CHAPTER IX

Summary and Conclusions

Introduction

The empirical studies on health care access and utilization have been of two types. The economic studies generally underestimated the socio-cultural or qualitative aspects and illness characteristics and provision aspects other than the public-private dichotomy and the costs. The social anthropologists, on the other hand, adopting the method of ethnographic analysis overlooked the economic aspects such as the role of provision and the various costs. In this study, we have tried to incorporate these diverse methods by integrating them. The aim of this study was to understand the different patterns of provision and utilization of curative care and the factors that determine their choices and preferences. The relevance of this study derives from the increasing concern over the growth of private health care sector in a lax regulatory environment in Kerala.

The emphasis of the present study is to understand the determinants of the utilization of health care services among the diverse providers by patients affected by curative illnesses. The study is an attempt to portray analytically the interaction between the provision and utilization behaviour in health care market.

The study differs from the usual economic studies in terms of the analytical categories of provision used for the purpose of analysis. The public-private dichotomy used in most of the studies were thought to be inadequate in explaining the use pattern as the distinction is more based on institutional or administrative identity rather than the nature of services delivered. Hence, our study takes “private-in-public” as analytical category apart from the usually used public and private categories.

Methodology used for this study differs from others in terms of the factors looked at, data used for the analysis and the logistic analysis. In order to sustain our classification of analytical categories of the provision into public, private and “private in public”, we have incorporated an analysis of the provision patterns and the provision behaviour of the providers. Basing such an analysis on factors such as accessibility, availability, quality and costs, the provision behaviour has been rendered comparable with utilization, where these
factors influence the choice of provider patterns. Moreover, it is useful in analysing and identifying the process of choice and utilisation from the provider perspective also. The data collected includes the opinion of patients on the choice of the provider and qualitative variables such as waiting time, diagnosis time, etc. The household morbidity surveys carried out at the national level such as NSSO and others do not have such information, which are very relevant for the analysis of the choice of provider. Also, data on the various types of treatments, and their costs are important, especially since we have taken pains to collect them across the different providers across sectors, systems and sizes.

The study does not look at costs in terms of absolute costs incurred on health. Rather, we have tried to look at the relative roles of various types of costs in the health expenditure. Since cost is an after-effect of the use of health services for treating illness and hence its absolute amount is not know at the time of the use of a provider, we thought rather than taking the absolute costs, it is important to look at what is the type of costs the patients are expected to pay when they choose a particular provider. We have taken the payment of consultation fees separately and with other costs as analytical categories for this. Our justification of taking these categories were the fact that the patients at least know the conventionally established rates of consultation fees they have to pay even before using the provider and therefore this information would indeed influence the choice of providers.

The Importance and Objectives of the Study

The choice of provider for the utilization of health care services is of concern characteristics of the health care is looked at from a welfare perspective. Health care is not an output; it is an input to achieve health, the output. Health care services are generally of three types – promotive care that is not patient related, preventive and curative care that is patient related. Of these, preventive care is considered a public good while curative care is treated as a private or merit good. The provision of health care could be by the government sector or by the market. Because of the public good characteristics of health care, the argument for government provision has always been taken seriously by welfare states. In Kerala also, the public sector is an important provider of health care services. The government took initiative from the nineteenth century onwards by creating a network of medical institutions, an example that was followed in the private sector only much later. The health care system in the state has brought out dramatic improvement in the health status of its population. Scholars like Krishnan (1975) have attributed Kerala’s achievements in health status to widespread
health coverage; the more important reason was however, the rising demand for health care facilities and the high rates of their utilisation facilitated, to be sure, by easy physical accessibility to them.

However, the public sector is not the only player nor is it, any longer, the dominant player. The majority of the health care services are provided by the private sector. Since both types (public and private) are involved in the provision of health care, elements of cost have to play a role in the health care market. Cost constitutes an important determinant of the use of health care. Moreover, there exist no public or private health insurance programmes in the state. In the context of increased physical accessibility and presence of costs for health care, the quality aspect too plays a crucial role in health care utilization.

The determinants of utilization of health care services were considered important for the policy makers in taking decisions regarding the monitoring and regulation of the health sector. The sociological and anthropological views have focussed attention around demographic, socio-economic and individual factors in the determination of utilisation of health care services. While it is important to acknowledge the influence of these factors on morbidity patterns, they are not sufficient to explain the choice of different providers by different segments of the consumers. The provision-determined factors such as costs, access and quality are important in the choice of providers and in the determination of health care utilization.

