CHAPTER VIII

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VIII.1 Introduction

Health is one of the major components of human development. There is a significant relationship between economic growth and health. Improved health contributes to economic growth by reducing production losses. Good health is not only a necessary condition for economic development, it is also the pre-requisite for human welfare and the development process. Development is the process for improving health and the quality of life and health is an indispensable component of the development process. However, economic growth alone does not guarantee better health for all unless it is inclusive.

Health is both an important component and cause of well being. Health finds centrality in all the debates and discourses of human development. The health outcomes by and large show the status of development. UP is one of the states of India which shows the poorest performance in terms of health outcomes and provisioning of healthcare services. The state is at the lowest rank in case of three major indicators of health viz. Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Nutritional Status.

Healthcare services are provided by multiple agencies in India, each differs from other, in terms of mode, cost, quality and efficiency. The main providers of healthcare services are the public and private sectors. The public sector provides health services through the central government, state governments, municipal corporations and other local bodies. The private health sector consists of the 'not-for-profit' and the 'for-profit' health sectors. The 'not-for-profit' health sector which is very small includes various health services provided by Non-Government Organizations (NGOs), charitable institutions, missions, trusts, etc. Healthcare in the 'for-profit' health sector is provided by various types of practitioners and institutions. The informal sector consists of practitioners who do not have any formal qualifications, like the tantrics, faith healers, bhagats, hakims, vaidyas and priests. In India, despite the relatively spread of public healthcare facilities, a higher proportion of healthcare services are
provided by the private sector. India probably has the largest private health sector in the world. Most of the manpower related to health is in the private sector. At the time of independence, only about 8 per cent of all qualified modern medical care was provided by the private sector. However, over the years the share of the private sector in the provision of healthcare has increased to over 80 per cent of all outpatient care and about 60 per cent of all inpatient care.

India's healthcare system is neither the capitalist type nor the socialist but is a mixture of the two. Public and private healthcare service systems co-exist in this country. The government's political ideology of democratic socialism allows both public and private health services to function side by side. The socialistic principles lay emphasis on the state to provide health services to its citizens. At the same time, our democratic principles emphasise upon the private individual's right to practice his/her profession. So, both public and private health services cater to the health needs of the various sections of society.

VIII.2 Research Issues

India's performance in the area of healthcare has been disappointing over the years. Though there have been improvements in some health-related indicators like birth and death rates, India's performance in a number of health-related development indicators has been worse than Sub-Saharan Africa. Also, the improvements have not been uniform throughout the country. Healthcare services are much better in urban areas and there are differences in the population's health across the states as well.

India is growing at a faster rate. The foreign exchange reserves are increasing, industries and other sectors are growing and there is all-round development in the economy. As a result, urbanization is increasing. Although urbanization acts as a catalyst in increasing the prosperity of the nation, it is also accompanied by poverty, deprivation and marginalization. Hence, access to basic amenities like healthcare, sanitation, water and housing is generally becoming difficult for the growing urban population. Among all basic amenities and facilities, accessibility to and utilisation of healthcare services is steadily becoming more difficult. It is true that there has been expansion of public healthcare services. The growth in private and non-government sectors has also been remarkable. Despite this progress, adequate healthcare to all has remained a dream. The people seem to be gradually losing faith in government
healthcare facilities and preference for private healthcare providers is increasing. Studies have shown that in the case of around 55 percent of all illnesses, treatment was received from private medical providers. This emerging trend raises the question that whether people are going to private sources of healthcare for treatment of their various ailments due to inefficiency of the public health services or they do find private sector more efficient and cost effective in comparison with public health services. The greater dependence of people on private and non-governmental health services minimizes the role of the state and prompts the state to silently withdraw from healthcare responsibilities of the public. However, for a large number of people the state still continues to remain an important provider of health services, despite the problem of inefficiency and poor governance. Thus, in the current scenario, state health services are used by a large number of people and at the same time people’s faith in state health services has been shaken leading to increasing dependency on private healthcare providers despite the latter being comparatively costlier.

