Chapter VI
Summary and Conclusions

Health is on the one hand a highly personal responsibility and on the other a major public concern. It thus involves the joint efforts of the whole social fabric, viz. the individual, the community and the state to protect and promote health.

Health status of populations, as of individuals, has two broad influences, which ultimately shape it: one, which can be characterized as the natural or genetic endowment, and the other as the environmental influence. The importance of one the other in particular situations may be debated, but it cannot be denied that in order to study the determinants of health, both groups of factors have to be considered.

The socio-economic status of an individual plays an important role in deciding the health status of the individual. This is well understood from Anderson’s model. According to Anderson’s model, three sets of determinants are identified as influencing the health care utilization pattern of a population. Society and systems determinants are postulated to influence individual determinants, which directly impinge on service use. Societal determinants include the current state of knowledge as well as people’s attitudes and beliefs about health and illness. The factors operate either directly to influence the individual determinant or indirectly through their influence on the system factors. System factors include health service resources (both volume and distribution) and organization of health services. However, it is the individual determinants that are directly related to health services and its utilisation.
Health is a fundamental right. It has the characteristics of a public good, which makes it imperative for the government to enter into the market. It is the duty of the government to provide basic health facilities.

Health, as a commodity, has an abnormality. It exhibits three distinctly different characteristics – those of public, merit and private goods. Most of public health and preventive measures are public goods. Merit goods comprise services such as family planning and certain primary care services whose consumption produces greater social benefit than private benefit. Another type of merit good, such as vaccination, produces externalities. A third type of merit good, includes services such as emergency services for trauma patients and medical services to relieve acute pain and basic health services to vulnerable people possessing significant interpersonal utility value. Finally, merit goods also include services where individuals lack sufficient education or rationality to make rational consumption decisions. For example, many people significantly discount preventive services that produce future benefits. As for private goods, most of the curative medical services and drugs fall into this category. Hence, only private goods have certain market characteristics.

According to economic theory, it is socially optimal for the government to finance and possibly provide public and merit goods while it may be more efficient for the free market to finance and provide the private good.

Against all the descriptions quoted above, it is felt that the segregation of different types of health provision changes ultimately according to the nature of purchase of service. If it is mostly out-of-pocket expenditure, market failure can exist in the case of health care delivery. It is usually this existence of market failure, which is quoted as the reason for government intervention in health. But it is quite often seen that government too, can fail if it fails to get ‘value for money’
renever it devotes public resources to health. And, in a situation where
government failures outweigh market failures, ignoring them can lead to large
public expenditures that benefit only the nonpoor or to services so defective that
their opportunity costs outweigh their benefits for most poor people.

The scene is made even worse in the case of economies, which have
adopted structural adjustment programme. There has occurred a conscious cut in
health expenditure. Primarily as government moves out of the health sector, where
a previously existed as a major provider of health services, the private players
come in. This increases the cost of acquiring health services. Keeping into
consideration the heterogeneity of the population within the country itself, not all
are affected due to the reduction in public health expenditure. It is the
economically disadvantaged who bear the brunt of the situation.

In India, since independence, health was overlooked in the overall, larger
development process. This resulted in an ad hoc approach to health without
linking it to other aspects of development like clean water, sanitation, removal of
poverty etc. The adoption of ‘primary health care approach’ in 1983 has shifted
the focus to primary prevention technique i.e., the approach prevents the condition
starting. It considers a more realistic, holistic view of the problem of health care.

Given the background of the poor health infrastructure, males and females
suffer from ill health. However, women face unique risks because of their
reproductive biology, and in a country with one of the world’s highest maternal
mortality ratios the dangers are particularly pronounced. One important
component of ‘primary health care approach’ is maternal and child-care, including
family planning.
The general health status of India reemphasizes its position as a third world country. However, the state of Kerala, a small state in India, paints a different picture. It is a state at par, with the socio-economic indicators comparable with that of the developed nations. The indicators of maternal and child health are almost equal to those of the West.

The research problem is centered on the utilization of health care facilities in the state for obstetric care. The problem assumes significance given the fact that above 97% of the deliveries in the state are institutional in nature. The ratio of deliveries in the private sector is 60% as against a share of 40% for the public (government) institutions.

Of the fourteen districts in the state, Ernakulam was found to have the largest number of private medical institutions. So, the district was selected as the sample district. Data were collected from thirty-three for-profit, private hospitals (population was ninety hospitals with mini-theatre facilities in the district) and all the government hospitals with the above-mentioned facility. The efficiency score for the hospitals was derived with the help of Data Envelopment Analysis, a linear programming based model. The efficiency concept used is that of technical efficiency. Due to differences in objectives, public and private providers should only be compared on the criterion of productive (i.e., technical) efficiency because it is "the only objective shared by both types of producer and the only objective not in conflict with other goals of the public producer".