The specific objectives of this study were to understand:

a) Patterns of provision in the state;

b) Provision behaviours in terms of their access, cost and quality;

c) Morbidity patterns;

d) Patterns in the use of health care services;

e) Costs on health services utilization; and

f) To estimate the relative influences of various factors in the determination of health services utilization and the choice of provider.

A micro-level analysis of the health care provision and its utilization along with its determinants necessitated a primary survey of providers and users (the individuals in households). The survey of 140 providers (physicians) belonging to Alappuzha district was carried out to describe
The results of the household survey of 1710 individuals (of 350 households) belonging to the rural and the urban areas of Alappuzha district formed the data base for analysis of the morbidity, utilization and expenditure patterns. The purposive and intensive field survey was conducted for a period of six months (December 1999 to June 2000), a season neutral for the seasonal variations affecting morbidity.

The Provision of Health Care Services in Kerala

However, in order to understand the micro-factors involved in the process, an understanding of the macro picture of health sector was found necessary. The provision of health care services in the state is organised into different sectors, systems and sizes. Utilisation patterns of the health services in the different systems, sectors and sizes of medical institutions were also examined. The provision of health care in Kerala is characterized by plurality and multiplicity. The state has recognized and institutionalised three systems of medicines – allopathy, ayurveda and homeopathy.

The large hospitals in the public sector are concentrated in the urban centres, making it difficult for the small providers to thrive in these areas. Their natural response to this challenge was to shift their focus of attention to the rural areas. Thus we find a proliferation of providers, most of them belonging to the small and medium sizes, in the rural areas. The resulting spatial distribution has made access to providers physically easy for the entire population, irrespective of the localities of their residence.

Kerala State is way ahead of its counterparts in India in terms of health status indicators that are comparable to those of countries like Sri Lanka, and Costa Rica. The analysis of the performance of the health care services sector in the context of the non-regulated environment in the state, based on the available secondary data showed that Kerala has adequate medical facilities in all the major systems distributed almost evenly across regions. However, regional disparities do persist in the state with the economically developed districts having greater health care facilities than less developed districts.

The most notable fact that comes out of the analysis of the provision of health care in Kerala is the dominance of the private sector provision in all the three systems of medicines. There were many factors that facilitated the growth of the private sector in the state. The absence of rigid regulations on private sector growth is often considered to have provided a favourable
environment for the private sector to flourish in the state. In fact, the analysis of the actual provision of private sector showed that more than half of the private sector medical institutions have not been registered at all, and of the registered medical institutions, majority were under proprietary ownerships, where charity do not figure at all as a motive.

The analysis of the provision characteristics showed two important features: (i) doctors engaged in practice at multiple sites thus increasing the number of sites of provision to exceed the number of providers; and (ii) the multiple site practice of government doctors has led to the emergence of the category, "private in public" sector. Here, doctors' practice experience in the public sector, their client management skills and most importantly, their specialisation advantages are put to use for their private purpose of earning extra incomes. The analysis also showed that general practitioners were found more frequently in the private sector and the rural areas than government and specialist doctors are found. The distinction of the private in public category from the private sector proper is important because it enables us to differentiate the characteristics of doctors into specialists and general practitioners, in terms of area served, and costs involved. Such a differentiation has enabled us to examine the utilisation patterns and draw conclusions regarding the choice of provider decisions. The provision analysis also showed that the practicing behaviour of providers influence the availability, accessibility, costs and quality, which has an impact on the utilization of these services by patients.

Morbidity Patterns

The analysis of the patterns of utilization of health care services would have been in fructuous without an understanding of the morbidity patterns across socio-economic categories, and region – specific, age – group wise and sex – wise classifications. A comparative analysis of costs of short duration and long duration illnesses and of treatment patterns was done based on the data collected from the household survey. Illnesses were classified into acute and chronic on the basis of duration and into fourteen illness groups. The morbidity prevalence rates were calculated for separately for acute and chronic illnesses for a three - month recall period; the exercise was done also for the different socio-economic groups and rural and urban locations.