Therefore, it becomes pertinent to investigate and analyze the various dimensions of access to and utilisation of healthcare services provided by the public sector in comparison with the private sector. Hence, the study has analysed the issues in one of the urban parts of the state of Uttar Pradesh as a case study. This is further substantiated by the fact that healthcare services available to a majority of the population in urban areas is in no way better than those available to a major segment of the population in the rural areas of the state. Hence, a detailed study in Lucknow city has been conducted.

VIII.3 Objectives

The followings are the main objectives of the study:
1. To study the growth of public and private healthcare infrastructure in Uttar Pradesh.
2. To study the patterns of public expenditure on healthcare services.
3. To study access to and utilisation of public versus private healthcare services by different socio-economic strata of urban society.
4. To study the determinants of utilisation of public and private healthcare services.
5. To compare the cost and quality of services provided by public and private healthcare providers
6. To study the concept of public private partnership in healthcare services in India and in Uttar Pradesh.
7. To draw conclusions and recommend suggestions.

VIII.4 Hypotheses

The following hypotheses have been tested in the study:

1. The growth of public health infrastructure has been sluggish while it has been faster in private sector.
2. The state expenditure on health services is declining in real terms during the post-reform period.
3. The private healthcare providers are growing on account of deficiencies of public healthcare providers.
4. A greater percentage of higher and middle-income households use private healthcare facilities while a greater percentage of lower income households use public healthcare facilities.
5. Income and education are the major determinants of healthcare seeking behaviour.
6. Cost of treatment of different ailment is relatively higher but quality is better in private sector than those of public sector.
7. Public Private Partnership model is a better alternative for healthcare of the people as compared to public or private healthcare facilities.

A large number of studies have been conducted on the various aspects of healthcare which include prevalent healthcare systems, accessibility, utilisation pattern of services, cost, quality, determinants of healthcare use and Public Private Partnership (PPP). Studies have found that over a period of time, India’s health indicators have improved and there is a vast development of the public and private healthcare infrastructure. However, government expenditure on health is very low which leads to deficiencies in the public healthcare system in providing health services to the population. The inability of the public health sector has forced the poor and deprived
sections of the population to seek health services from the private sector which is costly but easily accessible. Evidence indicates that in many parts of India the private sector provides a large volume of health services but with little or no regulation. The private sector is not only India’s most unregulated sector, it is also the most potent and untapped sector. To address the inefficiency and inequity in the health system, many state governments have undertaken health sector reforms. One of these reforms has been, to collaborate with the private sector through Public Private Partnership (PPP). State governments in India are experimenting with partnership with the private sector to reach out to the poor and underserved sections of the population. The reviews showed that public and private healthcare services are not competitive, but complementary to each other. Many scholars suggested public health insurance as a corrective measure. Research evidence on these issues in India is scanty and needs to be explored.

The review of literature has further indicated that few studies have been conducted on urban healthcare infrastructure and its utilisation. Most of these are general in nature and analyse how people from different socio-economic backgrounds use healthcare services differently. There are few specific studies which examine access to and utilisation of healthcare services in urban areas by comparing the efficiency and cost of public versus private healthcare providers in a metropolitan city of Uttar Pradesh (U.P.). In view of this, it was pertinent to examine the comparative access to and utilisation of both types of facilities.

The present study is an attempt to contribute to our understanding of knowledge of access to and utilisation of public and private healthcare services in metropolitan cities by studying the Lucknow metropolis as a case study.

VIII.5 Study Area and Methodology

Lucknow city has been selected for the study because this city has many big public and private hospitals, medical colleges and other diagnostic and pathology centres. Thus, the Lucknow metropolis provides an ideal case to study the various dimensions of access to and utilisation of public versus private healthcare services.

