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A HEALTH SURVEY OF KERALA

by Dr. C. N. Parameswaran

Ashwini Trichur-680 020. Kerala

Kerala is a long strip of ever-green land in the South West coast of India, somewhat isolated by the Sayadri mountains on its east side. Its climate is moderate, the temperature hardly ever rising above 33°C. It has got a wide net-work of rivers, backwaters and tanks, water being always in plenty even though reckless deforestation has of late been manifesting in the form of annual droughts.

Kerala boasts of having achieved total literacy, being the first to declare itself so in India. Its density of population is the second highest after West Bengal, even though its birth rate is the lowest after Goa. Each nook and corner of the state has been inter-connected by a wide network of all season roads and canals, transport and communication facilities are wide spread. Moreover, there is no physical operation or demarcation between villages and villages, or villages and towns, the separation existing only in the revenue department's papers. The whole state is a continuous unit of intermingling villages, town's field's estates and forests. Electricity and telephone have reached almost all the villages - and now T.V. also.

Educationally in the forefront, Kerala is economically the most backward, perhaps confirming the validity of the saying that Lakshmi and Saraswathy don't see eye in eye, one dare not enter where the other is lording over. Modern industry has hardly opened its shop here; the traditional ones have almost closed theirs. Agriculture is being discarded as non-profitable even by traditional farmers. Kerala depends on the neighbouring states for almost everything. It produces hardly anything for its own consumption. From being a producing society, it has become a consuming society. Unemployment, both educated and uneducated, is the highest here. And yet there is prosperity all around, not only seeming, but real. The source of this prosperity is the enormous sums of money being sent home by the expatriates, mainly from the Gulf. As to the exact amount, there is no reliable information, but a conservative estimate is that it should amount to hundred's of crores. When the per capita income is calculated, this massive inflow of funds is not taken into account.

People belong to either one of the three major religions: Hindu, Muslim and Christian. Hindus constitute more than half of the population while Christians and Muslims share the rest more or less equally. Christians are the most prosperous and progressive, while Muslims are least so, Hindus coming between. All the three religions are further subdivided into castes, Hindus having the largest number. Of late Caste organisations are growing both in number and power, even though untouchability between them has practically disappeared.

Politically, the left and the right go neck and neck, the latter having a slight edge over the former. There is militant trade unionism of all shades, hence labour exploitation is minimum in Kerala, and there is more equitable wealth distribution. Wages are perhaps the highest in comparison with the other states, mason or carpenter earning Rs.50/ - in 1992.

Health Status of Kerala

Kerala has the lowest infant mortality rate (IMR) in India, the latest figure available being 22 (1991). Kerala's IMR has been well below that of India right from the beginning of this century. It was 242 in Kerala in 1911 while the all India figure was 278. But it was since the late fifties that the Kerala IMR started its rapid decline. This merits special mention because during this period after the formation of the present Kerala state a large number of health care and educational institutions, including the two premier medical colleges, sprang up. This was also the period which opened the flood-gates of private agencies into the field of medicare. But a disquieting feature of IMR in Kerala is that it is still not free from the wide rural-urban divide.

Editorial

Consumer Courts and the private medical practice is currently the raging issue. The private doctors are fighting to prevent the 'onslaught' of consumer courts on their domain and there is panic about the implications of this development. In the existing system of accountability and morals, consumer courts must be viewed as one of the mechanisms to regulate the unruly private medical sector that of late has tended to be both exploitative and irrational. .But there is need for a greater and comprehensive regulation of the private medical sector, going into all aspects such as ethical practice, rational use of drug and technique, facilities in nursing homes, billing and fees, abuse of drugs (allopathic) by non-allopaths and vice versa, responsibilities and so on. Consumer Courts will provide a perfectly constitutional stage for evolving an atmosphere and experience for developing such a comprehensive regulation in the long run. This issue carries an report by Dr. Madhukar Pai on the arguments from both these sides.

The new economic and political realities have far reaching implications on the nature and extent of development of public health services in India and regulation of private medical sector. Although the Prime Minister has promised to put his money elsewhere - in education, health etc. after diverting it from the PSUs, nobody can swear by this assurance. What will happen to village level health care - a non-entity today- and the entire rural health care system is anybody's guess. The article on the South African situation may provide some parallel scenario. The lead article - a health survey of Kerala-provides another (an Indian at that) experience with its rather peculiar aspects, good public services plus a high consumerism.

An article on Community Health Volunteers by Anant Phadke should restart the debate on the nearly forgotten issue - but relevent as never before, since all trends indicate a total lull on the village level health care front - which should be our major engagement.

Readers are requested to respond on all the issues, for MFC bulletin is a forum and not a mere release from a group. Only a wider interaction will chisel out issues.

Editor

For example, the rural IMR is 23 while the urban one is only 15. This means that the rural IMR is 153 percent of the urban one in Kerala, while that for India is 169 percent, only marginally higher. In some states like Assam & Bihar this disparity is even less than that of Kerala! This was in spite of the fact that there is a very high rate of antenatal and natal medical care (90-95 percent) in rural Kerala. Then what is the cause of this large rural-urban disparity in IMR? It could be due to the general lower level nutritional status and lower female due to the comparatively lower level of medicare facilities in rural Kerala.

True, when compared to the all India IMR figure of 91 or of Orissa's 122, Kerala's achievement is remarkable. Even the next lowest rural IMR (43 of Tamil Nadu) is almost double of Kerala.

But this rural-urban difference practically disappears in the case of crude death rate which IS 5.9 for rural and 6 for urban areas - whereas rural mortality rate reaches 157 percent of the urban one in the all India setting (98 and 58 respectively). The probability of dying before age of 5 is also very low in Kerala when compared to India as a whole. The all India figure IS 244 percent of the Kerala figure (1981). It has been declining very fast in Kerala. For example, by 1981 it fell to 45 percent of what it was in 1961. Dying within one year in India is almost 4 times as great as in Kerala.

