Chapter I
CHAPTER I

DECENTRALISED HEALTH CARE DELIVERY SYSTEM IN THE UNION TERRITORY OF PONDICHERY

1.1.0. Background of the Study:

As a developing country, India faces a big challenge in providing a good quality of life for its citizens. There is undisputable evidence that suggests that economic growth goes hand in hand with the well being of the nation’s populace. Good health of individuals translates into personal development and economic security, which in turn creates a healthy populace that is critical for poverty reduction and sustained economic growth.

The efficiency of any healthcare service across the globe is determined by the availability of healthcare providers who can provide quality services, availability of drugs and medicines and cost effectiveness. Over the years, health services in India have been provided mainly by three sectors: the government (public), the private (for profit) and voluntary organisations. Although there has been a higher growth in government infrastructure after Independence, there is still a general expressed disillusionment and frustration regarding its efficacy. Studies conclude that quality of health care through public health delivery systems such as Primary Health Centers (PHC) needs to be improved. The public health system in India has been administered at the State levels as health is the “State Subject” with the national perspectives and directions as per the Constitution of India. The healthcare has been organized in three levels viz., primary, secondary and tertiary in the State. Most of the primary health care services are delivery through
Primary Health Centres (PHCs) and Sub-Centres (SCs) at the decentralised levels in the State.

Decentralisation is a striking policy issue, and has drawn substantial attention from a number of researchers, policy makers and policy analysts. Decentralisation plays a significant role in both developed and developing countries, because it tackles and to a large extent addresses the issue of effectiveness and efficiency in producing and providing services. Often, decentralisation is part of the wider reforms in health, which are undertaken by governments in the will to design health systems in a way that will maximize use of the scarce resources to meet ever increasing demand. As advocated by World Bank (1993), decentralisation should enable greater participation of people in development, planning, administration, more equitable distribution of benefits of economic growth to increase the productivity and income of all segments of society and to raise the living standards of the poor. In the health sector it meant increasing allocative and technical efficiency, local revenue raising, community participation and encouraging self-reliance. In other words, decentralisation could be perceived as a tool for change.

In fact, the system of centralised planning is under attack in the new era of liberalization in developing countries including India. The role of government run rural health care services is highly centralised with very little autonomy either over their programmes or resources. The common problems faced by this centralisation process were

- Service are unresponsive to local demands and needs partly because the population has few alternatives
- In spite of low services, there is an excess capacity in infrastructure with corresponding shortage of supplies and staffs
- Staffs are assigned responsibilities with no relation to output of services
Referral system do not work as many patients bypass the rural health infrastructure by going directly to hospitals

In the light of problems of centralised healthcare planning, it has been argued for decentralisation, which can reduce technical inefficiency (Rondinelli et al. 1983; World Bank 1997), can reduce bureaucracy and increase the speed of decision-making (Silverman 1992; Mills 1990), can increase representation by local populations—and therefore the potential for improvements to be more sustainable (World Bank 1997), and can bring service provision more in line with local preferences (Tiebout 1956; Oates 1972). In its Health Financing Policy Paper, the World Bank (1987) proposed decentralisation as one arm of a sector reform strategy that has since become a standard policy prescription in international development.

The long tradition of local governance and service provision has made possible this decentralisation of healthcare services through PRI’s (Panchayat Raj Institutions), most of which have population of fewer than 15,000. This PRI’s can provide services themselves or contract services from NGOs. Therefore, the extent of decentralisation leads to the consequent small size of many local bodies. However, the main concern about decentralisation is related to inequities between areas. The increasing exercise of user fees is known to be a more inequitable means of financing health care than direct taxation. This has been associated with increasing willingness on the part of local bodies, health professionals and hospitals to recover costs from patients. Although user charges are an inequitable and inefficient way of financing health care, they have remained as an official agenda. This increasing cost sharing by users has made it harder for the lower income groups to cover these costs. Thus Decentralisation need not imply as increase in cost sharing by users, but additional consideration needs to be given to the extent of choice allowed in financing services. Therefore, decentralisation of health care services may be organized in ensuring the equity aspects without comprising the quality of health care and means of financing of health care services. The rationales of decentralisation need to be analyzed in the Indian
context. On this background, the present study is setting a research problem specifically for Union Territory of Pondicherry (UTP) in India.

1.2.0. Statement of the Problem:

Healthcare system is an institution through which healthcare is provided to one and all in the Union Territory of Pondicherry. It is supported by the healthcare financing and delivery systems. The financing of healthcare, which is one of the major functions of health systems, has three inter-related areas (a) collection of revenue, (b) pooling of financial resources and (c) use of financing resources either by allocating them or purchasing interventions. It reflects generally five primary methods of funding healthcare systems such as (1) Out-of-pocket payments (OPP), (2) general taxation, (3) social health insurance, (4) voluntary or private health insurance, and (5) community health insurance or micro insurance. The healthcare delivery system could be explained in terms of utilization of healthcare services. The main challenge of healthcare financing functions in the UTP is to harmonize them through protecting people financially in the fairest way possible. This is achieved by providing appropriate incentives that are given to healthcare providers and motivating them to improve the health of the people which eventually improves the responsiveness of the system. However, the current healthcare financing system in the UTP has not sufficiently supported through government’s public funding method in terms of annual budget allocations. It is evident from the estimation that the government healthcare expenditure in relation to State Domestic Product of the UTP has been remained less 1 per cent over the 25 years of planning. The highest 0.85 per cent has been recorded only in 1996-97 in the UTP, which is more or less portrays a national level trends and patterns. As a proportion of the total health expenditure in the UTP, it accounts for under 20 per cent over the years, making UTP a member of a small group of States in extreme distress.