The study has been conducted on the basis of both primary and secondary data. For the primary data collection, the household has been the ultimate unit of investigation. To identify the households, the city of Lucknow, which has 110 wards,
was classified into the old city area, the central part of the city and the fringe area of the city. From each of the classified part of the city, 2 wards were selected from the old city area, 2 wards from the central part of the city and 2 wards from the fringe areas of the city. In the selection of the 2 wards from each area, care was taken that the inhabitants of 1 ward were relatively well off while the residents of 1 ward were not as much economically well off.

After identifying the sample wards, sample households were selected in two steps. First, a household listing was done that covered all households in each sample ward. In this process of household listing, name of the head of the household, address and information on the prevalence of any acute and chronic illness during the previous fifteen days and hospitalisation during the previous one year was gathered from each household. Out of the total households reporting any two forms of illness, 50 households were randomly selected from each ward for the purpose of survey. The random selection was based on the computer generated Table of Random Numbers. In this way, primary data were collected from a total of 300 households.

The data relating to the growth of private hospitals/nursing homes and various aspects of costs were also obtained from concerned departments. Two types of interview schedules were used. One was used for gathering personal information and the other for collecting data from public and private hospitals/nursing homes and diagnostic centres. The data were collected by the researcher herself. After collecting the data, entry was done by using the data analysis package, namely, CS Pro. After data processing, data analysis was conducted. The data analysis was guided by the objectives of the study. The tabulation plan was then prepared. The tables were generated by using the SPSS Software.

The secondary data were collected from various sources. The major sources are the Reports of Department of Health and Family Welfare, Governments of India and Uttar Pradesh, Reports of National Family Health Survey (NFHS), Household Survey of NCAER, Central Bureau of Health Intelligence (CBHI), various reports of IIPS and various rounds of National Sample Survey (NSS), National Health Profile and other publications. The tabular technique of analysis has been largely used but to understand the determinants of utilisation of public versus private healthcare facilities, correlations have also been used.
VIII.6 Major Findings

The following conclusions have been drawn in the study:

VIII.6.1 Inadequate Infrastructure in Public Healthcare System

A minimum level of physical infrastructure is needed to provide health services and also to increase access to health services. The infrastructure, both in terms of human resources and physical situations, is inadequate in low and middle income countries as compared to high income countries. Estimates of the number and density of the health workforce refer to the active health workforce participating in the healthcare system. High income countries have three to four times more doctors and nurses per unit of population than low income countries.

India has a vast healthcare infrastructure which is broadly divided into public and private sectors. The analysis has revealed that since independence there has been a phenomenal growth of healthcare infrastructure both in public and private sectors across India. However, a wide variation in health infrastructure across the states was evident and the status of health infrastructure in Uttar Pradesh was lagging behind almost all the states. Pressure of population on government hospitals and government hospital beds was very high in Uttar Pradesh. It was more than double of the national average in both the cases. The reason behind this was that medical colleges were less than the number required. Moreover, the number of MBBS and MD seats was less. These factors had created a shortage of specialised doctors.

At present, seven medical colleges at Agra, Jhansi, Meerut, Gorakhpur, Kanpur and Allahabad, a medical university at Lucknow and a Super Specialty hospital, the Sanjay Gandhi Post Graduate Institute (SGPGI), Lucknow were being run by the State Government. In addition to these, two medical colleges were also functional and these are owned by the Government of India. The state has the King George Dental University at Lucknow. The state is also in the process of developing four more Super Specialty Hospitals. These are Balrampur Hospital, Civil Hospital and Dr. Ram Manohar Lohiya Hospital at Lucknow and Saifai Hospital at Etawah. Besides these, the state also has 53 district hospitals, 13 combined hospitals, 388 community health Centres, 823 block PHC's, 2817 additional PHC's, apart from 20521 Sub-Centres.

In the private sector, the state has three full-fledged private medical colleges and hospitals and many are in the process of establishment. There are more than
twenty dental colleges and 4193 male/female hospitals/nursing homes at the district level. However, there are a large number of registered and non-registered medical practitioners in the state and they are providing medical service to the rural and urban population.

