CHAPTER I

Introduction

Health is one of the vital indicators of quality of human life. The World Health Organization defines health as a "complete state of physical, mental and social well being, not simply the absence of disease" (World Health Organization. 1984). Health care for the preservation and promotion of health is one of the most basic human rights, as declared in the Universal Declaration of Human Rights (Article 25). The need for health care services arises because discrepancy exists between the actual health status and the desired health status of individuals and societies and such discrepancy is capable of being set right to a great extent through medical interventions and provision of related services. Thus, health care is not the final product, but is an input to a more holistic product of health.

Health care is not a homogenous good. It is not like any other goods and services in the market. Categories of health care differ from patient related preventive and curative care to aspects not directly related to patients - namely promotive care. Commodity-wise, health care may be classified into public, merit and private goods. The opinion as to who should provide health care services - the government or the private sector - has remained a major area of debate. At present, health care services are provided by the state, the private sector, or simultaneously by both, depending upon the political economy of the country concerned.

Provision of Health Care Services in Kerala

According to the constitution of India, health care is a state subject. Kerala is one of the few regions, which has actively a policy of providing health care efficiently and equitably. The private sector is allowed to function along with the public sector that gives free access for the weaker sections to health care. The Kerala situation in the provision and the use of health care services is complex. This complexity is due to the diversity - plurality and multiplicity - of systems, sectors and institutions of health care services. The state has recognized and institutionalised three major systems of medicines – allopathy, ayurveda and homeopathy. Kerala’s governments have actively pursued a pro-active role in the provision of health care for the past several decades to all its needy at the public facilities in all the three systems.
The demand for medical care has grown rapidly in the state thanks partly to the spread of literacy; the spread of medical care facilities in every village in the state has taken care of the supply side. Health awareness of the people in Kerala is undoubtedly one of the highest among the states of India. Despite the State’s unimpressive performance in its productive sectors, inflow of remittance incomes, rise in wage rates and expansion of the service sector activities have pushed the demand for health care services to ever increasing levels.

The Kerala governments, particularly the governments of the erstwhile princely States of Travancore and Cochin, took initiatives for the promotion of medical care from the mid-nineteenth century itself. Along with establishing hospitals and dispensaries in the private sector, grants - in - aid were given to private sector institutions particularly in the ayurvedic system. However, the growth of the private sector during the period since independence has been on its own, without support from government. Now, private sector reportedly accounts for more than seventy percent of the total provision of health care services in the state.

However, along with the government provision and the private provision, there exists a hidden sector also, which is often not taken into account while referring to health care provision in the state. The growth of the public sector has meant the simultaneous sprouting of this third category – the private practice by government doctors which may be referred to as “private in public” (following Narayana; 2000), the size of which has become very large in recent years.

Thus a complex health care provider reality exists now in the state. Multiple systems of medicines and multiple institutional arrangements characterize the provision. This complex provision has a profound impact on the access and utilization of health care services in the state. The availability ranges from a next-door clinic to a super specialty hospital within a few kilometers, and from free of cost at the public sector to user-charged and cost for everything in the private sector. This spurt in the private sector growth has occurred in a non-regulated environment.

The Research Gaps in the Existing Studies

Though “health status” of populations and their health care aspects has received serious research attention, it appears that most studies have left some crucial dimensions of the health care activity untouched. The studies that have looked at the Kerala scenario of health care
have been, for example, related to certain specific topics health outcomes (infant mortality rates, birth rates, death rates etc), health care inputs (public expenditures), health care resources (number of doctors, beds etc), public policy, and other correlates of public health such as education, and political awareness. Most of these studies were centered around the question of role of the state in health care. The role that the private sector has played, the prevalence pattern of diseases and of provider choices and costs of treatment by illness types, sectors and systems do not seem to have the research attention they deserve.