The total population of the UTP is less than 1 million (i.e, 974 thousand people) as per 2001 census survey of Government of India. This one million people
has to be provided with easily accessible healthcare services within an average distance of less than one kilometer distance. In fact, the primary healthcare services has been catered through 39 primary healthcare centres (PHCs) 75 sub-centers (SCs), 12 Employer State Insurance’s (ESI) dispensaries and 17 disease specific clinics such as chest clinic, STD clinics, leprosy and malaria clinics in the UTP. These healthcare organisational networks at the UTP have been a failure on both efficiency and equity grounds in the UTP. On the efficiency ground, for example, though official figure claims that the government healthcare services are accessible within an average distance of 1.14 kilometers (kms) in the UTP, the potential government healthcare providers are not meeting the actual demands of the people. It implies that the government healthcare facilities are nearby but there will not be doctor. If even there is an availability of the doctors, there will not be drugs and medicines and the patients will get only piece of paper, which is a medical prescription and for that the patients needs to pay for the drugs and medicines at the available pharmaceutical stores. Therefore, the government healthcare facilities at the decentralised level have failed to meet the actual demands of the people in efficient manner. This is essentially because of the inadequate public spending that has been a constant unfortunate feature of not only at the UTP but also at the national levels.

The failure of the public healthcare system in the UTP, most of the people push to opt for private healthcare facilities, which often increase of out-of-pocket expenses account for all the private healthcare expenditure. This is inherently regressive and puts a disproportionate burden for healthcare on poor households. Most of the existing studies demonstrate that the curative healthcare services at decentralised level are delivered by the private nursing homes and hospitals irrespective of the presence of public healthcare system. Some studies show that rural people seek private healthcare services because of the efficiency and cost effectiveness as compared to the government healthcare service (Mathiyazhagan 1999). Further, results from the study carried out based on household survey of NCAER-UNDP in 1994 indicate that there is a significant difference in the choice of healthcare provider among the rural people and private healthcare provider are playing a dominant role in India (Mathiyazhagan, 2001). Another study suggested
that the perceived quality of services is more important than fees paid in the choice of health service. (Gilson et al. 1994, Mathiyazhagan 2003). This raises several questions.

- Are people seeking the private sources of healthcare out of frustration or do they seek them because they are efficient and cost effective?
- If so, what would happen to the population when such services are scarce in rural areas?
- Can voluntary healthcare services appearing on the scene in recent times fill the gaps in such a context?
- Are the private doctors in our country, functioning in a market economy answerable to the public not taking undue advantage of the scarcity?
- Do the Panchayat Raj Institutions (PRI) provide a basis for sustainable improvement in healthcare delivery system?
- Do the PRIs get adequate resources for efficient functioning of healthcare units?

Answers to these questions are important in the context of decentralised governance in organizing and delivering healthcare services. Recognizing the problems of healthcare delivery systems of public, private, and voluntary sources, there is a significant support on decentralised healthcare delivery system through Panchayat Raj Institutions by the policy makers at the State levels in India. In fact, the recent economic reform movement justifies the decentralisation at the grass roots level may increase efficiency in government healthcare services like the small UTP. Indeed, the existing Panchayat Ray System becomes an instrument for organizing the delivery of rural healthcare services in the UTP. However, these Panchayat Raj institutions are not having any substantial network to manage and provide the healthcare services to the rural people. Moreover, the efficiency and performance of village level health system is questionable. Most of our PHCs, Community Health Centre, and Anganwadis are semi-functional or non-functional and this has attributed to the high rate of chronic anomalies among a large number of people in the UTP.
In the present situation, the villages, which are not having any health units, may have a problem of organizing their own healthcare services. There is a need for an integrated healthcare program or a scheme, which could increase the efficiency of the healthcare system at the decentralised and protect financially the poor people in the UTP. Further, there is also evidence that people are paying for healthcare services at the private facilities. This could be reduced in terms of risk pooling methods or Community Based Health Insurance (CBHI) scheme at the decentralised level. However, there is no study to demonstrate that are there any viable options for alternative healthcare financing concurrently with government healthcare financing at the decentralised level in the UTP. It needs an assessment of not only the morbidity pattern, choice healthcare provider and its expenditures but also the people's willingness to pay for any healthcare alternative financing methods at the UTP. In this context, the main objective of the present study is to analyze "Healthcare Delivery System at Decentralised Level" and to suggest policy options and strategies for Union Territory of Pondicherry.

1.3.0. Objectives of the study

Based on the issues raised in the statement of the problem and research gaps emerged in the review of literature, the following objectives are framed:

- The general objective of the study is to analyze the healthcare delivery system at decentralised level and suggest the policy options and strategies for the Union Territory of Pondicherry.