Hypothesis of the study was that there is no efficiency difference between the public and private hospitals in delivering obstetric care. After analysis of the data and interpretation, the hypothesis was rejected as Private hospitals were found to be more efficient than the public sector.
Results of analysis

After analysis, it was found that the efficiency of private hospitals (0.8197) delivering obstetric care is much more than that of public hospitals (0.6648). Around 64% of the private hospitals had an efficiency score of 1 (which is the maximum possible score). The same is true in the case of 57.1% of the public hospitals. In the second stage, an attempt was made to find the institutional factors, which contributed to inefficiency in delivering obstetric care facility. A truncated regression was performed towards this end. The major output indicators were regressed with the efficiency scores to identify the institutional contributors of inefficiency.

From the series of analyses performed on the data collected, it is clear that the private hospitals are definitely in a better position as far as the technical efficiency is concerned.

As regards the technical efficiency, the attempt is to look at the provision and utilization of obstetric care services from the providers' perspective. The problem is the most efficient utilization of the facilities provided. The nurses availability ratio and equipment index are found to contribute positively to both public hospitals and private hospitals. This could be due to essentiality of the particular staff and also equipments in the case of obstetric care. The process of delivery, which consumes an average of four to five days of hospital confinement in a woman's life, has now a days become high-tech in nature. The process of delivery has become highly equipment-centered. Even in the absence of a qualified medical practitioner, the experienced staff (nurses) can keep efficient vigil with the help of the equipments. Foetal and maternal distress can be detected and monitored even in the absence of a doctor and timely intervention can be precisely planned by the time the qualified medical practitioner arrives.
Doctors' availability is another positive contributor to efficiency as far as public hospitals are concerned. This is due to the negligibly paid service available in the public hospitals. It is only natural that the poorest of the poor still have only one resort – the public hospitals. Medical care is highly physician entered. In the case of government doctors, they belong to the 'private in public' segment of providers. So they assure that whoever is approaching them for OP consultation, will be their clients till term. The availability of beds (which cannot be guaranteed otherwise) are guaranteed for such patients. In the private sector, economies of scale, economy measures of the management and multiple-hospital consultancy of gynaecologists together make it a negative influence on the efficiency of hospitals. The other factors like non-technical ratio, bed occupancy ratio, and physical infrastructure ratio are found to have a negative effect on efficiency of hospitals.

The poor performance of the public hospitals can be well justified with the fact that the capital expenditure going in to the health sector is getting reduced year after year. The combined contribution of the government and the hospital development societies is not found enough to pull up the public institutions to a satisfactory level of functioning.

When the essential staff ratio of the private hospitals are compared with those of public hospitals, the customers can be found better disposed in the case of private hospitals. When the doctors in the private hospital take care of 2.09 inpatients per doctors' day, those in the private hospitals take care of 2.97 inpatients per doctors' day. This may not be due to the over-supply of patients. This could be so because, as far as the number of doctors available is concerned, there is an under capacity of the hospital. Another possible factor is that, in government hospitals recruitment of doctors do not take place that often. The strength of staff does not increase that often. It is already discussed that even
though the salary component of health expenditure rose, it did not result in increased staff strength. Manpower in the government allopathic system declined or remained static during the 1990s while the bed strength grew moderately.

When the nurses in the private hospital, on an average take care of 0.92 inpatients per nurse day, those in the public hospitals take care of 1.42 inpatients per nurse day. This could be due to the fact that there is an excess number of nurses in the private sector as against the public sector. This is a case of exploitation of labour. The nurses, in the public sector, on an average, take home a salary of around rupees six thousand per month. It has to be noted that they are all graduates in nursing care. In the private sector, the hospitals are found employing nurses, who are only diploma holders, for an average salary of around two thousand per month. So, naturally in the place of one nurse in the public hospital, a private hospital can employ at least three more nurses. Another trend found in the private hospitals is that, most of the large hospitals have nursing schools run by them. The students joining the course are forced to execute a bond assuring the management that they will serve the hospital for a specified period of time on the payment of stipend. All these add to the total number strength of the ‘nurses’ force’ (sans proper qualification) in the private medical institution.

