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Promoting Financial Investments and Transfers

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COUNTRY ASSESSMENT

INDIA

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**Deloitte Touche
Tohmatsu**



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in association with:

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I. INTRODUCTION

This Country Assessment focuses on PROFIT's proposed project activities in India. The Country Assessment report is designed to provide a summary of relevant demographic data, examine the private sector environment at a macro-level and focus on areas where PROFIT initiatives may best succeed. The report thus helps to: identify feasible private sector interventions; assess potential impact of these projects in terms of PROFIT objectives; and guide the design and structure of PROFIT investments in a given country.

PROFIT conducted its first official visit to India in April 1994 to identify, together with A.I.D., areas for possible PROFIT intervention. These interventions will be discussed in more detail in the last section of this report.

The remainder of this document is structured as follows:

- Section II - provides an overview of India's demographics and a profile of the family planning environment. Elements of the macroeconomic, social and political environment which are relevant to the activities of PROFIT are identified for discussion.
- Section III - examines the mandated areas of PROFIT operation within the context of India: private health care providers, employer-provided family planning and innovative investments.
- Section V - describes potential areas for PROFIT intervention in India.

II. COUNTRY BACKGROUND

DEMOGRAPHIC AND ECONOMIC TRENDS*

<i>Total Population (1991) -</i>	846.2 million
<i>Crude Birth rate -</i>	30.6
<i>Crude Death rate -</i>	10.6
<i>Natural Rate of Increase -</i>	2%
<i>Total Fertility Rate -</i>	3.6
<i>Population Doubling Time -</i>	34 yrs.
<i>Urban Population -</i>	26%
<i>Contraceptive Prevalence (modern methods) -</i>	40%
<i>Infant Mortality Rate -</i>	80/1,000 Live Birth
<i>Per capita GNP (1989) -</i>	\$330
<i>Literacy rate (age 7 and above) -</i>	52.2%

* excerpted from the 1992 OPTIONS Country Profile

India, located in the southern peninsula of the Asian continent, is the seventh largest country in the world, and is the second most populous. By the year 2025, it is estimated that India's population will surpass that of China to become the world's most populous nation.

The magnitude of India's population growth overshadows the considerable progress achieved in fertility reduction over the last three decades. During this time, the crude birth rate has dropped from 45 births per 1,000 to approximately 30. The level of population growth remained at an increase of 2 percent per year since the 1970s. Contraceptive prevalence was at 4 percent in 1967 and rose to approximately 49 percent in 1990.

These nationwide statistics, however, do not express the significant disparity in fertility and contraceptive use among India's different states. In India, 22 major states have shown improved trends in total fertility rates (TFR) over the national average, currently at 3.2. In contrast the four northern states, Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh have an average TFR of five. A 1991 study shows contraceptive prevalence rates (CPR) in these Northern states at just under 32 percent, whereas a Southern states such as Kerala and Tamil Nadu have achieved CPRs of 80 percent and 59 percent respectively.

Much of the progress that India has made in containing its population growth can be credited to the Indian Government's (GOI) extensive, longstanding program of family planning and maternal and child health implemented through the Ministry of Health and Family Welfare (MOHFW). A 1992 Population Action International Report quantifies the impact of the MOHFW family planning program to have prevented over 90 million unwanted pregnancies since its inception in the 1950s. The MOHFW provides family planning services at no cost

to the user through a pervasive network of 131,000 subcenters, 22,000 primary health centers, and approximately 2,500 community health centers.

Officially, the program puts a strong emphasis on providing the full range of contraceptive options integrated within a broader context of maternal and child and reproductive health services. In practice, however, the program relies heavily on female sterilization. Sterilization comprises over 70 percent of all family planning usage with the remaining 30 percent split between the other modern contraceptive methods and traditional family planning methods. Persistent medical and social resistance to hormonal contraceptives and a system of management incentives and targets for sterilization, reinforce this single method strategy.

Studies show that this difficulty in accessing reversible contraceptive methods has been a contributing factor to unmet need for family planning. A 1988 all-India family planning survey indicated that over half of all couples had never used any family planning method and over 18 percent did not want any more children, but were not using any family planning methods. Many of the women surveyed cited the lack of contraceptives other than sterilization as the reason for not practicing family planning. In fact, according to the study, among younger women who are more inclined to use reversible methods, fertility has been on the rise.