Sex ratio (Females per 1000 males) is another index in Kerala which is in sharp contrast to the other states. In most other states of India the sex ratio has been steadily declining over the years whereas in Kerala it has been steadily increasing, to reach the present figure of 1040. In no other state has it reached the figures of 1000.

In 1930's life expectancy at birth in Kerala was at the same level as in India (32-33 years). Now Kerala's life expectancy of 67 and 72 years for male and female respectively is about 10-13 years higher than that off all India average. The expectancy of life at birth is higher for females by 5 years than for males. This again is an interesting contrast with India where till recently females had a lower expectancy of life at birth. Higher female life expectancy at birth is the picture seen in all advanced countries. If there is no discrimination against women they are expected to survive to a higher age than men. This results in a sex ratio which is favourable to the female, as is seen in the case of Kerala.

Birth rate of 19.8 in Kerala is lower than the Indian average of 30.5 (1989). Only Goa has a figure (15.5) lower than that of Kerala. The age-specific fertility has declined between 1971 and 1981 in all the age groups, especially in ages above 30. This decline is more manifest in the urban areas. Women in Kerala are avoiding birth in the early and late reproductive ages. Birth is mainly taking place in the ages 20-30 years. There are two reasons for this. One is that in Kerala women marry at a higher age. The second is that they avoid higher order births. Kerala had achieved the replacement level already in 1985 which India is hoping to achieve in 2000.

Human Development Index (HDI) is also very favourable in Kerala. HDI is calculated from three literacy still prevailing in the villages: and also indices: life expectancy, literacy and income.

Even though Kerala has one of the lowest income levels in India its HDI is the highest. In the ascending order of HDI, India's position is 37th, while Kerala's is 59th. Kerala comes between Botswana and Tunisia. Even though there are 101 countries with per capita income more than that of Kerala, there are only 51 countries with a higher HDI. In general HDI reflects the physical quality of the life of the people.

The K.S.S.P. Health Survey, 1987

The health survey conducted in July 1987 by the KSSP was a unique event not only in the history of the KSSP, but in Kerala's health research field itself. It remains unsurpassed in its quality, massive nature and near perfect execution. Nothing of this type has ever happened till then in Kerala. True, health related activities were nothing new to the KSSP. It included in the past activities such as publication of popular literature, awakening public awareness on irrational drug policies, highlighting the activities of multinationals in the production and marketing of harmful and wasteful drugs, education on preventive health, organising immunisation camps etc. etc.

The design of the questionnaire, preliminary pre-testing and other organisational work was completed by April 1987. Training camps were organised for supervisors and investigators at various levels and places. A hand book was published for the survey workers. The actual survey was conducted in two stages. Stage one was the survey of 10,000 households and stage two was the census of health care institution in all Panchayats and municipalities. The information gathered was on income, landed property, households, educational status, access to drinking water and electricity, nature of cooking fuel, . sanitary status, reading habits, food habits and nutritional status, smoking, drinking, antenatal and natal care, morbidity hospital attendance, system of medicine preferred, medical expenses, immunisation etc. 'etc. Analysis of the gathered information revealed the following picture.

More than one-third (35 percent) of the population of Kerala in 1987 was below poverty line – i.e. those whose income was below the minimum required per person. Here the question of underreporting of income should be taken into account. The general ten4ency is to conceal income. The planning commission's estimate of the poor is about 23 percent. The real figure could be expected to be somewhere between this and the KSSP estimate. This is borne out by another important characteristic, viz. the housing condition. About 27 percent of the population owned Jess than 10 cents of land. This figure could be taken as the real poor of Kerala.

But there is a curious feature about the poor in Kerala. The so-called poor are not uniformly poor in respect of all the four characteristics i.e., income, education, land and housing condition. Nearly half the households had atleast one characteristic which was above the bottom position. Undisclosed income from the Gulf could be an explanation. Similar is the situation in the 'Better off' (Top') group. That is, a number of households are not better off in all the four respects. This points out to a situation where the extremes of poverty and riches are relatively small in rural Kerala. Correspondingly, there is a dominance of middle groups, of which one-third comprises of what may be called the middle class.

Since Kerala has been declared a total literate state, analysis of the educational status may not be of much interest now, but it is all the same interesting to note that in 1987 more than 56 percent of rural households in Kerala had atleast one member with above - high school level education. Those households without any member were having above seven - year schooling were about 26 percent - the estimated poor of Kerala.

About 89 percent of the population was found to be dependent on wells, either owned by others or public, for drinking water. Less than 4 percent had tap water in their houses. 7 percent were dependent on what may be called unsafe sources of drinking water namely ponds or canals. Two-thirds of the households had no hygienically safe sanitary facility, and more than half the households did not have a private sanitary facility.

Morbidity and disability

A 'high morbidity - low mortality state' is said to exist in Kerala. Thus, the National Sample Survey of 1974 shows a rate of 71 morbidity cases per thousand populations for Kerala whereas the same for India was only 22. This is more than three times the all India average. It was only 10 for Bihar and Gujarat. It was Panikkar and Suman who COINED the 'high morbidity – low mortality' phrase for Kerala. The KSSP study of 1987 gives a still more alarming figure of 206. There is clearly something amiss in this. It is just not conceivable that such a high morbidity exists in a state where all the other health - related indices are highly favourable. Either Keralites are highly hypochondriac, taking every little uneasiness for illness, or people in other Indian states do not consider even moderate illness worth mentioning. Again, July in Kerala is an unhealthy season.

A survey conducted in July is likely to show a spurt of illnesses. The high morbidity - low mortality syndrome has to be verified by more scientific studies.

