Chapter-V

Discussions and Conclusion

This chapter attempts to summarize and reorganize the data analysed so far to bring out the emergent changes in the health care scenario of this country and the implications of these changes on public health. First, the study shows very obvious implications due to the changes in the health sector and some of the implications raise important concerns regarding the principles of health equity. Health equity is a very important principle of Public health and that should not be impinged by any policy decision in a country like India where large sections of its population are under poverty. Further, there are certain suggestions aimed at reducing the negative implications of the current developments especially on the vast majority of the poor people in this country. Second, the case study of Tirunelveli brings into fore many important and interesting facts in the development of private sector health services. There are hardly any studies on medium sized or intermediate cities as has been earlier noted. The private sector in Tirunelveli represents an emerging scenario that reveals the nature of private sector expanding in intermediate cities that can be conceptualised within a socio-economic framework. The case studies done in the city of Tirunelveli among different social classes on their utilisation pattern of health services gives an empirical insight to arrive at certain suggestions or recommendations in improving the state of affairs of India’s health care.

Summary of Findings

The first chapter describes and explains the growth of private sector in health care in India. Private sector in health care has a very dominant share in India’s health service delivery but it has been largely underestimated and neglected by the policy makers while formulating any policy, plan and strategy in the past. The private
sector has grown and diversified significantly in the last sixty years. During the initial periods after the country's independence the public sector was in its infancy and it was the private sector largely in the form of traditional healers practising indigenous system of medicines, which catered to the health, needs of the population. There were also a few private practitioners and hospitals offering allopathic care in big urban centres offering services mostly accessible only to the rich. The planners envisaged a public sector that would bloom to provide services to all people irrespective of their abilities to pay for it. The idealism and vision of the planners never materialised at a functional level while the private sector has grown enormously in enviable proportions. There has been number of variables that have contributed to the growth of the private sector and the most important among them are the social, political and economic factors.

In the last sixty years, the public sector in health care has received very little funding from the central and state governments. The meagre financing of public sector in health care created an environment within the mixed economy, which set up space for the private sector to grow and develop. The private sector seized upon this opportunity since health care had a very high demand. The structure of the private health sector is very complex since it includes a range of services from the state of art corporate hospital in the metropolitan city to the illiterate, unqualified medical practitioner who caters to the unsuspecting villagers or the slum dwellers. Though the primary goal of any private sector health services is profit making, there are also a less number of services within the private sector offered by charitable organisations, individual philanthropists, and co-operative civil society groups. The private sector would include both advanced modern allopathic medical care and indigenous systems of medical care.

The development of the private sector in health care has been largely dependent upon the public sector. The public sector educational institutions in medical sciences created a pool of health care professionals that was increasing everywhere but they were not
absorbed in the public sector due to lack of expansions in the services. Hence most of the professionals sought job in the private sector or became self-employed starting their own clinics. Second, the demand of health care was increasing with increasing population and the respective large disease burden created a lucrative market for health care. And finally, the public sector was offering very poor and inefficient quality of services so much so that people who could afford to pay started despising public sector and started preferring the private sector. The doctors in the private sector were earning more than their counterparts in the public sector and the medical profession began to be looked upon as a lucrative career opportunity.

The emerging new social classes were competing to get into the profession since it guaranteed a way into becoming a member of the new economic elite of this country. In the mid seventies the country experienced new social groups emerging with both economic and political statuses. The help of green revolution that helped hitherto under privileged classes to gain better and visible economic statuses further accentuated this. The rise of backward classes in Tamil Nadu and Andhra Pradesh into formidable political and economic powers is a notable development. Members from these class groups started competing with the already entrenched groups and this happened in the medical profession also. This paved the way for the emergence of private medical colleges that took huge amounts of capitation fees from the new class groups for medical education. The doctors who came out of these medical colleges also started their own hospitals as an entrepreneurial business venture. The private hospitals started indulging in high-risk practices of medical malpractice in order to earn high profits since the market started becoming highly competitive and capital intensive because of the technological developments. The technological developments in health care have unfortunately increased the cost of health instead of bringing down the costs and this is a global phenomenon not specific to India. Meanwhile there was no political will to regulate the private sector since in a peripheral
capitalist country like India the class interests are always been protected and promoted by the state.