In addition to the public sector, Indian women have access to family planning services and commodities through the private sector including an active PVO community, several GOI-subsidized social marketing programs, and commercial outlets. Combined, contraceptive sales from these sources account for the distribution of 42 percent, 49 percent, and 64 percent of condoms, pills and IUDs respectively. The proportion of contraceptives provided by the commercial sector is modest compared to total private sector contraceptive distribution, totalling 12 percent, 24 percent, and 17 percent for condoms, pills and IUDs respectively.

Other factors which have an effect on family planning conditions, and impact the overall environment for PROFIT investments in India are as follows:

- **Government Policy and Commitment to Family Planning.** As the first nation to adopt an official population policy in 1952, the GOI has long viewed the country's high population growth rate as an obstacle to economic development and social welfare. Beginning in the early 1960s, the government began implementing a series of large scale family planning promotion and delivery programs focused on single methods, the IUD and male sterilization. Although these programs resulted in substantial increases in family planning acceptors, this was achieved to the detriment of the quality of the services and the opportunity for informed choice of the acceptors. Program objectives were met through the imposition of rigid targets, harassment and coercion in some cases. The harshness of these measures invoked public outcry against the sterilization campaign in 1977 and led to the downfall of the government of the time.

Since then, the GOI family planning policy has called for the integration of family planning within the broader context of maternal and child health programs. Despite the lower profile afforded to family planning, funding of family planning programs has remained steady.

Government has recognized the need for reform of the Family Health and Welfare Program's planning, administration and implementation, and have made the necessary policy changes; but implementation has lagged behind. Fortunately, the GOI has recognized the need to mobilize all available channels in support of family planning. As a result the official GOI family planning policy articulates specific support for the NGOs, employer-based programs and commercial sales to meet fertility reduction objectives.

The government has also implemented a number of innovative approaches to expand family planning usage. In 1986, the Government started to promote family planning through the media, voluntary action, social motivation and economic incentives. In addition there are incentives for acceptors of sterilization and IUDs and monetary awards for states with high family planning acceptor rates. The Government also gives financial support to NGOs including to get them involved in the family planning program.

- **USAID Strategy and Programs.** In its most recent strategy document, the USAID/India - Strategic Framework FY 1994-2000, USAID names the stabilization of population growth as one of its three primary objectives to help India make significant progress towards sustainable development by the year 2000.

The USAID population strategy states that this will be accomplished through programs aimed at "empowering women to have greater control over their productive and reproductive lives; by introducing innovations in family planning services; and by upgrading child survival programs." USAID resources will increasingly be concentrated in the northern Hindi-speaking region where total fertility levels have not dropped since independence.

USAID recently initiated the agency's largest family planning program worldwide called Innovations in Family Planning Services in Uttar Pradesh, India's most populous state. By supporting increased access to quality of family planning services, and expanded public and government support for family planning, the program aims to achieve significant reductions in fertility in Uttar Pradesh.

Another USAID-funded family planning initiative called PACT/POP has been proposed and is awaiting GOI approval. PACT/POP is the proposed extension of the Program for the Advancement of Commercial Technology, which began in 1985 as a project to facilitate the development of product and production process technology for application in industry, health, energy, agriculture and other areas critical for India's

overall development. Implemented by the Industrial Credit and Investment Corporation of India Limited, PACT provides loan funding for collaborative efforts between U.S. and Indian entities and has a large portfolio of projects including some health and family planning activities. The PACT/POP project endeavors to use the same mechanism to fund projects which will expand private sector production, manufacturing, promotion and distribution of family planning services and products.