As far as non-technical staff is concerned, in the private sector, 1.4 inpatients are served per staff day as against 1.1 inpatients per staff day in public sector. But this is not a very significant difference. It can be interpreted that the doctors, the nurses and beds remain underutilized in the case of private hospital, or that there is idle capacity in the case of private hospital.

The comparison of mean values of explanatory variables show that there is an over-utilisation of facilities in the public sector as compared to the private sector. The available resources are found maximum utilized in the government
sector. As the efficiency score clarifies, this cannot be a final test for efficiency. It can be confirmed that the over utilized facilities offer low quality care. High occupancy rates and turnover rates could also be taken to suggest that the problem is more of under-capacity than oversupply.

Private versus public – the consequences

It is often seen that the health care in the private sector has been almost entirely curative in nature. In India, with about 85% of the doctors working in the private sector, practice chiefly curative medicine. Not only that, since the expansion of the private sector is taking place rapidly and account for over 80% of the health expenditure of the country, the overall trend is towards curative medical care. This is indeed highly detrimental to the interest of the community and is progressively reducing the social efficiency of the medical profession in making contribution towards improving the health status of the people.

More significantly, private sector has far outpaced the government facilities in the provision of sophisticated modalities of diagnosis and therapy, such as CT Scans, MRI Scans, Endoscopy Units etc. Simultaneously, public sector itself is being subjected to internal privatization. Because of the irregular supply of medicines and other materials patients seeking medical care from the government hospitals are forced to buy them from outside. Also the laboratory facilities are quite inadequate in the government hospitals and patients have to depend upon the private labs for getting investigations done in time.

In India, the private sector almost exclusively works on user charges, because insurance coverage is negligible. There are no restrictions or guidelines from the Medical council or the state on the quantum of fees charged by the doctor, the nursing home or hospital. In the for-profit private sector, this situation
as encouraged increasing of charges, especially by the experienced and well-known doctors. It is also seen that such doctors earn disproportionately high income as compared to their declared income.

While health care access for people in the rural areas is not that comfortable when compared with those in urban areas, (this rural-urban distinction is only partially applicable in the Kerala context, where we don’t have rural urban duality, it is a rural-urban continuum that we have) the problem in the urban areas is that of rising medical care cost. This rise in cost is not just due to the fee paid to the ‘celebrity doctors’, but also due to the usage of high technology. Doctors are regularly trained in the most recent, advanced medical technologies. In addition to the increasing cost, this trend is also found encouraging a tendency to advertise these technology/ ‘facilities’ to the general public. This becomes necessary because the investment involved in the purchase, housing and maintaining such instruments run in to crores and in the market set-up, for getting adequate return on such investment, continuous and unnecessary use of the instrument becomes an economic necessity. The issue of over medicalisation is another dangerous by product of surging private practice in the nation. A large majority of 50,000 drugs and formulations available in our country are hazardous, useless, unnecessary and irrational. Such products not only harm the interests of consumers and inculcate irrational medical practice, but are also causing waste of resources and increasing cost of medical care. This ruthless resorting and irrational over medicalisation in private practice is related to supplier-induced demands.
It is well recognised that the market failure affecting both the demand and supply sides of the market for health services will have significant implications for cost and quality of health care. Given the undesirable consequences of private sector growth in health, there has been virtual absence of various mechanisms, both within the government and outside the government, to influence the growth of this sector in desirable direction. The studies indicate that private health care significantly affects both the cost and quality of available health care services in India. The only possible solution is regulation of health care industry.

Regulation occurs when a government exerts control over the activities of individuals and firms. More specifically, regulation has been defined as “government action to manipulate prices, quantities, (and distribution), and quality of products”. The exact “action” is often described as the regulatory intervention or regulatory mechanism and can be legal controls or incentives. Legal controls are legislated requirements that can lead to punitive action if they are not met. To be effective, regulation requires substantial information and enforcement machinery. The regulatory process involves setting the policy agenda, designing the legislation, and implementing and enforcing its requirements. Regulation serves to discourage perverse practices and to improve equity.

The factors that contribute to the poor quality of services offered by the private sector are lack of monitoring by authorities, outdated and inadequate legislation, and the inability or failure of the government to enforce existing regulations. The respective medical councils in states in India are not enforcing the laws relating to the registration and licensing of individual practitioners. This situation has required the judiciary to intervene in affairs that should have been handled by the medical councils. The studies also indicated that professional
odies, whether sanctioned by government or voluntary medical associations, have not played a significant role in improving the practices of private medicine.