Availability of health infrastructure in terms of per lakh of the population showed a declining trend in all indicators in both allopathic as well as other systems in the public healthcare system of Uttar Pradesh. On the other hand, hospitals and nursing homes, pathology/diagnostic centres and health personnel were found to be increasing exponentially in the private sector. Uttar Pradesh has the maximum number of SCs, CHCs and PHCs but the average population served was far higher than that mentioned in the prescribed norms. Each centre was over-burdened with serving a population higher than that mentioned in the prescribed norms. These centres lacked basic facilities and services. The growth rate in the number of hospitals constructed and beds provided is quite disproportionate as compared to the growth rate of population.

VIII.6.2 Insufficient Investment in Public Healthcare System

The financing pattern of the healthcare system in a country largely determines the volume of healthcare available to the population as also the extent and ease of access to healthcare by the poor. In the absence of a strong public financing in the healthcare system, a poor household suffering from illness may be forced to spend a large fraction of its resources on healthcare at the expense of other goods and services.

It is desirable that health financing is so arranged that it reduces the overall out-of-pocket (OOP) expenditure on healthcare and protects the people against financial catastrophe related to healthcare. The global standard related to the desirable limit of OOP to protect people from financial catastrophe is less than 15 percent of total health spending. In contrast, the OOP is 71 percent of total health spending in India. Health expenditure in India is dominated by private spending which is a reflection of inadequate public spending.

Public health expenditure in India has been grossly inadequate right from the 1940’s. The government was then spending less than private expenditure on health. Public spending on health in India gradually accelerated from 0.22 percent in the 1950’s to 1.05 percent during the mid 1980’s and stagnated around 0.9 percent of the GDP during the later years. It has increased to 1.6 percent of the GDP in recent years.
However, public spending on health is miserably low in India in comparison to 6-8 percent of the GDP in developed countries. Public expenditure on health is only 27 percent of the total expenditure, 71 percent is private expenditure and the remaining 2 percent is financed by external sources. The total expenditure (both public and private) on health in India as a percentage of the GDP stood at only 4.2 percent in 2009.

Public and private healthcare expenditure across the states of India also showed wide variations. Kerala which is a leading state in terms of health indicators also accounted for higher household spending on health in India. In states like Uttar Pradesh, Bihar, Orissa and Madhya Pradesh both household spending, as well as spending on health were relatively very low. Per capita expenditure on health showed a positive and high degree of correlation with per capita NSDP. Health expenditure had a positive impact on health indicators. A very weak positive correlation was found between Per Capita Public Health Expenditure (PCPHE) and Per Capita Net State Domestic Product (PCNSDP) and health indicators at the state level. Per capita health expenditure as well as health indicators of Uttar Pradesh lagged behind some of the other better performing states of India, i.e., Kerala, Tamil Nadu and Maharashtra.

As far as Uttar Pradesh is concerned, there has been a steady increase in funds allocated for the health sector in Uttar Pradesh which has not been sufficient. In the First Five Year Plan the share was 8.5 percent of the total outlay from the Second Plan onwards it declined to 2.32 percent in the Ninth Plan. From the Tenth Plan an upward swing started and consequently in the Eleventh Plan, it was 7.29 percent. The per capita public expenditure on health in the state is extremely low. It has shown a fluctuating trend over period of time. It increased in real terms in 1990-91 but again declined except for recent years. The comparison of the health sector with other components of the social sector like the education sector showed that the education sector in Uttar Pradesh has received a much greater share of the revenue expenditure than the health sector. The state expenditure on health services declined in real terms during the post reform period. This showed that the health sector did not receive adequate attention during the post reform period in the national budget as well as in the state budget.
VIII.6.3 Accessibility and Utilisation of Public versus Private Healthcare Services

A number of studies and NSSO data have indicated a major decline in the use of public healthcare services in comparison with private healthcare services. The analysis of primary data has indicated that in Lucknow metropolis private healthcare facilities are easily accessible to people as compared to public healthcare services on distance criteria. The fact has also emerged that despite the availability of nearer public and private healthcare facilities, 51 percent respondents reported that they visited some other private health centres and 26 percent visited public healthcare facilities which were not nearer to their residence. Thus, almost 75 percent of total patients did not visit their nearest healthcare facilities. The major reasons that were attributed to not visiting the nearer public healthcare centres were the non-availability of good treatment, non-availability of required services and qualified doctors. More or less similar reasons were attributed to for not using nearer private healthcare facilities.

