is it causing more damage to their health is the crucial issue. Immediate relief from the suffering seems to be the main gain from RMPs.

8. Conclusion

The households account for about 75 percent of total expenditure on the medical care in the state. And about 75 percent of the household expenditure on the medical care is on the outpatient services. The high proportion of the RMPs in the private sector indicate that most of household expenditure is on the outpatient services provided mainly by the unqualified medical practitioners.

The RMPs are widespread in the rural areas and urban slums and the people depend on them for routine health problems mainly due to non-availability of qualified doctors either in the public or private sectors. Since the qualified doctors are not willing to practice in remote areas, there is no alternative to the unqualified medical practitioners.

Although the RMPs are the main source of outpatient care in the rural areas and urban slums, there in no information on their number, age, education, training etc. The RMPs' Welfare Association claims that there are 1,50,000 RMPs in the state and account for 70 percent of medical care for the poor. Given the huge number of RMPs, there is a need to make inventory of RMPs in the state along with their age, educational qualification, training etc.

The growth in the number of RMPs took place mainly during the last two decades. It correlated with the growth of organized private sector in the medical care. The NSSs have shown sudden increase in the share of private sector in the provision of medical care during the last two decades.

A high percent of RMPs are from the deprived social groups. The percent of young age groups with higher levels education was very high, particularly among those who joined the profession in the recent decades. Among them, the RMPs belonging to the SCs and other deprived social groups have higher levels of education than those belonging to the upper castes. Lack of adequate

employment opportunities seems to be driving the educated poor into this profession. A good number of poor students from the junior and degree colleges work on part-time basis in the private hospitals and clinics, and take up medical practice after the completion of their studies.

The RMPs constitute the informal sector in the medical care. Like in automobiles and other service sectors of the economy, they work on the basis of experience. They have no professional qualifications and no license to practice any medicine. The RMPs have no professional qualification but most of them display some unrecognized certificates. There are a large number of rural/private medical practitioners' associations registered under the Society or Association Act and the membership in these associations is displayed as the professional qualification. For legitimacy, these associations sometimes organize short-term training programmes by the qualified doctors before giving the membership.

In dealing with the RMPs, there are two options for the state: either to enforce the ban on RMPs or train them in the basic medical care and regulate their services. Under the Indian Medical Council (IMC) Act 1956, only persons having the basic MBBS degree are allowed to practice allopathic medicine. Similarly, under the Drugs and Cosmetics Act 1940, only persons with MBBS degree are eligible to prescribe allopathic drugs. Under the Dentists Act 1948, only doctors with basic BDS degree are eligible to prescribe allopathic drugs for dental problems.

Under the IMC Act, the state government, the district magistrate and the chief medical officer are responsible to identify and "stop the menace of medical practice by unqualified/unregistered". However, there is no single law exclusively to deal with the quacks. Quackery is a non-cognizable offence. The quacks are punishable under the IPC420 for cheating the public.

It appears that the state is not in a position to impose the ban on the RMPs. Despite the court orders, the state governments in different parts of the country are not able to enforce it. Individual doctors and their associations have approached the High Courts and the Supreme Court and obtained the writs of Mandamus directing the state governments to identify and take action against all unqualified/unregistered medical practitioners. But no state

government could initiate any action against them. For instance, the AP High Court directed the Union of India and the State Government to eradicate quackery in the petition filed by the National Medical Society against the fake medical degrees in 2000 AD. The attempts at the ban in some districts in AP have evoked public protest against administration. It is mainly due to lack of alternative sources of medical care for the bulk of population.

It is unlikely that in the near future the government would be able to provide alternative sources of treatment for the poor in the rural areas. Even after five decades of independence, the state is not able to ensure the presence of doctors in the majority of Primary Health Centres. As a result, the people in the rural areas have no access to the qualified doctors either in the public or private sector. It is therefore necessary to train the educated RMPs in the basic curative care and safeguard the interests of people in the rural areas.

The training of RMPs is necessary in the interest of public health. The ignorant and untrained RMPs will do greater damage to the public health. The training in basic medicine is to discourage unnecessary injections, inappropriate and incomplete doses of antibiotics and other dangerous practices. They can be trained in treating the minor problems and in identifying the serious problems for referral to PHCs and other public hospitals. It is necessary to develop referral mechanism with the government medical facilities in the rural areas. Their services can be also used in the followup treatment of TB, leprosy and other public health problems under the guidance of doctors at the PHCs. Given the nature of public health problems, the outpatient care is very crucial. It is easy to identify and treat most of the public health problems and they do not require any hospitalization if there is timely outpatient care.

The qualified doctors are against recognising the services of RMPs on the ground that it would give them legitimacy and make them more hazardous to public health. Even though the medical profession opposes any kind of recognition for the RMPs, they are an organic part of private medical sector which is well entrenched and free of any regulation. The RMPs have cordial relations and "professional" links with the qualified doctors. The private hospitals and doctors are utilising the services of RMPs for promoting their business interests. In the process, the qualified doctors are actually providing legitimacy to the RMPs by co-opting their services.

It may be noted that there is widespread community acceptance for the RMPs as a source of treatment. The very fact that the government is not able to ban their practice implies the necessity to use their services at least in the short run. Once the state is able to provide alternative sources of treatment, the RMPs will vanish on their own. The doctors who oppose as well as support the RMPs think that the only solution to problem is public awareness. Unless the people avoid the RMPs on their own, no one can stop their practice. However, it may be noted that the lack of easy access (spatial and financial) to other sources of medical care, not simply the lack of awareness, is the main factor for the system of RMPs.

As a long-term solution, the public policy should aim at providing a trained paramedic in every habitation to provide basic curative care. Introduction of medical courses, below the level of MBBS, is necessary for this purpose. Instead of creating a vast number of graduates in the basic sciences who are not able to get any gainful employment, there is immediate need for introducing the short-term medical courses which would provide better employment opportunities for the youth and at the same time provide access to basic curative care for the poor. The large number of degree colleges in the state can be used to introduce a short-term medical course. For instance, similar to the three-year degree programme in biological and physical sciences, a short-term medical degree can be introduced to train students in the basic curative care. The only obstruction is the organized resistance from the medical profession.