Recently researchers have begun to make mention of the private sector; in-depth discussions on its functioning in a complex of health provision patterns have yet to come. Some studies, which have tried to incorporate the private sector, have looked at its functioning in a public versus private perspective. The existence of a grey area in the form of government doctors practising in the private sector where there is a lot of self referral and related demand inducement affecting use patterns of the health care services have not received any attention. Although Pai Committee in 1978 mentioned private practice by government doctors and Jayachandran Committee in 1996 went into this specific issue, they have only pointed out the existence of the problem, not made any in-depth analysis.

On the utilization side, research has not gone beyond the role of socio-economic stratification, that too for the use of public versus private health care provision. No study on the behavioural aspects such as “who uses what services, for what illness and why” exists.

The Purpose of the Present Study

This study aims at approaching the issue of access and utilization of health care services using comprehensive categories. It plans to analyse the health care provision, health care seeking and health care utilization as a “process” rather than as inputs or outcomes. Considering the plurality of systems of medicines and multiplicity of institutional arrangements that exist in the health sector in Kerala, we take the public sector and the private sector as the major analytical categories. Following Narayana (2000), ‘private in public’ is used as a third analytical category to study questions of access and utilization. We examine the role of these categories, especially the role that the ‘private in public’ sector does to the overall provision, in terms of multi-location services, self-referral, practice and pricing. We try to explore the relative roles of access, cost and quality on the utilization patterns of health care services. The influence of differentials across socio-economic, gender and age groups on utilisation patterns
is also examined. We also make some effort to place the incidence of morbidity and utilisation of health services in a quantitative framework.

Objectives of the Study

The specific objectives of this study are the following.

1. To examine the existing provision of health care services in their plurality, spread and magnitude;
2. To assess the different aspects of the diverse types of provision and their relative contribution to the overall health care provision;
3. To understand the morbidity patterns - short duration (acute) and long duration (chronic) among the population by locality, age group, gender and socio-economic background;
4. To analyse the patterns of utilization of health care services according to illness characteristics across sectors, systems and institutions by access, cost and quality of treatment;
5. To analyse the choice of health care provider in the context of multiple provisions and the determinants of provider choice;
6. To quantify the direct and the indirect costs of treatment by their individual components.

The Study Outline

The study is presented in the following order. First we explain the rationale for a study of the access to and utilisation of health care, and of the provider choices made by the users. In order to provide the contextual background of the study we then explain the theoretical as well as empirical issues. An exploration of the empirical literature on the subject of access and utilization of health care services brings out the gaps in research. This is done in Chapter 2. The proposed framework of analysis, the methodology for collection and interpretation of data are also explained in this chapter.

Chapter three is on the provision of health care services in Kerala; the discussion in this chapter provides the background for the analysis of the providers' behavioural patterns regarding practise. The area of study and the details of the fieldwork done for data collection are discussed. The systems and sectors of medical care in position in the state are also examined in this chapter.
Data on the provision of health care services at the macro level undermine the actual level of provision. It however does not reflect health practices that are essential for an understanding of health care provision that is necessary for an evaluation of the micro reality of utilisation. Chapter four analyses the patterns of health care provision and practices.

In order to understand the health care utilization scenario, an assessment of the morbidity patterns is essential. Illnesses of the acute and the chronic types, and the differentials in morbidity patterns across different socio-economic groups and age groups as well as between sexes and locations are analysed in Chapter five.

Given the morbidity patterns, the provision characteristics and the individual attributes, the question as to how choices of the provider and utilization of health care services are made is examined in Chapter six. The utilization of health care services obviously involves cost. However, costs differ across systems, sectors and institutions. A discussion of the cost aspects is attempted in Chapter seven. In chapter eight, the determinants of morbidity as well as of provider choice are discussed in a multivariate logistic framework.

The analysis endeavour to show how in a health care system such as the one in Kerala, characterized by its plurality, the use patterns are dominated by the provision characteristics and the levels awareness, confidence and willingness to avoid of the provision on the part of the patients. It hopes to bring out the health care environment in the state and the manner in which utilisation of provision is governed by access, cost and quality of services.