

Social and Systemic Determinants of Utilisation of Public Healthcare Services in Uttar Pradesh

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Building on an earlier publication using the same data set plus case studies of three facilities, the reasons for the low utilisation of public health facilities in Uttar Pradesh despite the prohibitively high costs of care in the private sector are explored. The likelihood of choosing a public provider for hospitalisation care was 4.8 times higher in the poorest quintile and 3.4 times as high for women. Where access to public sector services is an issue, many go without any treatment and this could appear in the data to be a higher proportion of private sector utilisation. Inadequate facility density is one barrier to access. Facilities, which are by policy designed to offer very limited types of services—to collect user fees and prescribe drugs and diagnostics to be bought outside, and with no continuity of care between primary and secondary levels—lead to the diminishing of credibility of the public healthcare services. When services are available and there are incentives that facilitate access, like for childbirth, the choice shifts in favour of public services. Market-defined perceptions of what is good healthcare and an understaffed and demoralised workforce also contribute to poor utilisation.

In an earlier paper we had presented the incidence and intensity of catastrophic health expenditure in Uttar Pradesh (UP) and the impoverishing effect that healthcare expenditures have on the state (Verma et al 2017). The government's strategy to the problem of impoverishment due to health costs is through the provision of free or subsidised care in public health facilities and through publicly funded health insurance (PFHI). We noted that the state had introduced PFHI but officially only 23% of the eligible beneficiaries had been enrolled and our study showed that only 10% of households in one of the three districts had been enrolled (Verma et al 2017). Thus, financial protection rests largely upon the population's access to public healthcare facilities. However, the majority of the population is utilising private rather than public healthcare. This dependence on the private health sector contributes to inequities in access and utilisation of healthcare facilities, and in the health status of people (Verma et al 2017). It also reflects the gap between

formulation, implementation and execution of health policies in the country (Dey and Mishra 2014).

Being one of the poorest states in the country, with almost 809.1 lakh people (39.8%) below the poverty line (BPL) in 2011–12 (Planning Commission 2014), with the poorest health indices in the form of high infant mortality rates (48 per 1,000 live births) (Census of India 2016) and maternal mortality ratios (285 per 1,00,000 live births as of 2011–13), and with a high burden of disease, Uttar Pradesh requires to put in place a healthcare system where financial barriers to access are less and financial protection against the costs of healthcare is more. But, what we find from the National Sample Survey Office (NSSO) 71st round is that the average burden of healthcare expenditure on the people in UP is much higher as compared to that at national level (NSSO 2016). The average total medical expenditure per hospitalisation case in UP is ₹ 22,515 as against ₹ 18,260 in India. The average total medical expenditure per hospitalisation case in rural and urban areas of the state is ₹ 18,650 and ₹ 31,653 as against ₹ 14,922 and ₹ 24,443 in the rural and urban areas of the country respectively (NSSO 71st round). Much of this low health status and high costs of care is not only due to the social determinants, but also due to the lesser utilisation of public health services.

Our earlier paper had a focus on financial protection (Verma et al 2017). It presented the costs of ambulatory care and of hospitalisation in both public and private sectors and the consequent catastrophic health expenditure and impoverishment that this resulted in. The main objective of this paper is to analyse access to public healthcare services and its determinants, and to understand why utilisation of public health services is poor despite the private sector care being much costlier.

Methodology

In order to analyse the status of healthcare facilities and utilisation pattern in UP along with the social determinants, similar data set on the three districts of the state has been used. The survey design is based on the methods used by NSSO's consumption surveys, especially the 71st round, and is described in the earlier paper (Verma et al 2017).

Public facilities in this study refer to health sub-centres (HSCs), primary healthcare centres (PHCs), community health centres (CHCs), and public dispensaries. Public hospitals include district hospitals, and government-owned state general hospitals and medical college hospitals, etc. Private healthcare providers get categorised into private clinics—all private practitioners, registered or unregistered, functioning as doctors and providing only ambulatory care—and private hospitals and any kind of private facility that has beds for inpatient admissions; the latter includes private nursing homes, day-care centres, private medical colleges and hospitals, super specialty hospitals, etc.