The data further showed that for using public and private healthcare services most of the people travelled 2 to 5 km of distance and roughly spent 16 to 30 minutes time. The major reason for not visiting the nearby facility was the quality consciousness of the patients. Thus, the distance was not the major criteria to determine utilisation of both public and private healthcare facilities. The utilisation of public hospitals by patients was governed by three important factors. The foremost was the availability of specialised treatment followed by the availability of qualified doctors and the last was the economical treatment.

The patients have reported four important factors for choosing private healthcare services in case of non-hospitalisation. These factors were the availability of qualified doctors, specialized treatment, easy accessibility and relative time-saving.

Majority of them used their own conveyance to use these facilities. A general preference has emerged for utilisation of private healthcare services irrespective of diseases in both hospitalisation and non-hospitalisation cases. The private healthcare sectors was largely preferred for maternal and child healthcare by different caste groups. The study showed that there is a tendency on the part of people to use private healthcare services irrespective of age, education, occupation and income. However, the analysis also indicated that public sector healthcare services continue to be used by sizable number of people. It was observed that out of 370 patients, 95 patients (25.7
percent of total) were using public hospitals for both hospitalisation and non-
hospitalisation purposes. Out of these 95 patients, 62 (22.0 percent of total non-
hospitalised cases) used it for non-hospitalisation and 33 (37.5 percent of total hospitalised cases) used it for hospitalisation. Certainly they are from lower income groups. Therefore public healthcare sector should not be ignored at all and measures should be taken to increase its efficiency and quality so that public sector healthcare services can provide affordable and quality services to people.

VIII.6.4 Higher Cost of Healthcare in Private Sector

The study arrived at the conclusion that there is a mushrooming of the private healthcare sector. The primary data revealed that there were substantial variations of user charges between public and private hospitals. The charges in private hospitals were much higher than the charges in public hospitals. The private hospitals charge substantially higher fees than the public hospitals, for various diseases. Charges of various diagnostic tests like blood tests, X-rays, CT scans, ultrasounds, etc., were very high. Ambulance charges and bed charges in private hospitals and nursing homes were also exorbitant. Similarly, the cost of treatment of major operations and deliveries were much higher in private hospitals/nursing homes as compared to public hospitals.

VIII.6.5 Variable Quality of Care in Public and Private Healthcare Sectors

In terms of quality of services rendered in public and private hospitals, the experience of respondents was that all quality indicators were inefficient in public hospitals in comparison with private hospitals. Despite high cost of treatment in private hospitals/nursing homes, people were forced to use it as they had no option. The functionality of medical machines/equipments was reported to be relatively poor in public hospitals. Common complaints against public healthcare included, not satisfied with medical treatment, lack of availability of services, long waiting time, poor quality of care and poor interpersonal interactions.

The assumption that private health services offer superior quality of services was not adequately supported. While some private sector facilities do offer good quality of services, this cannot be generalized because of heterogeneity of facilities, personnel and their practices. The lack of variability and other lacunae were observed
in infrastructure, basic facilities, human resources and medical equipment which point towards poor quality in the private sector as well. A commonly observed phenomenon was over prescription of medicines, diagnostic testing and surgeries. The high cost of treatment did offer better infrastructure facilities in private hospitals, yet people felt that the quality of treatment was not superior to public hospitals as it should have been. The majority of respondents felt that quality treatment was not available in public as well as in private hospitals. The reason was that the competence level of doctors in public hospitals was certainly not less than of doctors in private hospitals and if the enormity of the number of cases be considered, the competence level was more in public hospitals than in private hospitals. Thus, despite paying a high cost for treatment people still felt that quality treatment was largely not available in private hospitals.