The analysis showed that the incidence and prevalence rates of acute and chronic illnesses differed across age groups. The young population was more affected by acute illnesses whereas the health of elderly was affected more by chronic illnesses. The severity of illnesses varied across the several illness groups falling under both acute and chronic illnesses. The morbidity
prevalence rates were higher for chronic than of acute illnesses. The morbidity prevalence rates varied also across age groups.

**Treatment and the Choice of Health Care Providers**

On the onset of a disease in most of the cases, patients opted for institutional treatment, or treatment by individual physicians. In a small number of cases, the patients resorted to self-treatment. There were also cases in which the disease was left completely unattended to. Most of the self-treated cases were found to be of the acute category not serious either. A few chronic illnesses of the types of aches and pains which people considered not “treatable” by doctors were also left untreated. The decision for self-treatment was based more on the severity of the illness than on any other considerations. Those who self-treated their acute illnesses resorted to allopathic drugs for quick relief, which they themselves bought from drug stores. Most of the chronic illnesses that were self-treated used medicines (e.g. medicinal oils, concoctions, pastes) of the traditional (mostly Ayurveda) system.

Multiplicity of factors influenced the choice of provider. The analysis in chapter six showed that the patterns of the use of health care services differed between providers - sectors, systems and sizes and across socio-economic groups, age, and sex and area of residence. The analysis also showed that the choice of provider from the systems, sectors and institutions and the qualification of providers differed across illness characteristics. It was found that for acute illness treatment, general practitioners in the private sector were used more than specialists, in clinics and small hospitals. On the other hand, for chronic treatments, the specialists at the public and private in public sector were used in more quantity. The reasons for the choice of providers were reported to be costs, accessibility and quality aspects.

**Treatment Costs**

The analysis of treatment costs was carried out in chapter 7. The main finding of this analysis was that there was not much of a difference in treatment costs between private general practitioners and the public providers. On the other hand, the treatment costs at the specialists in the “private in public” sector was much higher compared to the government and most importantly, from the private general practitioners. One reason for such a big difference is due to the type of illnesses treated at these different sectors. The treatment cases using private general practitioners were mostly acute illnesses while those who use specialists were affected by chronic ailments, and this naturally leads to recurring costs and hence high costs. Also, the
components of costs in these different sectors show differences. The specialists at private in public are usually paid the conventionally established amounts as consultation fees. Consultation is free in the government sector and the general practitioners in the private sector charges only a wage-rate type of consultation fees along with other costs such as medicines. The price elasticities of demand (utilization) of public, private and government providers showed that they were mostly inelastic, meaning that variations in price do not affect utilization much. This is because the people who use them have already decided to use them despite the presence of cost factors and the mere change in price would not affect them much. However, the price elasticities for the private in public were higher than that of private and public, which means that the use of this sector is relatively more vulnerable to change in prices compared to the use of public and private sectors.

**Determinants of the Choice of Providers**

After analysing the patterns of morbidity, utilization of health care services and costs, the possible determinants of utilisation of health care across providers was examined by using the logistic (MNL) regression technique. The analysis brought out the provision characteristics as the major factors that could explain a person's choice of the provider. First a MNL regression test for the determinants of a person being affected by some ailment was undertaken. It was found that more than the living conditions and socio-economic status (determined by income and community), capabilities determined by education and occupation were significant variables. The place of residence also influenced a person's the vulnerability towards illness; a rural person is more vulnerable for falling ill than his/her urban counterpart.

The MNL results for the choice of a provider showed that government sector is preferred when the cost considerations were important. The government sector was also used for its specialist doctors and tertiary hospital facilities, especially for treatment of chronic ailments. On the other hand, the private in public sector was also preferred for its specialist doctors, but for reasons related to the quality of service such as less waiting time and more diagnostic time which gave it an edge over the government sector proper. The private in public sector was used more than compared to the government sector when peoples’ willingness to pay overcame cost considerations. The private sector, on the other hand, was preferred for treatment of acute illnesses, requiring the attention of general practitioners rather than of specialists, by all socio-economic groups. This was also because of the perception of better quality associated with this
sector when compared to that of the government sector and lower costs compared to the private in public sector, again, as perceived by patients.

The analysis showed that people's preference for government, private in public and private sectors differed depending upon the cost, access and quality aspects of the provision of services. The qualitative reasons were found to be the most important especially in the choice of the private in public and the private sectors.