Logistic regression: Given the differing rates of utilisation of public health services across a multiplicity of interrelated social determinants, we developed a dichotomous choice logistic model to predict how the probability of usage of public/private healthcare facilities is affected by these determinants. On the basis of literature, it has been assumed that the utilisation of healthcare facilities is affected by various factors such as regional disparities, social category, place of living and income status (Dey and Mishra 2014). Based on descriptive statistics, the empirical model developed is as follows:

$$\text{Log } \lambda_i = \alpha + \beta_1 \text{ DIS} + \beta_2 \text{ PLA} + \beta_3 \text{ GEN} + \beta_4 \text{ SOCAT} + \beta_5 \text{ AGE} + \beta_6 \text{ EDUG} + \beta_7 \text{ INCG} + \varepsilon_i$$

where λ_i denotes public (private) sector utilisation, *DIS* means district, *PLA* means place of living, *GEN* means gender, *AGE* means age group, *SOCAT* means social category, *EDUG* means educational group, and *INCG* refers to income group. Wald test has been used to determine the significance level of the predictor variable. Odds ratio has been used to explain the odds of households using public healthcare facilities given particular conditions, against the odds of not using them.

Logistic regression was also used to find the determinants and likelihood of not seeking any care despite reporting an illness within the last 30 days. The logit model used was as follows (same abbreviations as above):

$$\text{Log } \lambda_i = \alpha + \beta_1 \text{ DIS} + \beta_2 \text{ PLA} + \beta_3 \text{ GEN} + \beta_4 \text{ SOCAT} + \beta_5 \text{ AGE} + \beta_6 \text{ EDUG} + \beta_7 \text{ INCG} + \varepsilon_i$$

The study included a qualitative case study from each of these three districts—where one block and the block facility in it were purposively selected and studied. In each of these three case studies there was gathering of secondary data from records, in-depth interviews of the manager, semi-structured interviews of the providers, exit interviews of 10 patients, five patient attendants and interviews of 10 community members, including a local leader. A thematic analysis of these three case studies was used to understand the main barriers to under-utilisation of the public health facilities and the apparent preference for private facilities.

Results

District profile in the survey area: Table 1 shows that though each district has specific features different from the others, taken together they have almost the same average household size, proportion of rural population, caste profile and type of house as the all UP averages as seen in the 2011 Census. The Muslim population in all the three districts taken together is 12.1% which is less than the state average of 19.3% though in one of the three districts, Aligarh, the Muslim population was marginally higher (21.6%) (Table 1). In Aligarh, the share of BPL households is 17.5%, less than half the state figures, in Hamirpur of Bundelkhand it is about the same—36.7% and in East UP's Kushinagar it is 44.7%, higher than the state average.

Pattern of utilisation of facilities for outpatient care: In this study, 17.4% went to public healthcare facilities for outpatient care and this was higher in rural (24.8%) as compared to urban areas (15.4%) (Table 2, p 56). In Kushinagar, the district with the highest poverty, only 11.8% of care was in the public sector, whereas in Hamirpur and in Aligarh it was 20.6% and 20.9% respectively.

This finding concurs with the NSSO 71st round data which showed public sector utilisation for outpatient care as 15.1%. What is different between the NSSO data and our study is that whereas in our study 53.4% of those who sought private care did so in private clinics (the rest going to private hospitals), in NSSO data the proportion for private clinics is 87.3%.

There was an increase in public sector utilisation in poorer quintiles—from 13.6% in richest quintile to 26.1% in poorest quintile—but what is noteworthy is that even in the poorest quintile, despite the hugely impoverishing effect of private healthcare, close to 73.9% had to utilise private healthcare facilities.

In the NSSO 71st round data, the private sector utilisation in UP in the poorest quintile is even higher—84.4% for rural and 85.7% for urban (NSSO 2016). Other studies also show that the private healthcare facilities catering to this quintile are diversified and the people choose depending on their ability to pay. Most of the time people from the lower quintiles are forced to seek care from less qualified or unregistered practitioners, practising a cross-system of medicine, while people from the higher quintiles prefer quality and expensive private healthcare facilities (Marriott 2009). Thus in the poorest quintile, only 27.8% sought ambulatory care from a private hospital whereas in the richest quintile it is 44.7% (Table 2). This is true even for the public sector hospital care since it has significant out-of-pocket expenditure (OOPE) (Verma et al 2017).