- **Social Environment.** The low social status of women relative men has been a significant impediment to the success of family planning programs in India. The traditional cultural attitudes which cause families to prefer sons and regard daughters as economic liabilities, are pervasive throughout India but particularly strong in the northern states. The most noticeable indication of preference for sons and the low social status of daughters is the sex ratio (female to male) which in 1991 was 879 in Uttar Pradesh as compared with 1036 in Kerala. Several studies have shown that boys have better access to food, health care and other resources than girls and this is particularly apparent in the north. The unwillingness of families in the north to invest in their daughters' education relative to those in the south is reflected among divergent female literacy rates. In 1991, female literacy in Rajasthan was 21 percent compared with 87 percent in the southern state of Kerala. Research correlating female literacy and fertility reduction is confirmed by the disparity in contraceptive prevalence in Rajasthan and Kerala which are 29.5 percent and 55.4 percent respectively.

The fact that Indian women's social status is primarily contingent on their role as wife and mother, is a major impediment to the success of family planning efforts. Despite a law which sets the legal age for marriage at 18 for women and 21 for men, early marriage and childbirth in India is widespread. Most women in the northern states are married by the age of 16. Also, a majority of women in the north, married and unmarried women are restricted to their homes, which limits their access to education, work opportunities and information on family planning.

The Government recognizes the importance of improving the status of women in achieving a decline in population growth, and has adopted a strategy to improve women's health, education and employment. Job training and educational programs have been diversified and expanded to include more women, and laws have been passed to protect the rights and benefits of working women. The growth in the proportion of women in the labor force, which reached 25.6 percent in 1989, and the increase in the average age at marriage from the low teens in the 1950s to approximately 19 today, are critical indicators of an improved status for women and the girl child in India.

■ **Economic and Investment Environment.**

Following the imposition of far-reaching reforms to modernize and stabilize the economy in 1991, India has achieved sustained economic growth which reached 4 percent in 1993/94 and is estimated to reach 5 percent in 1994/95. The current account deficit was just under 1 percent for 1993/94 down from 2.2 percent in 1992/93. Inflation is projected to increase from an estimated 8 percent in 1993/94 to 11 percent in 1994/95 but the GOI has taken steps to arrest price increases through imports of sugar, cotton and edible oils. Foreign investment inflows were up sharply from \$260 million in 1992 to \$572 million in 1993 with the U.S. contributing the largest share at 26 percent. Exports which had lingered at \$18 billion between 1990 and 1993 increased to \$22.6 billion in 1993/94. This has had a positive impact on foreign exchange reserves which grew by US\$8 billion during 1993/94 reaching US\$15 billion in April 1994.

Although 70 percent of India's population is engaged in the agricultural sector, the industrial sector has experienced significant growth since the economic reforms were initiated increasing from 0 percent to almost 3 percent in 1993/94. Mining, energy, machinery, electrical products, chemicals, automobiles, and textiles are the largest industry sectors constituting 75 percent of industrial production. India's main exports include textiles, gems and jewelry, chemicals, engineering products and leather goods.

Growth in India's industrial sector and a substantial increase in foreign investment are due in part to a major shift in the regulatory attitude towards the private sector both domestic and foreign. In 1991 the GOI instituted a number of policy reforms which created a much more conducive investment climate. On the domestic front licensing requirements for most industries were removed and the number of industrial sectors reserved for the public sector was cut to five areas including arms and defense equipment, atomic energy, mineral oils, minerals used in atomic energy and railway transport. The amount of equity participation permitted by foreign investors was increased from 40 percent to 51 percent for the 34 "high priority" industries which comprise the bulk of India's industrial activity. Those investments falling outside the "high priority" industries or exceeding 51 percent must be approved by the Foreign Investment Promotion Board (FIPB) and approved by a Cabinet Committee but in practice the GOI has rarely denied higher equity participation by foreign firms.

Conversion and transfer policies in India are accommodating to investors. The inflow and outflow of funds for remittances of profits, capital gains, and royalties are not restricted and foreign firms have generally been able to liquidate assets and repatriate proceeds without delays. The rupee is fully convertible and foreign exchange is readily available.

The GOI has also implemented a number of tax and duty reductions which have liberalized the trade regime and facilitated foreign investment. The GOI has

eliminated all but a few import controls and reduced peak tariffs from 150 percent in 1991 to 65 percent in 1994. The measures impacting foreign investors include the lifting of foreign exchange controls, the removal of a ban against foreign brand names and trade marks, a reduction of the corporate tax for foreign companies from 65 percent to 55 percent, a lowering of the capital gains rate to 20 percent, and an exemption of export earnings from the corporate income tax for foreign and domestic firms.