VIII.6.6 Lack of Accountability in Public and Private Healthcare Sectors

The regulatory and institutional mechanisms for promoting accountability for providing health services to consumers were extremely weak in both the public and private sectors. Some key areas in the public sector that lacked accountability were absenteeism of among doctors, their indifferent behaviour and corruption. The private sector was prone to overuse and misuse of technology, unethical practices and little accountability. Patients reported of corruption in terms of bribes demanded for admission and treatment in public institutions. Corruption was not restricted to the public sector alone. The private sector had also its share of corruption in the form of unethical practices. Government supervision in the delivery of healthcare benefits was highly inadequate and casual. In actual practice, government was indirectly helping the private sector to spread its area as no restriction is placed by government in the pricing of services rendered in private hospitals. However, the recent trend was that people preferred private hospitals though services were costlier. This was because the quality of services in public hospitals deteriorated over a period of time.

VIII.6.7 Emphasis on Public Private Partnership (PPP) in Healthcare Services

Recently, national and international agencies/policies are putting pressure on low income states (low HDI ranked states) to improve their health indicators but for
that they need huge resources which cannot be made possible, at least in a short time, as these states have no capacity to generate extra resources. These states have developed a huge physical public health infrastructure over time, but they do not have sufficient man power to deliver efficient healthcare services. Consequently, their utilisation is very low because of their sub-standard quality. On the other hand, these states have huge private health personnel (health potentials) who are competent. The latter are in heavy demand by the public but they do not come forward to join the public health sector because of lack of incentives and a clear cut government policy. To get rid of this lacuna, Public Private Partnership (PPP) has been conceived as a popular mode of implementing government programmes and schemes. Thus, it is not only the lack of funds but also lack of political, managerial and technical ability in the government healthcare delivery system that necessitated Public Private Partnership.

Public Private Partnership has emerged as one of the options to influence the growth of the private sector with public goals in mind. Used judiciously and fitted to local circumstances, it clearly has the potential to drastically change the healthcare landscape in India and naturally Uttar Pradesh as well. PPPs will survive only if the interests of all stakeholders are taken into account. Thus, PPP is a popular term in engaging the private sector for delivery of services. A true partnership requires shared objectives, shared risks, shared investment and shared rewards.

Public Private Partnerships promise an enormous potential for a state like Uttar Pradesh. However, it must be understood that there are no fixed templates for appropriate PPPs or a set formula for the success of PPP contracts. In addition, a PPP is not a universal remedy for all that ails the health system. PPP models fail invariably, owing to poorly drafted contracts or weak implementation/management of contracts and not due to the PPP strategy itself. Emerging evidence across the world indicates possible benefits of PPPs. However, PPP is neither an alternative to government provision of health services nor does it denote privatization. Analysis of various PPP projects showed that till date PPPs in the healthcare sector had not proved successful in Uttar Pradesh. Thus, the state lacks an effective PPP model in the healthcare delivery system. Generally, private partners are not very dedicated. They remain keen in clearing their bills and payments. They are more profit oriented rather than welfare oriented. Through PPP, a lot of corruption and administrative difficulties creep into the system. They enjoy the subsidies and other benefits given by the government and
themselves take the back seat in delivery of services. The Merrygold Health Network is one of the PPP healthcare models adopted in U.P. which generally lost its objectives and now has become defunct.

Thus, Public Private Partnership in healthcare sector of U.P. needs to be redefined as a complementary to public healthcare services, not as an alternative to public healthcare services. The importance of the public healthcare sector for the poor cannot be denied. A large number of poor people still depend on the public healthcare system, as they cannot afford treatment in the private sector. The utmost need is to look into the quality and working of the public healthcare delivery system in order to streamline and strengthen it. The PPP model can be experimented in specific healthcare needs, not on wider scale covering all healthcare needs.