This estimate of disability is likely to prove more objective and hence more realistic. The NSS studies three disability factors of vision, speech and hearing and locomotion in 1980, and found Kerala to have a much lower disability rate (1647 per 100000 population) than India with 1844. The KSSP study showed that this was 1322 for Kerala in 1987. This should indeed be so, for all these three disabilities have a large preventive component, and as such, with more social and medical advancement the rates should be lower. This is borne out by the finding that disability rates are much higher in the socio-economically lower strata's of the society. The difference between the two extreme classes amount to 149%, 139% and 201% respectively for each of these. The disability rate in the poor classes approximates the all India average. These figures suggest that there is still ample scope for reduction of disability among the poor classes in Kerala.

Maternal and child health

It is well-known that there has been tremendous child health improvement in Kerala during the last 2-3 decades thanks to the following circumstances.

1) A rise in the age of marriage and child birth. The average age of women's marriage is now 21.8 years in Kerala and of men is 26.9 years. Kerala has the highest age of the first child birth in India.
2) Acceptance of a small family norm, fall in birth rate and larger birth spacing. The vast majority of the couples have only two children. About 46% have only one child. But Kerala has some dark islands, especially in its northern parts. For example, the Muslim majority Malappuram district has figures about equal to those of India. In other parts of Kerala it has now become the usual practice to undergo sterilisation operation after the birth of the second child, be it male or female.
3) Near total female literacy. Female literacy is known to playa crucial positive role in maintaining maternal and child health. Maternal mortality rate is 1.3 in Kerala compared to 2.3 in India.
4) Increasing antenatal coverage
5) The near universal practice of delivering in hospitals. It is more than 80 percent now. This has considerably reduced maternal morbidity, mortality and perinatal mortality.
6) The universal practice of prolonged breast-feeding. The enhanced female education and consequent influence of mass media have not had any negative impact on the traditional practice of breast-feeding, even among the well-to-do class.
7) The fast spreading popularity of immunisation. Apart from the government's own immunisation programme, a large number of voluntary organisations take pride in conducting free immunisation camps, not only in urban areas, but predominantly in rural parts. Before 1985 the immunisation coverage was below 30 percent only. But in 1991 it has reached 78 percent.

Health care utilisation

The different health systems are organised under two broad sectors, namely Government and private. Each one includes modern medicine, Ayurveda and Homeopathy, the dominant one being the first. Here we shall confine ourselves to modem medicine only.

Even though health is a state subject under the Indian Constitution, its organisational structure is more or less of a uniform pattern in all the states. Hence no need to discuss it in detail. At the lowermost level is the rural dispensary and at the highest is the medical college hospital, the PHCs, the G.H.S, taluk hospitals and district hospitals coming in between. Besides these, there are two central institutions namely a Regional Cancer Centre and Sree Chitra Thirunal Centre. The PHC covers about 31000 rural populations. There has been a tremendous increase in the number of PHCs after the formation of the Kerala state, i.e. form just 51 in 1956 to 881 at present. No other health .institution has had such a rapid increase in number. 82 percent of the Panchayats have got a PHC in it. The numerical increase alone is not enough. Much more crucial indicators are the number of doctors, beds and para-medical staff. In 1987 there were in the government sector 4,800 doctors and 35,300 beds. This gives a doctor per 5300 population and a bed per 720.

The private health care system has also been expanding very fast, not only in quantity, but in quality as well. Thus, two decades ago the major private hospitals in Kerala could be counted on one's fingers. Today each district in Kerala has at least a dozen major private hospitals; many of them doing superspeciality work, comparable to that in any government institution. Private sector today is handling the lion's share of medicare in Kerala. There were in 1987 more than 7600 doctors and 65000 beds in the private sector. This is almost double of the government sector. There is a private doctor for 3333 people and a private bed for 388 people compared to 5300 and 720 respectively in the government sector.

Even though the above figures give a very favourable population coverage, there is a wide disparity between urban and rural areas, both in government and private sectors. Thus, while one government doctor covers about 1000 urban people, he has to cover about 9000 rural population. This is 877 and 1054 respectively in the private sector. Again, when there is one government bed per 128 people in the urban area, in rural areas there are 1394 people waiting for it. In the private sector the corresponding figures are 109 and 519. In every respect the urban area is conspicuously maintaining this high lead over the rural area. But, compared to the govt. sector, the private sector appears to have reduced to a good extent this rural-urban divide.

Regarding the utilisation of the medicare systems, in the case of acute illnesses only 23 percent of the patients go to the Govt. hospitals for treatment, 66 percent go to the private sector and 11 percent 1I1dulge in self-treatment. Even in the poorest section of the people only 33 percent go to the govt. hospitals. As people move up the socio-economic scale the share of those who go to the govt. institutions decline sharply, to a mere 8 percent at the top. Even the PHC which is the backbone of I he govt. health care system is visited and utilised by only 39 percent of the population. Only 52 percent of the poorest go to PHC. The other 48 percent go to private institutions. It seems that the govt. health care system is slowly loosing its credibility. A number of reasons have been cited for this poor show. Whatever be the reason, the decreasing popularity of the government health care sector is something to be viewed with alarm. As many of the government schools are being closed down for want of patronage by the public in Kerala, it is not unconceivable that a time may came when govt. health institutions will down their shutters for want of patients.

Cost of medical treatment

The average cost of treatment in 1987 worked out to Rs.1656 for the reference period of Rs. 430.56 per person per year or Rs. 178.33 per capita per year 111 rural Kerala. This works out to a total private expenditure of Rs. 403 crores for the rural population as a whole in Kerala. Atleast the same level of expenditure is assumed for the urban population also. Then there is the govt. expenditure for health.