The failure of the government to enact the necessary legislation and strengthen existing laws permits many of these market imperfections to proliferate. In many instances, powerful medical lobbies have opposed the government’s efforts to regulate. Many state governments that wanted to enact and implement legislation governing private hospitals found their efforts thwarted.

In India, with its dominant private health sector and relatively weak government oversight, there is a need to develop self-regulatory systems that involve the stakeholders and that are less threatening to providers than government regulation. One of the foremost steps for any intervention or involvement would be to develop an appropriate information base on the private health sector. Many governments are handicapped by a lack of information on this dominant sector. Information on private providers could be linked with registration and licensing mechanisms. The presence of a strong public health care system is important to check many of the undesirable and unintended consequences of growth of private sector. The access and availability of public services critically influences the price structure, availability and even the quality of services in the private sector.

Until recently, professional bodies exercised regulatory authority over medical and allied professionals in India. Although several explanations can be given for regulatory authorities’ lack of control over their members, it cannot be denied that they were also constrained in their performance by a lack of autonomy and certain external factors, such as civic-public interactions, political structures, and preference. However, they also clearly suffered from a lack of motivation and self-interest, which undermined their efficacy.
In India, there is no system of effective continuing education of doctors engaged in medical practice. Once registered with the medical council, the doctor is not required to undergo retraining or examination for renewal of registration. As a result, there is no effective mechanism to provide correct information to doctors and to orient them to rational medical practice. This lacuna in doctors continuing education is sought to be filled by the industry through their medical representatives. It is virtually that educates doctors after they start practicing. This often-unholy alliance is detrimental to the interests of the patient.

These follies on part of the doctors and the system as such get reflected in obstetric care delivery in magnified proportions. The concern for the baby and the mother is emotionally exploited by the doctors. The unnecessary prescription of medicines, tests, ultrasound scans at different stages of pregnancy and at the last stage going in for caesarean delivery has all become a part of a ‘medical racket’ to which the doctors are also a party and the women are victims.

Standard models of hospital behavior, discussed by Leemore, 2003, predict that hospitals will respond to a diagnosis-specific price increase by raising the intensity of care provided to patients in that diagnosis, where intensity is measured by total costs, length of stay, number of surgical procedures, and number of intensive-care-unit (ICU) days. This explains the highly technical and unnecessary interventions and the increase in the case of caesarian sections in the specific case of obstetric care delivery.

For example, now Kerala has one of the highest rates of caesarean deliveries in the world. Caesarean rates were reported to be 22% of all deliveries in rural areas and 34.5% in urban areas. (In the present study, the percentage of c-sections to normal deliveries in the study field was around 60% and 40% respectively.) The extra cost of caesarean deliveries in the state was estimated to be
Rs. 25 million (US$ 540 000) in the year 2000. Around 75% of the pregnant mothers had at least one ultrasonography test without any notable change in the management or outcome of pregnancy.

Whatever is the nature of competition between the public and private sector, or the regulatory environment in the state is, the fact that the private sector is influencing the public sector must be accepted. The public sector does not merely coexist with the private sector. Since private sector is dominating above 60% of the patient market and has more than 80% of the doctors working for it, the public sector is in many ways led by the private sector. The reality is that the norms of medical practice are therefore set by the private sector. The value system of the private sector medical care, namely, commercialization, high technology orientation etc. have come to dominate the practice of medicine.

Women as a genre, are a health-wise high-risk group. Women face unique risks because of their reproductive biology, and in a country with one of the highest maternal mortality ratios, the dangers are particularly pronounced. Obstetrics is largely preventive medicine. The aim of obstetrics and preventive medicine is to ensure that throughout pregnancy and after delivery, the mother will have good health and to ensure that every pregnancy will culminate in a healthy mother and a healthy baby.

Maternal mortality claims 514,000 women’s lives each year. Nearly all these lives could be saved if affordable, good-quality obstetric care were available 24 hours a day, 7 days a week. Most of the deaths are caused by haemorrhage, obstructed labour, infection (sepsis), unsafe abortion and eclampsia (pregnancy induced hypertension). Indirect causes like malaria, HIV and anaemia also contribute to maternal deaths. For every woman who dies, an estimated 15 to 30 women suffer from chronic illnesses or injuries as a result of their pregnancies.
Obstetric fistula is a serious and isolating injury that would be significantly prevented through Emergency Obstetric Care. About fifteen per cent of all pregnancies will result in complications. Most complications occur randomly across all pregnancies, both high- and low-risk. They cannot be accurately predicted and most often cannot be prevented, but they can be treated.

Unless and until accessible medical care is given to women, the government can never even think of talking about equity in health care provision.