III. OVERVIEW OF AREAS FOR PROFIT INVESTMENT

The PROFIT Project is mandated to operate in the areas of Private Health Care Providers, Employer-provided Family Planning and Innovative Investments. These areas are analyzed below in the Indian context:

- **Private Market-Based Providers** PROFIT seeks to work with health care providers, insurers, hospitals and medical professional associations towards the goal of expanding existing family planning service delivery and increasing the availability and quality of method mix in contraceptive commodities.

Private Practitioners

The Indian Medical Association (IMA) estimates that there are over 220,000 qualified practitioners, or those who hold MBBS degrees, in India. IMA has roughly 85,000 members 75 percent of whom are in private practice. Among the private practitioners, 70 percent are general practitioners and 30 percent are specialists. The majority of physicians in India, over 80 percent, are located in urban areas.

Private practitioners in India have not traditionally been involved in the provision of family planning services due to a number of different factors. One of the primary reasons is the lack of accurate information and training in family planning methods and procedures; as a result many physicians are not capable of providing family planning services or are not supportive of family planning, particularly hormonal methods. The lack of monetary benefit to providers for provision of temporary family planning methods also diminishes their appeal. The exception here is voluntary surgical contraception (VSC), which can generate a sizeable fee (Rs. 500-1,000 in 1992).

In a pioneering effort to expand knowledge of family planning among physicians, the Indian Medical Association has been providing training in non-clinical contraceptive technology, counselling skills, as well as clinical training in IUD insertion, no-scalpel vasectomies and mini-laparoscopic sterilization to member physicians in Gujarat and Uttar Pradesh. IMA, with assistance from the Family Health Training Program and JPEIGO, plans to sustain and expand access to their training by charging for the training and placing the proceeds in a revolving fund. Also, they will be developing a correspondence course for which they will charge a fee.

A 1992 report by Population Action International asserts significant potential exists for an expanded role for private practitioners in family planning service delivery and cites the poor quality and inaccessibility of public sector services as a main factor. Although the public sector has an extensive health care infrastructure, it lacks the necessary resources to commit to staffing, training, equipment and supplies. As a

result, public sector services are perceived as poor quality and the majority of Indians, upwards of 80 percent, access the private sector for health care.

Preference for private sector health care is highlighted by the fact that household expenditures on health care, estimated to be 7 percent to 9 percent of annual household expenditures, surpass those of the government which approximate 5 percent of the gross domestic product (GDP). A contributing factor may be the relative accessibility of private health care facilities; whereas only 25 percent of public hospitals are in rural areas, 35 percent and 41 percent of private and PVO hospitals are in rural areas. Also this preference for accessing the private sector cuts across all income groups. A 1987 study of the Jalgoan district of Maharashtra State indicates that 72 percent of poor, 75 percent of lower middle income, 80 percent of middle income, 84 percent of upper middle income, and 95 percent of the rich utilize private sector health facilities.

Although the proportion of private ownership of health facilities varies by state the average number per state is substantial. The 1988 Directory of Hospitals indicates that 57 percent of all hospitals and 31 percent of all hospital beds are owned by the private sector and private volunteer organizations (PVOs). In some states such as Kerala, Gujarat, and Maharashtra, the proportion of private ownership in hospitals is much higher - 78 percent, 77 percent, and 62 percent respectively. If these figures included nursing homes and private clinics, the numbers would be larger still.

Health Insurance

Health insurance in India has been offered through subsidiaries of the government-run General Insurance Corporation (GIC) since 1974. The insurance plan currently available, called the Hospitalization and Domiciliary Hospitalization Benefit Policy or Mediclaim, offers indemnity coverage. The plan's two schemes afford the beneficiary coverage for hospitalization and personal accident insurance or just hospitalization. Each scheme has a number of different premium levels which determine the financial limits on reimbursement. The fact that several common diseases and health conditions are excluded from coverage, eligibility is restricted to those between the ages of five and 70, and only health services rendered within India are reimbursable, has limited the appeal of this plan. A feasibility study for a health maintenance organization in New Delhi conducted in 1990 indicates that the success of Mediclaim has likely been hindered by adverse selection and claims fraud, which has at times resulted in claims exceeding premiums collected. The government also provides health insurance coverage to employees in the formal sector through the Employees State Insurance Scheme, which will be described further in the Employer-Provided Services Section of this document.