There is a lot of wasteful spending in the health field by the public. A sort of health mania has caught hold of Keralites whose motto appears to be 'health at any cost'. Many a time this takes ridiculous and tragic dimensions. A man for instance would go to any extent and spend any amount in trying to preserve the life of his aged parents paralysed by stroke or terminal cancer or one whose brain has suffered irreversible damage. In health the public wants the latest and the best-be it investigation like C.T. Scan or MRI, be it treatment in Vellore or Apollo. This mania sustains a fertile soil for high-tech medicare. In a small state like Kerala there are already about 10 C.T. scans doing brisk business, and more is in the offing. Atleast one of them is situated in a village.

Near total literacy, social reforms, leftist political movements etc. have created a consciousness that health is a birth right. This has been keeping up a persistent demand for more and more govt. health care institutions and consequently has pushed up the govt. health expenditure which was Rs.98/ - per head in 1990. This is one of the highest for Indian states and has recorded a 300 percent 1I1crease from 1980. This is only what the govt. spends. The consumer also has to spend as equal amount to get a service done in the govt. hospital even though everything is supposed to be free. There is no defil1lte way of knowing the real health expenditure in the private sector, even though it can be assumed that it must be many times the govt. spending because, as we have seen, the private sector accounts for more than two-thirds of the medicare in Kerala.

There are several reasons for this high medicare expenditure in Kerala:

1) People's increased health consciousness at times taking the dimensions of a mania.
2) Readiness to spend any amount for treatment purpose.
3) Easy access to medicare institutions
4) Demographic shift of the population towards the aged. Thus, Kerala's population aged 65 and above constitutes 5.8 percent of the total, only marginally lower than that of China's 5.9%. If the high income economics are excluded, this takes the top position in the world, even though it is way far below the U.K's 15.5%. The aged being more prone to illness spend more for health, and Kerala hav111g an increased proportion of the aged has to spend more. Aging IS an expensive affair.

Conclusion

1. The over all health profile of Kerala is the best in India and one of the best in the developing world.
2. There is a very strong bias in favour of urban areas in all the aspects of health indices.
3. A high morbidity- low mortality syndrome is said to exist in Kerala; this has to be verified by more scientific surveys.
4. Government health care institutions are fast losing their credibility and popularity.
5. Private medicare system is stealing the show from the government sector and has already become by far the stronger of the two.
6. Cost of medical treatment in Kerala is very high.

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WORKSHOP ON ' PATIENTS, DOCTORS AND THE LAW': A REPORT by Madhukar Pai.

Who is a consumer? Docs the medical profession falls within the ambit of the Consumer Protection Act? Or is it excluded because its 'service' is not the same as other services? Will consumerism open the floodgates for unnecessary litigation. These are some of the issues begin debated currently. To sort these out Consumer Action Group (CAG) of Madras organised a workshop on July 25th. The tempo for this was set by a spate of articles and letters which appeared in the press and, notably many on these writers were invited. The workshop came at a time when a serious controversy was brewing, what with all the arguments and counterarguments flying from all corners. This mfc member was invited for the workshop and what follows is a report on it.

The Background

The Consumer_Protection Act of 1986 offers, for the first time in India, speedy redressal for consumer grievances - from shoddy goods to poor services. Though medical services are not explicitly named in the Act, consumer forums have been handling complaints of medical negligence for quite some time. Earlier this year, the Kerala State Forum had awarded damages in two cases filed against Cosmopolitan Hospitals. The Hospital protested on the grounds that medical service is a 'personal service' (exempted from CPA) and there were state Medical Councils to handle such cases. In what is now being regarded as a landmark ruling, the National Consumer Disputes Redressal Commission upheld the Kerala state Forum's verdict that the medical profession can be taken to consumer courts in the event of any deficiency in service. Predictably, this sparked off a raging debate with the IMA appealing against the National Commission's judgement (pending before the Supreme Court). So, unless the SC reverses the verdict, doctors will be covered by the CPA.

The Arguments

Doctor, on the one hand, do not like to be compared with traders. They argue that CPA is essentially against unfair trade practice and -consumerism must limit itself to traders for whom it is meant, and not extend it to cover professionals. The consumer, thus, is a buyer of foods or service for a price. Moreover, Medical service is not listed under section 2(1) of the Act ('medicine', however, is listed under Clause (b). Another claim is that medicine is a 'personal service' and not a commercial service. Since CPA does not cover this doctors should be excluded. Medical practice is very complex and the doctor always acts in the best interests of the patients. The relation is based on trust and if, in spite of best efforts, something goes wrong, the doctor should not be held to blame. These intricacies cannot be understood by consumer forums who have no means of assessing the shortcomings of doctors. Many are concerned that once the floodgates are opened, frivolous, unnecessary litigations may follow resulting in the practice of defensive medicine and rising costs, the ultimate loser being the patient.

On the other hand, consumer activists argue that doctors, contrary to their belief, are covered by the CPA. The idea of a consumer being only a buyer of goods is a narrow one. A consumer is defined as 'one who has rights of safety, information, choice, representation, redressal and consumer education'. Consumer protection means 'the protection of their rights whether they relate to goods, services, safety of environment or even the quality of the air we breathe'. Thus considered, the medical profession should also be covered. The CPA itself evolved because lawsuits in our country are expensive and long-drawn. Consumer forums offer quick redressal without a fee. Activists say that frivolous litigation will not happen because only genuine cases, after scrutiny~ will be allowed and there are enough safeguards for the doctors. Therefore, a doctor acting with a bona fide intention of helping the patient has nothing to fear. Every one agrees that standards are falling in medical care. There is inadequate information to the patient, lack of records/audit, unnecessary tests and therapic-thanks to an unhealthy collusion between doctors and commercial interests like labs and drug firms. Thus, the main argument is that patients in our country have been exploited for a long time and since the IMC has done little to make doctors accountable, consumer forums should be allowed to intervene.