Pattern of usage of facilities for inpatient care: Of those utilising hospitalisation services, 31.35% went to a public provider (Table 3). This is as compared to 41.2% for UP according to the NSSO 71st round (NSSO 2016). Again, the lowest utilisation of public sector healthcare was in Kushinagar with only 22.56% using public facilities and even within this most use the CHC or PHC level of care. In Aligarh, over 34.37% of hospitalisations are in the public sector but it is overwhelming at the larger public hospital and less than one-thirds at the sub-district level. In Hamirpur, hospitalisation in public sector healthcare services is the highest amongst the three districts with more or less equal distribution between the CHC/PHC and the public hospitals. Gender-wise, there is a significant difference in the utilisation pattern of healthcare facilities, as 55.6% of women seek inpatient care in public facilities, possibly because of inclusion of obstetric services. This may also account for a major part of the public sector hospitalisation taking place in primary healthcare facilities, since this is not otherwise a site for hospitalisation.

The proportion of population utilising the private sector services is more in adults and the older age group, general caste population, Hindu religion, and with higher educational

levels (Table 3). The biggest difference, however, seems to relate to economic status with 71.7% of hospitalisations in the lowest income quintile happening in public healthcare facilities (of which 45.3% is in primary care facilities) (Table 3). In the richest quintile, 73% people seek inpatient care from private facilities of which almost all are in hospitals.

Utilisation of inpatient care by ailments: The largest proportion of any ailment category undergoing hospitalisation, at the primary care level in the public sector (which includes CHCs) is not surprisingly, institutional deliveries (38.5%). The next highest is blood diseases (11.63%), probably all due to anaemia, and the next in descending order are skin diseases, infections, nutritional (including endocrine), and respiratory illness (Table 4, p 57). Only about one-fourth or less goes to the public sector for any of the other diseases. We note that all the diseases of the national health programmes where universal coverage is part of the design—tuberculosis, HIV and leprosy are part of this category of infections.

Social and demographic determinants: Based on the logistic regression model (Table 5), it can be said that regional disparities, place of living, gender, age group, social category, educational status and income group are significant determinants of healthcare utilisation. This implies that the odds for people of Hamirpur for public sector utilisation are 1.7 times higher than Aligarh while in Kushinagar, the inclination is marginally more towards private healthcare facilities. Urban residence correlates with greater public sector use. The changes with social category are minimal. Women are 3.4 times more likely than men to use a public health facility. The odds for public sector utilisation for children and adults are 1.7 and 2.9 times higher than old age people. Education has a reciprocal relationship—the higher the education the lesser the likelihood of public sector use. There was little difference with caste, though the Scheduled Caste (SC) population was marginally—about 1.2 times—more likely to use a public facility as compared to the general caste. Of all the determinants the one which makes the largest difference is economic status. Households of the poorest quintile are 4.8 times more likely to use public services, and in the second, third and fourth quintile it is 2.7, 1.9 and 1.6 times more likely to use public services as compared to the richest quintile.

Non-utilisation of ambulatory care: The true picture of “choice” of provider emerges only when we examine the proportion of those in need who are unable to access any healthcare services. The proportion of unmet needs for hospitalisation is difficult to assess in a survey, but our survey did provide reliable information on the unmet need for ambulatory care. The proportion of those who had an ailment in the last 30 days but did not take medical advice or treatment is a useful indicator of unmet need for ambulatory care.

In our study, such non-utilisation of any healthcare services was a high 35% (Table 6). Even in NSSO 71st round we find this pattern of lack of access to treatment much higher in UP than the all India average—but it was 15%. This figure ranged from 11.27% in Aligarh, to 25% in Hamirpur to 34.42% in Kushinagar. This puts an entirely different light on Kushinagar’s pattern of high utilisation of private care. It is not, perhaps, an active choice of

the private provider, but an inability to access even the public provider due to barriers which we cannot ascertain from the quantitative survey. Clearly, this distribution pattern suggests that access and affordability of care in public facilities is a key determinant of choice of provider. The figures for non-utilisation with respect to gender, rural residence, religion, age, education and income are all presented in Table 6. Whereas this table describes the variances, we rely on the qualitative study done in the three districts for understanding why this is so.