The present available data on the private sector tabulated from various health related information indicates that 82 per cent of all out patients in India seek health care in the private sector without any significant variation among different social classes. However there is a rich variation among the social classes in the use of inpatients' services in the private sector. Among the members belonging to the poorest quintile only 39 per cent of them utilise the inpatients’ service but quite contrastingly 77 per cent of the population from the richest quintile utilise the inpatients' services of the private sector (Mahal, Ajay, et al, 2001).

The second chapter brings out the macroeconomic reforms, structural adjustment and its implication for India’s health care and public health. The increasing visibility of the private sector has attracted attention among the policy makers especially in the late 1980’s. Interestingly, this has been the same period the role of World Bank has come in restructuring of health care services in many countries that were suffering from the balance of payments problem to various international creditors. Evidently, the World Bank in a report published in 1987 argued that the promotion of the private sector in health care would generate extra resources and allow the redistribution of existing government resources to the poor (World Bank, 1987). In the early 1990’s India also had to go through similar economic crises and since then the International Monetary Fund and World Bank entered the scenario advocating restructuring and reforming of the Indian economy. The World Bank had specifically advocated the restructuring of the public sector. In the health sector it meant cutting back on the investments and expenditure made in the public sector and encourage the private provisioning of health care. The World Bank further articulated since the public sector provisions are over extended there was a need to cutback the investments from secondary and tertiary levels of care and it could focus on primary
health care (World Bank, 1993). This idea is expressed with great conviction in the World Development Report of 1993 for all the developing countries that have opted for structural adjustment programmes.

The recommendations of the World Bank have been implemented by the central government and by many state governments but these policy and shifts in the roles bring in many issues of concern. There has been no doubt that the private sector already plays a very significant role and there is a need for the policy makers to identify the proper roles of the government and the private sector, and the necessary actions by the government to improve the accessibility to and quality of services offered by the private sector. But the fundamental question that remains in this context would be whether the public sector and private sector could divide between them the roles in provisioning care and function promoting the health goals of the society.

The restructuring of the public sector with its role limited to the essential primary health care services disconnecting from the interlinked secondary and tertiary levels of care is both structurally and functionally detrimental to the effectiveness of any public health since they are mutually complementing and contributing to one another. Second comes the most important question in sharing the responsibility of the state with the private sector since both are in pursuit of totally different goals. The public sector has a commitment to serve the health needs of the population irrespective of their ability to pay. And there is no doubt that private hospitals and clinics are primarily profit-seeking organisations and thus the question arises whether they can participate effectively in a partnership that addresses health problems of the poor. Already there have been vast regional differentials in the distribution of private sector and they are scarcely present in poor and rural regions of this country. Finally the private sector in India is vast and complex that has mushroomed without any regulation by the state. A few efforts by certain state
governments in Tamil Nadu, Kerala, Andhra Pradesh and Madhya Pradesh has faced severe criticisms from the doctors in the private sector and strict resistance from the owners of the private hospital. The medical professionals representing the powerful elite of the society along with entrenched class interests have made the government give in to the resistance. An unregulated private sector offers services that are hardly gauged against any standards and represents an unequal partner in any reform measure.

The existing public sector has been recommended to contract out its ancillary services to the private sector since the private sector is considered more efficient. This argument, usually made by the advocates, of the World Bank does not have empirical evidence to prove the point. It has been similarly been proved in states like Tamil Nadu where the contracting out of ancillary services to the market in government hospitals is far from satisfactory raising the fundamental questions on the economic prudence of such a move (Bennett S. and Muraleedharan V. R., 2000).

Then there is the issue of cost recovery in government hospitals by charging user fees to the patients utilising diagnostic and other facilities of the hospital. This is to tap resource for the hospital from the middle and upper income groups. The generated revenue would be used towards the recurring non-salary expenditure in running the government hospital. Any attempt in charging user fees to the poor patients would further alienate them in seeking health care from the public sector, therefore there should be attempts to identify the poor which would be a high task involving a large administration and bureaucracy. There are dangers in the whole exercise since the ground level realities have shown such exercises to fail miserably in the past for other schemes and the privileged once again prevail upon in garnering the benefits at the cost of the poor. The introduction of user fees also indirectly promotes the private sector since many would be hesitant to pay money for the services that are already mired in inefficiency and poor quality, and they would move to the private
sector thereby creating more demand in the health care market. In certain cases, like in the state of Madhya Pradesh fieldwork data reveals the revenue generated through user fees has been very low and insignificant and in most hospitals the generated revenue is not spent since there has been no precedent in carrying out such an exercise.