Since the early 1980s, a number of private entities, mostly private practitioners, have sought to enter the insurance business often in conjunction with subsidiaries of the

public sector GIC. Currently, most private hospitals have agreements with these public sector schemes where beneficiaries are only entitled to coverage if they use the designated facilities. A number of hospitals in Bombay, Madras, and Hyderabad have established health care associations which provide in-patient health care coverage at the associations' member hospitals.

One of the more successful efforts in this area is the Appolo Health Association established in 1986 in Madras with help of a public sector insurance company. Members of the Appolo plan can access hospital coverage of up to Rs 17,000 with payment of Rs 999 membership fee. Programs such as these vary in the range of services and types of financing mechanisms but have all elicited interest from consumers and their growing ranks of subscribers indicate a substantial demand for health insurance services.

- **Employer-Provided Services.** PROFIT seeks to assist firms with large employer populations in offering family/planning as an employee benefit. PROFIT can assist by providing technical assistance, cost/benefit analyses, investment in on-site clinics and collaboration with providers seeking to serve employee populations.

UNFPA estimates that nearly 28 million people are employed in the organized sector or the formal economy, comprising roughly 11 percent of the labor force in India. This proportion reaches almost 20 percent if the semi-organized labor force and cooperatives are included.

The organized sector has been at the forefront of family planning promotion in India. Pioneering firms like the TVS-Lucas Group of companies in Madras and the Tata Iron and Steel Company in Bihar initiated family planning promotion efforts for their employees prior to the launch of the Government's program in 1952. Large scale family planning programs have been implemented by national employers associations like the All India Organization of Employers (AIOE), the United Planters Association of India, the Indian Oil Corporation, and the Employers Federation of India. The programs' emphases have ranged from motivational and educational activities to delivery of family planning services. For the most part these programs have sought to motivate member companies and firms to promote family planning among their employees. Funding has been provided by the International Labor Organization, the United Nations Population Fund and U.S.A.I.D. to establish population cells within these organizations to oversee family welfare education and motivational activities taking place among the member companies.

Indian employers are also required to contribute to the health and social welfare of their employees through the Employees State Insurance Scheme (ESIS). ESIS provides health insurance benefits including illness, maternity, disability, and funeral benefits to employees making less than Rs. 1600 per month. All factories employing ten or more workers and non-factory employers with twenty or more workers must

participate. The ESIS is funded by a payroll tax on employers and employees, contributing 70 percent and 25 percent respectively, and contributions by state governments. The ESIS provides health care services directly to member employees and their dependents through a dedicated network of health dispensaries and hospitals, or indirectly through local registered health providers designated as "Insurance Medical Practitioners".

Despite the accessibility of and range of services provided by ESIS scheme, the ESIS facilities are not popular with employees and studies show that many employers provide additional health care coverage and service delivery in addition to their ESIS contributions. A 1990 survey of over 2,100 employees and 300 firms in New Delhi indicated that over 85 percent of the firms supplemented the ESIS benefits with additional health services. Of these firms, 60 percent reimbursed employees' medical bills and 8 percent purchased health insurance for their employees. The survey, which represented 1 percent of all the established companies in New Delhi, was conducted as a part of a study to test the concept of a managed care plan among employees and employers and assess its financial feasibility. The authors of the study asserted that the high percentage of employers already providing health services suggests a willingness to pay for services through a third party payer.

In a 1992 survey of 165 employers in the state of Uttar Pradesh (UP), the employers also expressed dissatisfaction with the quality of ESIS services and showed that a comparable number of companies augmented the ESIS plan with additional coverage. Of the firms surveyed, 77 percent received health services through the ESIS and of that group, 67 percent were paying for or providing health care services indicating significant overlap. Over 85 percent of the firms with 500 employees and more have on-site clinics. The range of services provided is typically limited to treatment of injuries, curative care, and physical examinations.