The Workshop Participants:

Mr. Justice S. Ramalingam (Judge, HC)
Dr. M. Anandakrishnan (Vice-chancellor, Anna Univ.) Mr. Shriram Panchu (CAG)
Doctors Panel: Dr. CV Krishnaswami (SMC, Madras) Dr. M.S. Venkataraman (Surgeon)
Legal Panel: Mr. Yashod Varadan (Lawyer)
Mr. N.L. Rajah (Lawyer)
Consumers Panel: Mr. Henry Tiphagne (Lawyer, activists) Mr. R. Desikan (Consumer activist)
At the outset it was clarified that the workshop will not debate whether the CPA covered doctors or not (since the matter was before the SC) but to examine issues like patients' rights, avenues for redressal, how to distinguish between negligence and error and define standards of reasonable care.

These were the views of the Doctors Panel:

1. The doctors opined that medical practice is a complex one where every drug or procedure, as much as it can do good, can also harm.
2. According to Dr. CVK, we are 'putting the cart before the horse buy advocating consumerism before forming a code of ethics for doctors and educating the public about it'.
3. He made a strong plea for educating the public about the nature of any therapy, difficulty in diagnosis, rationale behind tests and so on.
4. He expressed concern about the many 'semi-scientific and unscientific alternative systems' which were'" unstandardised, making prediction difficult if patients took these and allopathic drugs.
5. Dr. MSV listed the rights of the patients: to know the nature of the illness, needs, risks and costs of tests, nature of treatment, side-effects, informed consent, right to records etc.
6. He stressed their importance in preventing litigation because of any misunderstanding.
7. They expressed an urgent need for a Code of Ethics for doctors and strict adherence to it and also a similar code of patients' Rights to inform the public.

Views of the Legal Panel:

1. Mr. Varadan explained the 'test' of negligence: the methods of a doctor are compared with what any doctor with 'reasonable degree of efficiency and skill' would have adopted. Thus, a honest error in judgement or difference in opinion is not tantamount to negligence.
2. How can the injured get redressal? They may approach the IMC but not many know of this. Moreover, the IMC cannot award damages even if negligence is proved. Civil suits are expensive and delayed. Thus A consumer forums offer the best avenue.
3. He countered the claim of unnecessary litigations by saying that even in USA, only 10 - 15% of the injured parties comes forward for compensation.
4. He suggested that
   a) Regd. medical practitioners should be made to attend a specified number of CME programs failing which their registration be annulled.
   b) The IMC can frame guidelines for all doctors to maintain records and action taken against those erring. (Dr. CVK responded to this by saying that compulsory attendance of CME programs will not necessarily mean that a doctor has learnt anything)
5. Mr. Rajah outlined the safeguards for doctors.

Views of the Consumers Panel:

1. Mr. Henry clarified that activists were not after honest doctors but after those 'who don't even deserve to be called professionals'. Many doctors, he said, do not even have the courtesy to reply to their notice. Thus, there is a need to defend the poor and vulnerable from such people.
2. He said that almost 60-70% of the complaints they get are rejected at the first instance because they

are not genuine or not strong enough – another reason why unnecessary litigation won't happen.

3. He said trust is very important and it's built only by exchanges between doctors and patients. With mutual tr
4. According to him, corporate medical care is the main reason for today's impersonal care. He voiced concern about the shady dealings in the profession aimed at making money. If doctors make their profession a business then patients will have to treat them as traders.
5. Mr. Desikan gave instances of the IMC not even acknowledging the letters sent to it. He said very few doctors have been pulled up by the IMC and hardly any punished.
6. He reassured doctors by stating that all complaints are first sent to a panel of doctors who ascertain their validit
7. The activitists expressed serious concern about the selection system for MEBS because, according to them, that is where the problem is. Those who pay capitation fee are the ones who exploit patients.
8. They opined that the genuineness of consumer groups should be shown by their not only fighting for patients but also protecting doctors from false and frivolous complaints.

Recommendations Of The Workshop

a) A campaign to educate the public about their rights and avenues of redressal; and the problems and constraints of doctors.

b) The formulation of a Code Of Ethics for doctors and making them abide by it.

c) The need to prevent unnecessary litigations by pre-trial screening by a medical committee.

d) Unless guilt is proved, the name of the doctor should not be published (to protect identity and reputation).

e) Formation of local bodies of eminent people including doctors to look into medical complaints.

f) Allying the fears of doctors by educating them about their fights and safeguards.

Conclusions

It is abundantly clear that there is an urgent need to protect the rights of the patients. But how to do this without pushing doctors on the defensive and creating panic amongst them? Are we heading for a crisis, like the American, which Don Berwick so succinctly described: 'technology out of control, rising costs, variation in care, rising malpractice suits, angry payers, hospitals going broke and patients afraid'. But can we really imagine such a crisis when the majority of our people are not even aware of their basic human rights?

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IS C H V RELEVANT TODAY?
By Dr. Anant R. S. Phadke

Is the Community Health Volunteer relevant today? One can not give an unqualified answer to this question. '"The CHV Scheme in the Governmental Health Sector is currently almost non-functional and is being starved to death due to deliberate ne8lect. Hence even the concept of CHV raises doubts 10 the minds of many. It is therefore necessary for us to take an overall view and clearly state the role and limitations of CHV, taking into consideration the experience in both the Governmental and the NGO sectors.

(There is a second context to the issue of relevance of CHV. Medical technology has changed rapidly during last twenty years and private medical services have percolated beyond cities. Hence some people feel that perhaps CHV is now an obsolete concept. I would argue that though medical services of some quality are now available at Taluka-level, a few kilometers beyond the Taluka-level, the situation has hardly changed. Unqualified quacks have increased, unnecessary intravenous saline infusions by these quacks is now the new mode of cheating the villagers. But medical care of fair quality is still a far cry. The PHC-structure is primarily geared to family-planning, immunization and a couple of National Programmes. Villagers are still deprived of primary medical care, health-education, leave aside proper water to the people and sanitation. The CHV is, therefore, very much needed even today.)