The health sector reform put forth has been largely devoid of any empirical evidence and is without a proper understanding of the welfare perspective in health care. The changes in the roles of public and private sector have implications for public health in India. The third and fourth chapters of this study have focused in bringing out some of the implications through a case study in Tirunelveli, Tamil Nadu. The third chapter brings out the structure and dynamics of health care services in both public and private sector with an extensive focus on the growth and characteristics of the private sector, mainly the secondary and tertiary care. The fourth chapter is on the utilisation pattern of health services among different social classes. The important factors that determine the choice of the people in choosing between public and private sectors is brought out through the case studies presented in the chapter. The city of Tirunelveli in Tamil Nadu is selected because it represents an intermediate urban location that still retains a strong rural character. There are numerous such second-class cities in India with similar character representing large populations and there have been only a few studies that have focused upon such intermediate cities.

Tamil Nadu is a middle-income state ranked eighth in terms of per capita income during the period 1988-91 when structural reforms were introduced. Tamil Nadu is a state that has made an impressive progress in health care. The state has especially progressed in health indicators that are visible through the reduction of child mortality rates and total fertility rates in the last two decades. The state has been pioneering in the introduction of noon meal scheme that has made a very positive impact on the nutritional status of the
population. The public sector health care services are considered to be performing better in comparison to the north Indian counter parts. The state government's expenditure on health is relatively high at 5.6% of total revenue expenditure in 1999-2000. Apart from the expenditure on health care a study by Leela Visaria (2000) shows the quality of health services offered by the public sector is in sharp contrast to many other states. There have been many reasons attributed to the relative better presence of public sector in health services, the chief among them is the populism practiced in Tamil Nadu politics.

However in recent times Tamil Nadu stands tall in the country for its notable private health care services. Chennai, the capital of Tamil Nadu has large number of private hospitals, most of them corporate hospitals with state of art advanced health care facilities and it attracts patients from all over the country. The growth of private sector can be attributed to the emergence of the backward classes in the last sixty years that have benefited out of the non-brahmin movement and subsequent ascendancy in gaining political power of the state. The backward classes of the state have economically gained because of the political and social mobility. Since health care has become a lucrative business there has been plenty of investment from these groups and have transformed the private sector of the state. The state also has a number of charitable missionary hospitals established by Christian missionaries from both Europe and America in the past two hundred years since Tamil Nadu has been an important region for propagating of and conversion into Christian faith.

The analysis of the private health sector in Tirunelveli needs to be seen in terms of its political, social and economic development of the various social groups in terms of caste since they have been the largest factors contributing towards the new entrepreneurial class in the city. Tirunelveli is a traditional city that has been an important region during modern times because it was an important colonial
administrative centre that was also a region of prolonged missionary activities. The missionaries had led to two important social movements for the whole Tamil society.

Robert Caldwell was a well-known Christian missionary in Tirunelveli, Tamil Nadu during the late nineteenth century. Robert Caldwell (1856) also being trained as a linguist did some research on languages in India and wrote a book comparing the Dravidian languages with the North Indian languages. His thesis formulated the idea of the Dravidian language is different from the Sanskrit group of languages and hence, the Tamil language speakers to be a separate ethnic identity native to the land. This theory was further developed by the Tamil scholars that Dravidians are the earliest inhabitants of India in order to argue that other populations were oppressive interlopers from which Dravidians should liberate themselves. This gave rise to the Tamil nationalism that was explicit in the anti-brahmin movements and anti-hindi agitations earlier led by the Justice party and later by the Dravidar Kazahagam. The city of Tirunelveli was a hot bed of the subsequent social and political activities. The dominant upper caste Vellala community of Tirunelveli was in the forefront asserting indigenous Tamil culture and identities. Later after independence when the political parties emerged out of these movements organised themselves mobilising all the non-brahmin castes under a single fold. They formed the Dravida Munnetra Kazhagam that emerged to power in 1967 routing the Congress party. The shift in the political power had greatly benefited the non-brahmin castes in various ways. The important among them are the reservation policies adopted to benefit the backward classes in education and government jobs, the sharing of political power by the non-brahmin castes and the populist policies of the regional parties such as granting free electricity to agriculture that helped the small and middle level farmers, most of them were members of the backward classes. The backward classes in the last thirty years have emerged from the shackles of the past into new elite groups.
Apart from these developments the Christian missionary activities in Tamil Nadu had greatly helped in the mobility of the lower caste groups the most notable ones are the Nadars of Tirunelveli region. They have emerged from a subaltern position into one of the powerful entreprenurial classes of the state. The heterogenity in the social composition of doctors and significantly in the ownership of private medical colleges and hospitals can be thus be explained in political sociological terms within the class framework.