The logistic regression done shows that the odds of people from Kushinagar and Hamirpur for not seeking treatment despite reporting an illness in the last 30 days are 3.4 and 2.4 times higher than in Aligarh (Table 7). This is, as we discuss later, a reflection of the differences across these three districts in both socio-economic status and in access to public health services. Likewise the odds of females for non-utilisation of ambulatory care are 4.8 times higher than for males, which reflects huge a gender bias in health seeking behaviour. In rural areas, the odds of foregoing treatment are 2.23 times higher than in urban areas. Those from the SC and Scheduled Tribe (ST) group are 2.1 times more likely to forego treatment as compared to those from the general category. The odds for adults forgoing treatment are 1.79 times higher as against old people. Those with no education at all are 4.3 times more likely to forego treatment despite reporting illness as against people with education above the diploma level. Similarly, people with education up to primary level are 3.4 times more likely to forego treatment. However, the economic quintile is the most dominating factor which effects the non-utilisation of resources. The odds for people from the lowest quintile for not seeking treatment are 4.9 times higher than for those belonging to the highest quintile and the odds for the second quintile against forgoing treatment are as high as 3.8 times. This shows how economic status acts as a barrier to seek healthcare and people from the lower socio-economic strata are forced to forego treatment due to lack of resources.

Systemic Factors

To understand further the determinants of non-utilisation of public sector health services, we compared the density of public health facilities across the three districts, and within each district, did a case study of one apex primary healthcare facility. Here, we refer to the primary care facility that acts as the first site of referral and reporting for all the sub-centres and PHCs in the block. For the case study we chose the Sumerpur block PHC in Hamirpur district, Hata CHC in Kushinagar and Harduaganj CHC in Aligarh district.

We find that only Hamirpur has a facility density as per the recommended norms. Both Kushinagar and Aligarh need almost twice as many primary care facilities as they have now to meet the norms (Table 8). To a considerable extent, there is some compensation available in Aligarh because of a much greater number of public hospitals and public hospital beds. There are two district-level hospitals of 100 beds each, plus a new district hospital of 150 beds plus a medical college hospital with 1,500 beds.

The case study findings of the health facilities can be summarised as follows:

First, there is an excess of outpatients at the block headquarters CHC of Hata where approximately 450 outpatients are seen per day by two doctors. Even in the best of the three districts, Hamirpur, in the block PHC studied, there are 250 outpatients per day who have to be seen and treated within six hours by two doctors and this allows less than one minute per patient. Even if doctors take longer time, patients become impatient, after having waited in queue for hours. The resultant poor quality of interaction is clearly a major determinant of poor quality of care. We also find that the low utilisation of public services in Kushinagar relates to a lower density of functional public healthcare facilities, and where it is functional, there is no problem of under-utilisation. Second, the range of services being offered are very minimal. In Kushinagar, even basic diagnostics are not available. All that is available is services for conducting normal deliveries and services for treating some simple acute medical illness—notably fever, acute upper respiratory illness, diarrhoea and minor injuries—all the rest being referred away. Even basic diagnostics has to be done outside the facility. In Hamirpur, the situation is the same, but with a somewhat better availability of basic diagnostics as related to the national health programmes. In the Aligarh CHC, the range of services is a bit larger with simple surgeries undertaken, and more diagnostics being available. None of the facilities provide for regular treatment of chronic illness though as we have seen this forms a major part of healthcare needs. At the more peripheral level, the situation on the availability of services would be worse.