Of those not providing on-site care, many had some kind of service agreement with local health care providers. Payment was mostly arranged through capitated or retainer fees to the provider and in some cases the employee contributed a copay. Smaller companies were more likely to refer their employees to public sector facilities or provide only basic first aid services on site.

The OPTIONS study also looked at provision of family planning by employers in UP. The results show that although the majority of employers have established the necessary health care infrastructure or mechanisms to provide coverage for health care, they are contributing only nominally to overall family planning usage. Employers complained that a shortage of supplies and medical staff hamper the quality and performance of ESIS health and family planning service delivery. Additionally, although many of the employers surveyed saw health care as their responsibility, they viewed population growth and family welfare as the purview of

the government. The survey showed that only 16 percent of those employers that provided health benefits in addition to ESIS coverage, included family planning.

However, the authors of the study believe there to be significant potential to expand the role of employers in family planning service delivery in the UP. The organized sector offers access to a population, the majority of which is of reproductive age and has had some education. According to the study, many managers appreciated the impact of family size on worker productivity, and expressed interest in increasing their participation in family planning provision.

- **Innovative Investments.** PROFIT is mandated to invest in projects that promote contraceptive production and distribution. PROFIT can also work with local groups toward privatization of services, the reduction of trade barriers if they have an adverse impact on the family planning environment or availability of contraceptives, and in leveraging funds through innovative financial transfer mechanisms.

Local Production, Distribution, and Marketing, of Contraceptives. Of the 148.5 million couples eligible for family planning in India in 1991, only 14 percent were using temporary methods including condoms, IUDs, and pills. This number is significantly lower than other developing countries with active family planning programs. In these countries the proportion of non-clinical family planning method users typically falls between 30 percent and 40 percent. The most common reason expressed by women for not using contraception is the unavailability of methods other than sterilization, especially pills and condoms. Little room exists for expansion of sterilization use, but clearly unmet need exists for reversible methods among younger couples.

Figure 1

METHOD OF FAMILY PLANNING	SOURCE OF DISTRIBUTION			
	PUBLIC	SOCIAL MKTG.	COMMERCIAL	TOTAL
Condoms (million pieces/yr)	680 (58%)	296 (30%)	153 (12%)	1,185 (100%)
Pills (million cycles/yr)	17.5 (51%)	8.1 (24%)	8.5 (25%)	34.15 (100%)
IUDs (in millions)	6.4 (82%)	---	1.4 (18%)	7.8 (100%)

Of the current market for condoms pills, and IUDs, the majority is covered by free distribution through the public sector and government subsidized social marketing programs as set out in Figure 1. The commercial sector represents only about 12 percent, 25 percent, and 18 percent of condom, pill and IUD markets, respectively.

This is due in large part to the distorted nature of the market for contraceptives in India. Free contraceptives are available through the extensive MOHFW network of health facilities. In addition, the government funds a long-standing, well-established social marketing program offering condoms and pills through commercial outlets at subsidized prices. The social marketing condoms and pills are sold under the brand names Nirodh and Mala D respectively, and there is a high degree of brand recognition for them; in fact, in India a condom is commonly known as a "Nirodh".

Another component of the MOHFW social marketing program, involves the subsidized sale of condoms and pills to any organization interested in marketing and distributing them under their own brand name; participants include Population Services International, Parivar Seva Sanstha (PSS), and DKT. This program further contributes to market distortions in that the government sells commodities to these groups at a price substantially lower than the original procurement. The only stipulation is that the final price be lower than the full commercial price. Commercial firms who already have a difficult time competing with the social marketing firms' prices are further challenged by rising raw materials costs, import duties on raw materials, a devalued rupee, and strict price controls on contraceptives.

Despite these challenges, commercial sector companies have played a substantial role in the manufacturing, marketing and distribution of condoms, pills and IUDs in India.

Condoms: The total condom market for 1993 was over 500 million pieces of which 153 million or 12 percent was commercial sales. The government has established its own manufacturing company called Hindustan Latex but also sources from the TTK business group which is affiliated with the British company, London Rubber. Other local manufacturers include J.K. Chemicals and Polar Latex, both of which supply condoms to the GOI for the social marketing program. There is a plethora of condom brands on the market but the leader is Nirodh with a market share of 75 percent. The two market leaders in the commercial sector are TTK and J.K. Chemicals with approximately 16 percent and 4 percent of the market respectively.