The colonial administration has been instrumental in creating most of the public sector health care facilities in the city. Since independence there have been only a few developments in the city. The existing government hospital has been upgraded establishing a medical college and the state government has also established a teaching hospital for Siddha medicine. The city also has its share of charitable hospitals established by the Christian missionaries. In the last ten years there has been a spurt in the growth of private sector secondary care hospitals and a few tertiary care hospitals in the city.

The private sector hospitals have owners who are represented from various caste groups showing a heterogeneous social representation. Apart from the two hospitals, all other hospitals studied show the owners of the hospital representing various caste and religious groups. The absence of any private hospital owned by members of scheduled caste groups reflect the sad status of the marginalized groups even in Tamil society where social justice had been an important political agenda.

Most of the hospitals are offering secondary care services and only a few hospitals offer tertiary care and this indicates that middle level entrepreneurs unlike in other metropolitan cities dominate the health care market. Doctors who have earlier been in government service own most of the hospitals and many hospitals have government doctors on the roll of visiting doctors. The government doctors who practice in private hospitals usually bring down the quality of the government hospitals since they focus more on private
sector. The missionary hospitals are no more receiving funds from the western countries and therefore with very less revenue generated they find it extremely difficult to cope with offering charitable services. The hospitals are increasingly becoming capital intensive since procurement of modern technology for diagnosis and treatment are very expensive. The hospital receive loans from public and private sector banks and the whole process has become very customer friendly since banks are happy to give loans for hospitals as they are considered successful business ventures. The private hospitals have a very poor track record in paying salaries and other emoluments to their paramedical staff according to existing labour laws. Most of the hospitals have not got registered and the civic authorities of the city also do not insist the hospitals to register their premises. The registration apart the private hospitals hardly follow any professional norms or rules.

The hospitals do not follow uniform protocol in the diagnosis and treatment of patients and, they with the exception of specific instances do not report on the burden of diseases to the civic authorities. There is a discrete commission system that exists among the hospitals that refer patients to specific diagnostic centers, pharmaceutical shops and to tertiary health care centers. The private insurance companies for health care are not present in the city and even many of the owners of the private hospitals are quite unaware of it. The missionary hospitals apart, none of the private hospitals offer any concessions to the poor patients.

In the fourth chapter utilisation of health care services by different social groups show differential patterns in the choice of health care. The upper income group significantly prefers the private sector in health care. However, their choice in the private sector is not limited to the allopathic medicine and there is also high demand for indigenous system of medicine especially for chronic problems and lifestyle disorders. The private sector in indigenous system of medicine largely operates through the traditional healers and it has not been
highly institutionalised like the allopathic medicine. The lower and middle income households seek health care for minor ailments that do not require any hospitalisation mostly in the private sector. The preference for the private sector is overwhelming in outpatient care because of the convenient timings and less expenditure incurred in the treatment process. The doctors in private clinic offer consultancies both in the mornings and evenings, and most of them on an average charge around twenty rupees per visit. There is also a high incidence of over the counter purchase of medicines from chemist shops for minor ailments and while this behaviour is common among all social classes, sections of low class groups completely depend upon these services. The lower income group stop taking the medicine usually when there is symptomatic relief in order to cut further expenditure.

The middle class households though do not prefer the public sector utilise the services of the government hospital for inpatient care for maternity care and other major illnesses. However, they pay bribes to receive 'good quality' of health care. Most of these households fall under the lower economic category within the middle class. However, the upper strata among the middle-income groups utilise the private sector. The middle class households frequently change the hospital within the private sector and on certain instances between public and private sector since they give primary importance to the quality of health care.