VIII.7 Suggestions

The micro level situation was analysed in detail by studying access to and utilisation of public versus private healthcare services in Lucknow metropolis as a case study. On the basis of analysis carried out in previous chapters, the following suggestions are recommended as guidelines for policy planning:

VIII.7.1 Identify the Infrastructural Gaps and Fill them

Sub-optimal performance creeps through shortages. The requirements and gaps in the healthcare system are normally related to health personnel, medical inputs, equipments, institutional reforms and relevant changes. It has come out in the study that all the items of health infrastructure are inadequately available and their growth over the years has also mismatched with growing needs. Therefore, the public health infrastructure should increase at a faster rate. More government hospitals should be opened to keep pace with the requirements of the growing population. More MBBS, MD seats are required in order to meet the demand for health personnel. Vacant positions in the hospitals should be filled up. Shortage of major equipments and their improper functioning discourage patients to visit public hospitals. These shortages should be minimised. Infrastructure, like waiting room facilities, ambulance services and availability of water should also be improved.
VIII.7.2 Increase Public Expenditure on Healthcare

The share of expenditure on health has increased since independence in absolute terms, but in real terms its growth has been sluggish. India's health needs are large which demand a relatively high level of spending. The centre and state governments should increase allocation of funds for healthcare to at least 4-5 percent of GDP. The per capita allocation for Health and Family Welfare is also low in Uttar Pradesh, in comparison with other states. A special package for rejuvenating healthcare services for Uttar Pradesh is required. Expenditure may have to be raised at the state and district levels to ensure better performance. Moreover, even if the current national average is considered, the expenditure in Uttar Pradesh on health and related sector would need to be more than double. User charges should be raised in public hospitals so that they could raise resources which could be used in maintaining the services in public hospitals.

VIII.7.3 Adopt Planning and Management for Increasing the Efficiency and Quality in Public Hospitals

Certainly the efficiency and quality of public services could be improved by better planning, management and administration. Such improvements, if they could be realized, could significantly augment the efficiency of public services. Though, high level spending on healthcare is essential, but not alone enough to raise the quality and efficiency of the public healthcare services. However, reorienting the planning and management of the existing system may yield good results additionally. More money is certainly needed for many of the cost effective public health interventions. However, better use of existing funds, reforms as well as expansion has to be given higher priority, especially in this era of fiscal constraint. The low level of utilisation of public services suggested that without monitoring of the way money is used and large increase in spending will not produce the desired result. Even an active effort to streamline and improve the usage of existing resources in public hospitals will bring remarkable efficiency and quality in services of public healthcare sector.

No doubt, structure of public financing for healthcare is also an important factor that affects performance. Public healthcare services are financed by the central, state and local governments but the division of their respective roles and responsibilities is very complex. Effective administration is only possible if it can be properly managed.
through a Specialised Management Unit. Thus, reform in the public financing of healthcare may be critical to improving public services and enhancing their performance.

Equality, quality and accountability are badly wanting in both public and private health sectors. Therefore, there is need to focus our efforts on ensuring quality, efficiency and accountability of health services in both public and private sectors. The need of the hour is the introduction of technical innovations and improving management.

The lack of basic information about India’s private healthcare sector is also a big issue. National data showed the vast majority of ambulatory care with non-government providers, but there are no reliable estimates of how many of such providers are in open practice, nor of their training, quality and cost. The government should focus more on managing the whole health system in ways that support public goals, seeking to derive more public benefits from private services and less of substitution of public by private. This dimension of public policy and action is underdeveloped in India.

Generally, people do not want the waiting period in hospitals to be long. Some strategy should be adopted to avoid crowding in public hospitals. Good Managers and Public Relation Officers should be appointed to manage public hospitals efficiently.