CHV can play an important role in the health system if:

(i) he/she is properly trained and retrained;

(ii) is provided with adequate, proper health-educational material;

(iii) is supplied with adequate amount of drugs in time;

(iv) is not treated with disrespect by the doctors and nurses;

(v) the PHC-team, of which s/he is a part is competent team with credibility amongst the people;

(vi) there is some mechanism to ensure a degree of accountability of the CHV to the people.

The success of the CHV is directly proportional to the degree of fulfillment of the conditions listed above. This is particularly true in developed rural areas and cities, where medical care delivered by doctors (of whatever type and quality) is easily accessible. The most important issue for CHV is his/her credibility amongst the people. This can be achieved with a good medical team and/or by the credibility of the developmental team or social movement of which the CHV could be a part. Today, CHV seems to be an

Unsuccessful idea because -of its poor performance, the poor functioning of the CHV also. The question therefore is not merely, is CHV relevant today?' but is Governmental health - system relevant today?' With decreasing funds, motivation, the PHC-structure IS turning into merely 'Centres of immunization and Family Planning'. But in the NGO sector there are a number of health-centres, who have a good reputation and a good CHV -programme.

As part of a good team, CHV is very much relevant and useful. Let us reiterate the rationale and the advantages of CHV in such a context.

i) Since CHV is part of the community, s/he is more accessible at any time compared to an outsider.

ii) Secondly s/he is culturally more acceptable and hence more effective in health-education. Health-education is a very crucial component of medical-services, and the most neglected one. Health-education by CHV involves propagation of specific, predetermined messages and is intellectually not a very demanding task like diagnosis and management of a whole of variety of ailments. Hence this task can be easily carried out by a lay-person after a short course of training. (This is not to suggest that health-education is 'easy' or is devoid of theoretical basis. It only means that a short course of training is sufficient to teach the basics of health-education to CHV). The additional, specific advantage of health-education done through the CHV is that CHV can present the health-messages in a language and in the cultural context which people can understand. S/he can even modify the message in a far better way than an 'educated' outsider can do.

iii) CHVs are in a far better position to elicit people's cooperation for community action on health-issues.

iv) Diagnosis and management of some common ailments like diarrhoea, malaria, viral fevers, simple respiratory tract infections, scabies, conjunctivitis, simple wound9 etc. can be done by a lay-person after a short period of training. A doctor is not required in such cases. In India, in rural areas, where qualified doctors are hard to come by, medical services for such ailments can be rendered without decreasing the quality of work. This CHV must, however, be trained to refer appropriate cases in time.

v) Limited training means cheaper human power. (CHV's honorarium should not, however, be too paltry as it is today. This is a distinct advantage in a poor country.

vi) CHV is a living example of how to demystify medical science. The fact that a lay-person from the community can treat ailments and give guidance in health-matters helps demystify medicine. Secondly CHVs many times use more appropriate words, phrases etc. to explain medical points. This also helps to demystify medicine.

vii) I have recently realized that some of the traditional herbal medicines seem to be effective in certain conditions and CHVs have a lot of knowledge and a great deal of interest in this issue; whereas outsiders are deficient in both.

viii) Ravi Narayan has argued that the CHV can be a 'consumer-activist' at the village- level. For example, since s/he knows the value of cold chain in immunization against polio; or knows the value of aseptic precautions during injections; knows about different medical services that ought to reach the villagers; s/he can represent people's interest to see that these services are properly delivered in rural areas.

This is an interesting idea. But the health-team has to support the VHW to fulfil this additional role. VHW on his/her own is rather powerless.

xi) CHVs can be community-organizers, as has been seen in many health-projects. At grass-root level, there is many times no clear division between health-work and non-health-work. Many CHVs have leadership qualities, which take them far beyond health-work alone. But this role of community leader or community-organizer is not an essential part of the role of CHV. If a CHV can play this role, it is to be considered as bonus.

I

Different scope in different areas:

Lastly, the role and scope of CHV in different areas may differ. In areas where modern medical care is not only unavailable, but is also inaccessible due to difficult terrain and lack of proper roads and other facilities, CHVs are readily accepted by the people and would have larger therapeutic responsibilities to share. Secondly, though any CHV has to be part of a health-team in remote areas CHV's link with the team is rather loose. In such areas, CHVs have to carry out tasks without direct help from the health-team. On the contrary, in areas where medical services are easily accessible, (periurban areas, and developed rural areas) the roles of CHVs are less readily accepted by the people. People prefer to go even to quacks for injections rather than take rational advice and treatment from CHV. In such areas CHV will have to be given tasks not carried by the established medical services. For example, early detection of various disabilities in the community; health-education about these disabilities etc.

This is in addition to the usual training of the CHV. Even in these areas, if CHV's training is upgraded, people will accept their services. With very rudimentary training being given to CHVs today, they are primarily useful only in remote areas. This situation must change.

CHV's training must be upgraded.

Philosophically speaking, CHVs should be useful in all areas, even in urban and well-to-do areas. One of the rationales of CHV is that in health-care delivery, there are not many situations wherein we neither require a doctor, nor doctor is the best suitable person for a variety of tasks in health-care-delivery. If there is a well-trained CHV even in a middle-class educated colony, would not it be better to go to him for a neighborly, informal advice about minor ailments, or to read about a health-issue from his health-library, rather than to lengthen the queue in the doctor's clinic?

Even if there is a social revolution, and hence far more availability of doctors, it is unlikely that the availability of doctors in rural area would improve dramatically. Hence CHV would remain relevant for many years even after a social revolution.