1.3.1. The specific objectives are:

- To examine the structure and organisation of the healthcare delivery system of the government at decentralised level.
- To evaluate the role and levels of healthcare services provided by private and voluntary sectors at decentralised level.
To investigate the efficiency of healthcare services of the public, private, and voluntary sectors at decentralised level.

To study the accessibility of healthcare services provided by public, private and non-government (voluntary) at the decentralised level.

To study option of viability of alternative healthcare financing methods for the healthcare delivery system at decentralised level.

To suggest the policy options and strategies for efficient healthcare delivery systems at decentralised level.

1.4.0. Data Material and Methods:

The study focuses only on Union Territory of Pondicherry in order to analyze the healthcare delivery system at decentralised level and suggest policy options. In order to fulfill this objective, the approach to analyze is a combination of both formal and informal research methods.

The formal method is based on collection of data published by the Department and Directorate of Health at both Union territory level and national level. It reflects the state geo-demographical and health characteristics, the determinants of demand and supply of healthcare services, constraints and risks of the Union Territory in terms of delivering and organizing healthcare services at decentralised level. These reflections are captured in terms of indicators analyzed based on growth, trends, patterns and its proportions within the Union territory as compared to the national level. It also includes the analysis of people’s choice of healthcare provider and design of hypothetical health insurance scheme and people’s willingness to pay for the scheme.

1.4.1. Research approach:

The study conducted with two research approaches viz., survey research and heuristic / documentary research for the primary data. The survey method, used to get the data for available rural healthcare services through private and voluntary
organisations, the cost of the services, and the value judgment on the healthcare of the people, and their satisfaction with existing healthcare services. The heuristic/documentary method will be used in order to obtain the opinions of the people on community based health insurance scheme at the decentralised level. The secondary data for the structure and organisation of healthcare delivery system at decentralised level were collected from the published records of Government of Pondicherry.

This study is confined to the entire rural segment of the Union Territory of Pondicherry. There are 237 inhabited villages with a population of 2.9 lakhs (2001 census), spread over essentially over two regions, since Mahe and Yanam are considered entirely urban. A two-stage sample design is employed. In the first stage, all the Communes were visited in both the regions. Since socio-economic development is diverse among the villages, it was decided to use a post stratification of 1702 individuals of the selected 404 households. The criteria used for stratification were sex, occupation, age, education level and caste in order to ensure the representative nature of the sample.

In order to find out the cost efficiency of the public and private hospitals in the UTP, the study also has carried out a hospital facility survey. It selected 40 hospitals and 20 hospitals each respectively from public and private sources.

1.4.2. Analytical Methods:

The analytical methods used in the study are directed to achieve the specific objectives. The chief methods are as follows:

- **Trend Analysis** based on least squares principle to examine the structure and organisation of the healthcare delivery system.
- **Qualitative models like Logit or Multi-nominal** for analyzing the role and levels of healthcare services provided by government, private and voluntary sources.
• Chi-square tests are used to examine association between morbidity pattern and attributes like age, occupation, income level, education and caste. The same test is used to measure the bi-variate magnitudes of the morbidity and socio-economic characteristics of the people.

• Two stage least square method is used to estimate the determinants of the household healthcare expenditure and its the component.

• Hospital cost efficiency function of the UTP has been estimated by setting parametric and non-parametric models. It uses the Stochastic Frontier Analysis (SFA) and Data Envelopment Analysis (DEA).

• Examining the scope of financial and provision providers of healthcare services to determine the viability of community based health insurance scheme through a Contingent Valuation (CV) approach. The same analysis also examines the people’s willingness to pay for CBHI scheme as an alternative healthcare financing provision at the decentralised level.

1.5.0. Limitations of the study:
The study has the following limitations

• In view of the time constraint, a sample survey has been carried out rather than a census of the households.

• Lack of details in the secondary data about the individual programme expenses made by health sector.

• Non-feasibility of direct investigation of long term diseases in a short time frame of the study.

• A recall period of just four weeks used in the study may not be really adequate to monitor and assess the morbidity situation.

• Inaccessibility of source of information in Non-government sectors.

1.6.0. Chapter scheme:

Chapter I sketches the problem, research issues, objectives, data sources and methodology of the study. The concepts and review of literature are covered in the
Chapter II and followed by the profile and organisation of the health sector in Chapter III. The analysis of morbidity pattern at the decentralised level of the UTP is placed in the Chapter IV. The demand for curative healthcare services and the decentralised is analyzed in the Chapter V. The Chapter VI is having the detailed analysis on the cost efficiency of the public and private hospitals at the decentralised level in the UTP. Healthcare expenditure of the households are covered in the Chapter VII. This chapter also covers the components of the healthcare expenditure and its determinants of the households in the UTP. The Chapter VIII presents the analysis on the viability of alternative healthcare financing at the decentralised level. It also discusses the hypothetical community health insurance scheme, the people’s willingness to pay for the proposed community health insurance scheme in the UTP. The final chapter summarizes the major findings and research recommendations, including the scope for further research work.