Conclusions

The price elasticity of demand for health services showed that this demand is relatively inelastic and that the factor that contributes significantly to the determination of demand is the perception of quality of services. This perception of quality is associated with low waiting time and better or longer consultation duration. For acute ailments the most available and least costly health service in the form of private general practitioners in the rural areas were preferred. For acute ailments, immediacy of the cure and the easy availability of the service took precedence and yet the services the patients used were not free. People preferred specialists in the 'private in public' category more often for chronic ailments and the elasticity of price in this context was also insignificant. However perceptions of provider quality were associated with experience and such a provider has the time to gain experience in the public sector and use this to feed his/her status as a 'quality' provider in the private in public sector. It should also be remembered that travel costs constitute between one tenth to a maximum of a quarter (only when in-patient care is also involved) of the total cost expended per episode which may not determine which health sector is being sought. Perceptions of distance were different for the nature of ailment and therefore may not also be a significant factor in shaping concerns regarding transportation costs while seeking health care provider from within different sectors. Clearly the cost of the consultation, which is a major component of cost did not seem to hinder patients from using the health services. Therefore there are clear policy implications in line with revamping the existing health services called for here. The enabling environment for health sector reform exists.

The study showed that the choice of providers is not necessarily between public and private, but between public, private and private in public. This study is one of the first to look at the private practice by government doctors as an analytical category. The study also tried to differentiate the services of private general practitioners from the specialists. It showed that the health care
costs, which is one of the issues of concern for policy makers and welfare economists is not uniform across private sector and that not all private providers are costly. However, the costs are not high with general practitioners because of the large supply of providers and the resultant accessibility of health care services, especially for the poor and rural populations.

The Policy Implications

In the absence of regulation of the health care services, it is important to bring accountability to the providers to ensure the quality of the services and equity of provision. There have been great concerns over the increasing private influence on health care services and the policy makers and academicians often doubting whether health care services are at cross roads. However, our study revealed that not all health care services provision in the private sectors are costly or fleecing the users of their resources. Pressure of a large number of providers in a region forces the new comers to move on to the economically less well-off regions to seek their fortunes. They may adopt pricing strategies, which would not affect their practise and survival in the field. The providers in fact, were found to be price discriminators who adjust their pricing policies to the prevailing market emotions. There are clear differences between general practitioners and specialists in their pricing behaviour. The incorporation of variables that explains the aspects related to quality of provision emphasises the need to improve quality of provision for making them more acceptable to people, especially in the government sector.

The study revealed that more than the “ability to pay” it is the “willingness to pay” on the part of the patients that determines utilization decisions and socio-economic status is found irrelevant in cases in which consultation costs were present. The implication of such a result is the fact that there is “willingness to pay” for health care services, provided the quality (as perceived by the patients) are assured. Here, there is a strong case for having insurance policies for health care services at least those in the vulnerable sections of the society. Since the demand for curative care is inelastic, the introduction of health insurance schemes can take off the burden of treatment away from the needy, rather than providing them freely in the public sector.

There is scope for a social sympathetic costing of the health services. Since, the private sector is already providing more frequently for acute ailments care for a fee and it will not be possible to re-deploy them within the public sector within a democratic, market friendly political situation. It is time, we thought of using the willingness to pay as a positive key towards income generation to improve quality of services in the public sector. This can be
done by initiating commonly affordable user-fee (as users are already paying) and providing specialist care (for which demand is price-inelastic and a clear willingness to pay in the private in public sector) at the public sector institutions. But one pre-requisite for this is ensuring quality, at least in the form of less waiting time and more consultation time per patient by re-deploying existing doctors in appropriate positions. By making this similar to the National Health Service or like the socialized Canadian Health Care System, we can also make an attempt towards solving the problems related to cost recovery and sustainability. This is the direction in which health sector reform in Kerala should move towards.

However, the precise method of introducing the health insurance schemes as well as its scope and coverage should be based on intensive studies, an exercise which lies beyond the scope of the present study.

**The Limitations of the Study**

The study is a case study of a district and as such, the results are more influenced by the characteristics of the district. Though Alappuzha is a representative of the Kerala state in respect of demographic characteristics, its eligibility in the case of health care services is limited in the sense that the district has one of the major tertiary sector hospital in the government sector and this sizably widen the access of the government sector. However, the relative roles of private and private in public that comes out of this study is more or less the feature of Kerala’s health provision.