The lower class households invariably utilise the public sector for in-patient care but they despise getting hospitalised in a government hospital because they feel the doctors and paramedical staff give scant respect, care and concern for them. Their inabilities to pay any bribes make their situation worse and on certain occasions very hostile treatment from the paramedical staff. The disdain they receive in the government hospital prevents many members of the lower class to neglect their health from going to the hospital. The old age people of the lower income households mostly seek treatment from traditional healers since the expenditure is very less and they are
more comfortable with the interaction in the traditional set up. Magico-religious treatment is also uniformly found among all social classes to get relief from their illnesses.

The lower income households suffer from lack of basic amenities such as potable drinking water and sanitation. The slums do not have regular visits by any public health staff and hence they are not mostly aware of the various health programmes or the health camps that are available to them. The lower income households are also not aware of any of the causes of major endemic health problems and the lack of such awareness puts them more at risk.

The data on health care in Tirunelveli brings out two sets of problems. The first set of problems is the limitations that mire the public sector health services and this has come out very well through the case studies on patterns of health care utilisation done among poor and middle-income households. The second set of problems is related to the private sector that has been explicated through the interviews with the owners of the private hospitals.

The teaching hospital in Tirunelveli is overcrowded in both outpatient and inpatient departments therefore the poor patients prefer the private sector. There is an urgent need to introduce a tiered urban health care service similar to the rural structure since the people living in slums belonging to lower income households will greatly benefit from those services.

The public sector doctors who are also practicing in the private sector are highly detrimental to the quality of services offered in the government hospitals because of the rent seeking behaviour. There should be an effective regulation on this aspect in order to salvage the public sector. The early attempts by the government has since failed because of the stiff resistance from the doctors therefore it is necessary to evolve a compensatory mechanism that would prevent the cross loyalties of the doctors.

Since the traditional medicine still enjoys popularity among people of all social classes, it can effectively be put into use for offering
cost-effective primary health services. A state sponsored public health insurance scheme will be a boon for the suffering poor. The public sector has vital role to play in meeting the vast health needs of the people. The problems withstanding, the public sector is the last resort for the poor masses when they fall ill. The reforms should be aimed at preserving welfare goal of the state and improving the public sector to achieve the health goals of the society.

The data on the private health services in Tirunelveli shows that there has not been any regulation of the private sector health services. The data available on the private sector either with the government authorities or with Indian Medical Association do not reveal any information on the exact size of the private sector, the size of population it caters, the pricing methods, the types of services offered, the protocols followed in the treatment and care of various health problems and finally the epidemiological data on the different types of diseases treated. Apart from the government authorities and the IMA, even the management of respective hospitals do not possess any data on these aspects. The lack of data clearly shows lack of internal review or introspection within the private sector and it puts the patients at a disadvantageous position because of this information asymmetry. The lack of proper data makes the government or the professional organisation difficult to effectively regulate the private sector. The private sector caters to sizeable population of the city but it has not been able to generate any epidemiological data and thereby hinders the government planners from understanding the health status of the population. It is high time that necessary measures are taken to rectify these lacunae in the health system, so that the private sector becomes transparent and accountable. A regular medical and social audit can be an effective measure to ensure the quality, transparency, and accountability of the private sector.

The private sector health services have closely allied itself with chemist shops, diagnostic centres and pharmaceutical companies. This nexus has led to increased unwanted diagnostic referrals.
prescription of expensive medicines and unwarranted treatment procedures. A regulation on the private pathological labs, diagnostic centres, chemist shops and also the large pharmaceutical companies is necessary to curtail the unfair practices that have been the outcome of the nexus.

Therefore the current environment desires a lot of problems to be rectified before envisaging any new role for the private sector as blindly advocated by the pro-reform groups. Similarly the role of the public sector in Indian health services is also very vital since the poor, vulnerable and the marginalized sections of the population are largely dependent upon it. The private sector is also an important player in offering health services to the population and the government instead of blindly accepting or rejecting their part should attempt to harness the resources of the private sector while also understanding the limitations of the market in offering health services. The state's welfarist agenda should be the guiding force in shaping and rethinking of the health policy. Therefore any changes in the roles of health sector should strive for equity and universal access in health services.