Pills: The commercial pill manufacturers rely solely on commercial distribution for their market as the GOI does not source through them. Free distribution of pills makes up just over 50 percent of the market with social marketing programs and commercial distribution splitting the remaining share. The commercial market is dominated by international firms including Wyeth, Schering, Johnson and Johnson, and Organon. Manufacturing is done locally but the bulk hormones are imported. A 1994 study assessing the potential for expanding the commercial contraceptive market conducted for PACT/POP indicates that there is sufficient infrastructure for local manufacturing of hormones and other bulk ingredients but given the abundance of donated product in the market, manufacturers are reluctant to invest at this time. This is a situation that is unlikely to change in the near term. Among commercial firms

the market leaders are Wyeth with over 60 percent of the market and Schering with 26 percent of the market share.

IUDs: Currently five companies manufacture IUDs in India. Three firms sell almost exclusively to the GOI while two others, Zieta Pharmaceuticals and Infar Ltd., sell them through the commercial market. The GOI has a strong preference for the Cu-250A despite concerns about its quality relative to the newer models like the Cu-380A. Zieta Pharmaceuticals imports components and assembles and markets the Zicoid Cu350 locally with technical assistance from a Swiss company and Infar Ltd. markets both the Multiload Cu-250 and the Cu-375. In commercial distribution Infar Ltd. is the market leader followed by Zieta Pharmaceuticals and together they distribute approximately 1.4 million devices annually. Zieta Pharmaceutical management believes there is significant potential to boost demand through increased marketing and promotional efforts to India's over 50,000 gynecologists. They estimate projected demand for IUDs is 21.8 million devices a year which far exceeds actual consumption estimated at 6.4 million devices in 1993.

In interviews with a number of contraceptive manufacturing firms conducted as a part of the PACT/POP feasibility study, they cited a number of factors in addition to market distortions, which limit their ability to expand their market. One of the most obvious is the low prevalence of temporary contraceptive method usage. The MOHFW program continues to favor clinical family planning methods despite official policies which support the full range of methods; also generic family planning promotion and education efforts by the MOHFW are limited. Another deterrent is the opposition from the medical community and womens groups to hormonal contraceptive methods based on moral, religious and women's health concerns, but also exacerbated by inaccurate information and lack of training. Because of this resistance and a desire on the part of the GOI to control family planning activities in India, manufacturing firms are reluctant to promote their products too conspicuously. According to the study, all these factors have made expending the substantial costs associated with marketing contraceptives too risky for manufacturing firms in India.

Even so, the PACT/POP study asserts that potential exists to expand the commercial sector's manufacturing, marketing, and distribution of contraceptives. There exists significant untapped demand for temporary contraceptive methods. The limited nature of current marketing efforts by commercial pill, IUD and condom manufacturers and distributors suggests potential for growth in this area. The study suggests that with appropriate assistance, pharmaceutical firms would be interested in stepping up efforts to manufacture, market and distribute contraceptives in India. Those companies interviewed indicated that their greatest need for direct assistance is in accessing affordable financing for investment in marketing, promotion, and manufacturing.

IV. POSSIBLE PRIVATE SECTOR INTERVENTIONS

The previous sections provided an overview of the Indian health and family planning environment in the sectors relevant to PROFIT's mandate. In summary, the following conditions in India create a positive environment for private sector interventions to promote family planning:

- A regulatory and policy environment conducive to investment and the private sector in general
- A strong awareness of, and commitment to, family planning by the Government of India (GOI)
- Expressed interest by the GOI to increase the private sector's involvement in family planning provision and promotion
- A developed private sector health care infrastructure and preference among Indians for accessing health care services in the private sector
- An organized sector that is active in the provision of health and family planning services to its employees
- Significant unmet need for short term contraceptive methods
- A well-developed contraceptive manufacturing, marketing and distribution infrastructure with potential for expansion.