Legal status for CHV

None of the paramedics are today legally allowed to render medical service beyond carrying out standing instructions of a doctor. CHVs are, therefore, today, legally vulnerable, since they are to carry out many independent medical tasks. They need legal protection. We should lobby to change the existing laws towards that effect. The meaning of 'standing-instructions' should be broadened to include specified tasks for which CHV has been trained. When the Government is today effectively withdrawing the CHV -scheme, CHVs in the NGO sector would now be more vulnerable socially as regards their legal status is concerned. This legal vulnerability is an obstacle in CHV's assuming a proper role in our society.

On the one hand, the existing establishment looks upon CHV merely as a cheap populist measure to create a semblance of health - care for rural area. But since t is not committed to the success of this programme, what remains in practice is a mockery of the philosophy of the CHV - programme. The official CHV -programme exploits CHVs and hoodwinks the people with empty slogans of 'Your health in your hands'. On the other hand, some radicals tend to dismiss the idea of CHV as a mere ideological tool of the ruling class to cover up its failure to provide qualified doctors in adequate number for rural area. Let us keep away from both these extremes by appropriating the rational kernel of the CHV-programme.

(This note was prepared for the meeting of the Primary-Health' Care Cell of MFC. It has been modified in the light of the discussions during this meeting on 22nd June.)

A NATIONAL HEALTH SERVICE AND THE FUTURE QF THE PRIVATE SECTOR - The Case For A NATIONAL HEALTH INSURANCE

By The Centre For Health Policy

Debates about how the future economy will have to tackle entrenched inequalities are forthcoming and necessary. However, there has been a neglect in debating how to restructure the disproportionate public and private sector health services. This article examines a number of options concerning the financing of health services and, in particular, examines the future role of the private sector.

The Need For Debate On Social Policy

The economic policy of a future 'Post-apartheid' government is one of the most hotly contested issues at present. Some of the main opponents in the debate do however share some common ground. They agree that a future economy will have to combine both:
i. Sustained economic growth and
ii. The reduction of the massive social inequalities that have resulted from apartheid. There will need to be rapid social and economic development for previously dispossessed communities.

Development, it is agreed, cannot occur without growth. Growth cannot occur without the stability brought about by development.

While there has been intense debate about the broader economy there has been little public debate about the future organisation and funding of social services such as health, welfare and education. This absence of debate is also worrying because may reflect the mistaken belief that the elimination of apartheid, will itself correct the deep inequalities that apartheid has brought about in our social services.

This paper aims to examine some issues relating to the financing of health care, and most particularly to the future role of the private sector.

The Size And Impact Of The Private Health Sector

The private sector is a crucial part of the present health system. Total health care expenditure in South Africa was about Rs.12 Billion in 1989 (nearly 6% of the Gross National Product). The private sector consumes nearly half of this amount.

Furthermore, the private sector employs about 50% of the doctors, 90% of dentists, many nurses, and the vast majority of pharmacists. About 25% of hospital beds are found in the private sector. The private sector also enjoys the loyalty of many of its "consumers'(that is, patients} because of high standards of personalized care, continuity of care and the freedom to choose ones doctor.

There is little doubt, however, that the private sector in its current form is a major obstacle to the creation of an equitable, efficient, and appropriate health service.

The private sector and inequality

Despite consuming nearly half of all resources available for health care, the private sector provides (largely curative) care to only 20% of the population. Due to the fact that the private sector operates in response to market forces, private health care delivery is heavily concentrated in the densely populated wealthier urban areas. The private sector contributes little to alleviating the desperate shortage of resources in rural areas.

The growth of the private sector has also contributed to the deterioration in public sector care, by attracting many highly skilled doctors and nurses away from the public service, and towards the more highly paid jobs in the private sector.

The Private Sector and inefficiency

In an economic sense the private sector is highly inefficient. Measured by medical aid contributions, the cost of private care to the consumer has risen by 23% a year for the last decade. This is several points above the general rate of inflation, and is a trend that appears to be escalating.

The uncontrollable cost increases are evidence of the excessive and often unnecessary use of services in the private health sector. This result from the nature of incentives in the private health sector: there is an incentive for hospitals and doctors to do too much, and for patients to demand too much, and neither the users nor the consumers are concerned about the costs since 'the medical aid is paying'.

As the costs of belonging to medical aid schemes increase, medical aid schemes are paying for a smaller proportion of medical costs. Proposed changes to the law, if passed, will even enable medical aid schemes to withhold cover entirely from high risk individuals, such as the elderly and chronically ill.

Medical aid schemes, attempting to control the costs of medical care, are increasingly involved in bitter disputes with private health care providers-general practitioners, private specialists and private hospitals. A full-blown crisis in private health care seems likely if the medical aid schemes and the providers of private care health care remain deadlocked while costs relentlessly escalate. Indeed, it is arguable that the crisis has only been prevented by the major subsidy which the state provides to employers in the form of tax concessions for their contributions to employee's medical aid. (The value of this subsidy in 1988 was about Rs. 1.5 Billion).

How the crisis will manifest itself is difficult to predict. At best, private care will become inaccessible to all but an even smaller elite - the young, healthy and wealthy. At worst, the private health care market may collages completely. Either extreme would push many additional patients into the under-funded public sector.

The Private Sector and inappropriate priorities

People will 'buy' health care when they are sick. There is little incentive to pay for preventive services when healthy. As a result, market forces tend to ensure that private care emphasises high technology curative care, and tends to neglect appropriate preventive and promotive services. These latter services do not generate enough revenue to justify their provision by private sector entities in search of profit: left to itself, the private sector will inevitably focus on providing curative cart." and ignore preventive services.

The debate about health service options

The debate thus far:

Before February 2, 1990 the battle lines in the health sector were clearly drawn. On the one hand, the government and most of the private health care. On the other hand,'progressive' voices in the health sector, including anti-apartheid organisations and a wide range academics, vigorously opposed privatisation and called for the building of an equitable and affordable National Health Service.