VIII.7.4 Regulation of Public and Private Healthcare Services is required

This is critical for controlling costs and improving quality and accountability. For the private sector, accountability can be assured by a combination of legislation, involvement of professional organizations and consumer rights groups and public action. The significance of the role of the private healthcare sector cannot be denied but it’s over encouragement in the present situation is inappropriate as it has a tendency to marginalise the poor. The government should enact legislation for regulating minimum infrastructure that is needed for running a private healthcare organization, pricing of health goods, quality standards and costs in the private healthcare system as it provides 80 percent of healthcare. An overall monitoring of the health sector by the state is urgently required. There should be a proper accreditation system for private hospitals of the country so that the activities and performances of these institutions become compatible with the health needs of different segments of the population.
VIII.7.5 Strengthen Public Healthcare System rather than to Encourage Public Private Partnership

It is found in the study that, the public healthcare system is still used by substantial number of people because it is economical. Its weaknesses should be removed, quality should be improved and these will increase the efficiency of the system. A High Level Expert Committee should be set up to look into the quality and efficiency of the public healthcare system in Uttar Pradesh. The recommendations of this Committee should be implemented in order to strengthen the existing public healthcare system which is the hope of the poor people of society. The Ram Manohar Lohia Hospital of Lucknow can be taken as a model public hospital where patients undergo treatment and were satisfied by its facilities and efficiency. Other public hospitals of the city should be improved in a similar manner so that good healthcare facilities become accessible to people at large in the state.

Uttar Pradesh completely lacks ‘Class A’ hospitals and also lacks relevant infrastructure. Private hospitals provide good medical treatment but the costs are exorbitant. This is where intervention from state is required. There has to be an MOU, signed between private healthcare providers and the government to ensure that healthcare cost remains within the spending limit of people of the state. Weaknesses of PPP should be removed and new ventures based on experience could be taken up. A redefined partnership between the public sector and the private sector is the one way of reducing gaps in supply in meeting the need and demand for human resources in improving the organizational efficiency of public sector facilities and of better management of available human resources. This way the private sector would also become socially accountable, the motive will become service and not only profit.

VIII.7.6 Strong Political Willingness is required

The government should seriously commit itself to the goal of universalisation of primary healthcare and pay serious attention to the creation of adequate health infrastructure. The public hospitals can improve if, they receive more attention and aid from the government and secondly, look at private partnerships for improving services. The existing network of healthcare facilities which suffer largely from inefficient management can be rejuvenated by the improvement in delivery of services.
The low priority given by the government to the social sector, exhibited by the constant cuts on the social sector in budget allocation whenever government faced revenue deficiency is required to be changed rather the aim should be to provide more funds to this sector. Till the political machinery retrospects on the problems that ail the healthcare sector and tries to eradicate corruption from the healthcare sector, universalisation of the health will remain a distant dream.

**VIII.7.7 Campaign for the Utilisation of Public Healthcare Services is required**

Awareness should be created through the media among the people about the new developments/new departments in public hospitals. A greater utilisation of public hospitals by all sections of society will improve the system. More accessibility should be provided by improving the quality of treatment and by introducing longer OPD services. The doctors’ availability should be ensured. It has been observed that doctors perform more administrative responsibilities than carry out their primary duties. This trend needs to be reversed. Generally, timings of public hospitals do not suit people as a result, their utilisation is below par. If the time is extended till the evening, utilisation of public hospitals will increase. Establishment of a Grievance Cell and proper redress of the grievances of the people could help in increasing utilisation of public healthcare services. All this needs to be achieved through media campaign.

**VIII.7.8 Adopt Innovative Health Insurance Schemes to Reduce Financial Burden**

In order to reduce the financial burden of people, a two prolonged strategy needs to be adopted. First, services in the public sector should be improved by making these affordable and second, health insurance for the poor should be encouraged. Health security in India needs to become an urgent national and political priority. Rapid improvements in health are needed not only to accelerate and sustain India’s economic growth but to implement the idea of inclusive growth. For this, a good option could be the health insurance plan.

By managing the above weaknesses and following the suggestions given in the thesis, the public healthcare sector will certainly be able to provide better healthcare services to the masses. The private sector can also be streamlined not to be as commercialised as it has become today.