PROFIT's mandate is to increase the resources for family planning by encouraging greater private sector involvement. Given the situation in India, PROFIT perceives its priority objectives to be to:

- Support improvements to access and quality of products and services, particularly for short term methods.
- Sustain and expand the activities of private enterprises - commercial and NGO - in family planning activities of manufacturing, marketing, health care financing, and service delivery.
- Encourage switching from public to private sources of family planning.

PROFIT seeks to invest or lend to sustainable commercial ventures that will have a positive impact on family planning. In keeping with its mandate, PROFIT would seek to advance these objectives in three main areas:

- Employer-backed projects which maximize the health care service delivery and financing mechanisms already provided by the majority of India's large employers

Given the Mission's expressed need for assistance in the area of employer-based provision of family planning services in UP, this will be a major area of focus for PROFIT. Given the fact that a large number of employers are currently providing health services for their employees through on-site facilities or contracts with local providers, PROFIT has identified specific approaches which will maximize the existing infrastructure and make the best use of PROFIT's expertise and unique mandate.

- ■ PROFIT will look to identify on-site health facilities that are currently providing family planning and have sufficient capacity to be expanded to serve several employers health and family planning needs. Based on economies of scale, services could be provided in a more cost-efficient manner. The employer could obtain contract management for the facility or spin-off the facility and purchase the services.
 - ■ PROFIT will seek to expand the service delivery capacity of private providers in close proximity to several employers, enabling them to provide health and planning services on a fee for service or capitated bases. As these kinds of arrangements already exist in India, PROFIT sees this as a possible scenario.
 - ■ PROFIT would also seek to work with existing employers' associations and chambers of commerce that have experience in the promotion of family planning to employers. They would provide valuable insight for the development and implementation of marketing plans for the pricing and packaging of health and family planning services to be provided in the approaches outlined above.
- Contraceptive manufacturing, marketing, and distribution projects which build on the substantial infrastructure, expertise and experience of existing contraceptive manufacturing and distribution firms.

A number of factors create opportunities for PROFIT in these areas. They are: 1) the demonstrated unmet need for reversible contraceptive methods in India; 2) the lack of generic efforts to promote these contraceptive methods through the MOHFW; 3) existing manufacturing, or requisite infrastructure for, the production of condoms, IUDs and diaphragms through commercial firms and parastatals (although the infrastructure for manufacturing pills exist, the government domination of hormone

procurement precludes development in the near future); and 4) manufacturing firms expressed need for capital. Given these conditions, PROFIT will explore the potential for the following activities with commercial manufacturers.

- ■ Initiate or expand production of condoms, diaphragms, spermicide, or 380A IUDs
 - ■ Enhance the sustainability and quality of current production of contraceptive products
 - ■ Expand the marketing and distribution of commercial products
 - ■ Increased accessibility for new products, and to expanded markets.
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- Projects with private market based providers including physicians and other health care providers, private clinics and other kinds of facilities, as well as health insurance firms.

The obvious preference exhibited by the Indian population for accessing health services through the private sector, and the growing private sector health infrastructure, create a conducive environment for PROFIT investment. PROFIT will seek to work with private health care facilities to expand their financial viability and capacity for family planning provision.

Given the innovative activities surfacing in India with third party payment schemes, if the regulatory and legal environment is conducive, PROFIT would seek to explore opportunities to promote the development of health insurance and managed care schemes with an emphasis on primary health and family planning. In this case, PROFIT would provide financial and technical assistance to expand the capacity of private health facilities to act as preferred providers or as facilities owned and operated by the insurance entity or corporate buyers. PROFIT would also seek opportunities to work toward the privatization of the ESIS system, possibly through the identification and enhancement of private facilities which could provide health and/or family planning services to the ESIS membership on a contract basis.

Although there is a great need for training of physicians in family planning, ongoing efforts conducted by other Cooperating Agencies (CAs) preclude the need for PROFIT assistance in this area. However, PROFIT could play a coordinating role in providing access to selected private sector providers for the assistance available through other CAs.

PROFIT is drafting a separate scope of work (SOW) which gives a more detailed description of PROFIT's proposed activities in India for submission to USAID/New Delhi. The SOW delineates specific interventions and development strategies for future interventions to meet the above stated objectives.

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