Today the distinctions are both less obvious and more complex. On the one hand, everyone professes to favour equitable and appropriate health care for all and no-one, least of all the government, publicly defends the notion of health care privatisation. On the other hand, the proponents of a National Health Service (NHS) face a very difficult question: what is a National Health Service, and how do we create it? More specifically, what do we do about the large and powerful private sector? The essential question IS how a future government should intervene in the health sector so as to ensure increasing equity, without destroying the system it is trying to improve?

Three forms of state intervention are commonly mentioned. We discuss each in turn. It is not possible to discuss these subtleties here.

Option 1 : Nationalise the private sector

This is the simplest option. It would involve nationalising the private hospitals, banning private practice and forcing all doctors into state employ. However it is both practically untenable as a course of action. Health personnel, particularly doctors would leave the health sector (and the country) in droves, and a black market in private care would soon emerge to undermine the public sector. If all the doctors did indeed stay on, this would practically double the number of doctors on the states'

payroll - an impossible burden given that public health care is already badly under-funded.

At present nearly half of all the money spent on private health care comes of private pockets. If the private facilities were to be nationalised, that money would simply disappear. There would be no reason for people to pay for health care that was now provided by the state.

Thus nationalisation would greatly increase the state's liability to pay for care. There are also additional demands on state revenue that will be made by post apartheid education and welfare services. Alternative funds could only be raised through the application of higher taxes, a move that would hardly be popular.

Quite apart form these arguments it is likely that the state would face a sustained and powerful campaign against nationalisation from both the providers and users of private health care. It is unlikely that any future government would seriously contemplate this option.

Option 2: keep public and private sector separate

There is a school of thought which argues that the post-apartheid state should concentrate on strengthening the public sector, and transforming it into an egalitarian and high quality service open to all. The private sector, so that school of thought goes, should be left alone to provide private care to those who want, and can afford, to make use of it. The sting in the tail of this approach is that the private sector should be substantially reduced in size by a series of measures aiming, firstly, to make those who use private care pay the full cost, and secondly, to control some aspects of private sector behaviour.

Suggested measures include:

Doing away with any tax rebate for employer contributions to medical aid.

Making the private sector pay the full costs of training of professionals who end up working in the private sector. Instituting a system of licensing for private hospitals private practices, and the use of new technology.

In this way it is argued the private sector can be made less attractive and more expensive thus substantially reducing its size, its influence and its ability to undermine the public sector. The public and private sectors would be kept rigidly apart

Critics of this course of action raise a number of problems. In particular, they suggest, it underestimates the ability of the private sector to adapt to new circumstances. In fact, they argue that it would leave in place a large and robust private sector, operating largely outside of national goals and priorities. The private sector would continue to consume a disproportionate share of resources, including doctors, entrench the two tier system of health care, and indeed continue to undermine the state's ability to develop an effective public health service.

This proposed course of action would potentially release some additional funds to the public sector (the current tax rebate on medical aid contributions) but it would not provide sufficient funds to allow the rapid development of the public sector.

Option 3: Centralise financing for public and private providers

This option seeks to draw the private sector into a national system of health care provision. The proposed mechanism is the establishment of a national health insurance system in which current medical aid contributions are replaced by a compulsory health insurance contribution for all those in formal employment.

The national health insurance system would bring public and private finances for health care into a single fund controlled by the health authorities. The money would then be used to pay for a package of health services for all citizens, provided by either private or public sector providers.

The national health authority would be involved in the development, and enforcement, of norms governing the private sector, such norms would include, for example, methods of practise and payment that reduce inefficiency. Also, the private sector would be obliged to participate in the training of health personnel, thereby contributing to the national pool. This amalgamation of resources would create a powerful single purchaser of health care which would act on behalf of all citizens in the country. The health authorities would ensure cost effective care by purchasing medicines cheaply, negotiating appropriate methods of payment with private providers and only paying for appropriate tests and procedures.

Such a system would guarantee all citizens access to a uniform range of essential health care that would be free, or nearly free, at the point of use (Health care, over and above what is defined as essential could be purchased by those who could afford it). National Health Insurance, as a sum earmarked specifically for health care tends to be more acceptable to people than an ordinary tax increment.

Such a mechanism, which has been implemented in many countries, including Canada and Australia, would leave in place many of the aspects of the private sector that are attractive to both providers and users of the health service. At the same time it would create a real possibility for the state, over time, to redistribute resources towards underserved areas, to create incentives for people to use the public sector, and to attract private doctors and nurses back into the public sector.

The major criticism of this option is that, by paying or everyone's use of the private sector, it would dramatically expand private health care without modifying at all the cost escalating behaviour of the private sector. The real danger emphasises the need to define, and cost, very carefully the package of

care that would be paid for by the national insurance fund. It also points to the need to negotiate in advance with private providers over methods of payment, procedures an cost saving possibilities.

Conclusion

Like so much else about South Africa today, the future of health care will have to be negotiated. What is clear is that the present structure is detrimental to the goals now espoused by all parties in the health sector.

To the extent that the needed fundamental changes can be achieved with a broad consensus, this would be a good thing, and should be the aim of negotiations.

It is our opinion that nationalising the private sector would make that consensus impossible, and that maintaining the private sector as a separate and elitist service would make it impossible to meet the social goals of the new South Africa.

A National Health Insurance system may provide precisely the correct mix of state guidance and private initiative and choice.

This article was jointly written by members of the Centre for Health Policy.

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XVIII ANNUAL MFC MEET 12, 13, 14 SEPT.1992.

SATURDAY 12th	General Body Meeting
SUNDAY 13th	Discussions of Theme for next MFC meet (National Health Policy)
MONDAY 14th	Non-theme discussions.
TUESDAY 15th	Meeting of Primary Health Care Cell.

All members and friends are requested to attend the meet.
Venue: Yatri Niwas, Sevagram, Wardha.

Manisha Gupte (Convenor).

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