Third, except for minor simple illnesses, drugs and diagnostics are not available, or the available medicines are not prescribed. In one PHC, out of 92 drugs on the list only 24 were available and these largely related to the usual shortlist and not the expanded care package that includes chronic illness. Drugs and diagnostics have to be purchased outside as noted in both, our quantitative study and in the NSSO 71st round. This accounts for the major part of OOPe in the public healthcare facility. There are also significant user fees being charged and this is also a major reason for exclusions more so in those districts which are poorer. In the one year between 1 April 2016 and 31 March 2017, the Hata CHC in Kushinagar district (the district with highest levels of poverty, and highest incidence of non-utilisation of any healthcare) had collected ₹ 1,45,234 as user fees. The Harduaganj CHC (Aligarh) collected ₹ 72,750; and Sumerpur block PHC (Hamirpur) collected ₹ 76,680. The most important source of such user fee collections were from charges for diagnostics.

Fourth, all three case studies show that upward referrals are not an organised service. The visit to the peripheral facility is thus perceived by the patients and community interviewed as a waste of time and not as part of traversing the ideal care-seeking pathway.

Fifth, across all three case studies we observe both problems of inadequate health seeking and inappropriate high-set expectations. Thus, understandably, many women would prefer home delivery. But also less understandably one interviewed a patient who reported having fever repeatedly for many weeks but had never sought medical care, till a senior family

member was increasingly ill with cough for three months and had to be shown. Underlying such reluctance is no doubt concerns about the consequent expenditure and time lost. With women there is an additional factor. Many women interviewed reported being unable to come to the facility if there was no male escort available—and often, especially for referrals they were not. This could account for the much higher non-utilisation of care by women as measured in our data analysis. The paucity of women doctors—a feature of all three public health facilities studied—is also a serious problem.

There are also inappropriate expectations. One woman with tuberculosis complained of being given the same medicines for every visit and was not sure of its potency, though she was on a well supervised directly observed treatment, short-course (DOTS) regime. Many patients compared the public facility to private facilities where prescriptions usually included a syrup and where intravenous drips were very common. The irrational care of the private sector becomes the standard of care against which public outpatient care is compared.

There are also provider side issues. Many of the providers are on contractual appointment—as part of the reluctance of the state to increase its salaried workforce. The problem with contractual terms of service, as told to us by both the contractual provider and the permanent staff, is that they are always reminded of the fact that he is getting half the salary that his regular employed counterpart is getting for performing the same duties. This grievance, combined with insecurity, limits their ability to relate to the local community or build a sense of ownership and provide in facility performance. In such a context it was easier to start up a private practice, and to lure patients there, even during duty hours, since there are high chances anyway of the contract not getting renewed. There is also the nature of task allocation. Thus one PHC reports six doctors, with four of them allocated to the Rashtriya Bal Swasthya Karyakram (RBSK), which means that on five out of the six working days these four doctors are visiting schools and therefore are available for outpatient care on only one day in the week. A legitimate question is whether this is the best use of medical workers, but the state has no choice since the National Health Mission (NHM) is paying for these contractual doctors and only on these terms. In a state with scarce medical staff, the first call should have been the overcrowded outpatient services, with enough doctors to enable each patient to receive at least 10 minutes of doctor-patient interaction time.

It is interesting to note that almost all the above problems lie in policy and design issues and are not implementation problems. The only exceptions are the demand side cultural issues. In all three case studies the positive role played by the accredited social health activists (ASHAs) in addressing these demand side issues was mentioned. However, successful as they are in this, the presence of the ASHAs would not make any dent on the supply side issues which the case studies illustrate.

Discussion

We have three sets of data from which we can reflect on why patients choose between a public and private provider for their healthcare needs. One is the multiple logistic regression model that explores the social determinants of the choice of provider for hospitalisation in the last 365 days. The second is the multiple logistic regression model that explores the social determinants of the non-utilisation of any type of ambulatory care despite having an illness in the last 30 days. And the third is the case studies in each of these three districts where we looked at both secondary data for density of facilities and qualitative studies with providers, patients and community for understanding the key processes.

While cultural and behavioural aspects no doubt contribute to the pattern of utilisation of public healthcare facilities, it is the lens of political economy that helps us explain these divergences more clearly. The pattern of utilisation is a resultant of three factors, the levels of poverty and underdevelopment in the district, the degree of access to public healthcare facilities, and the availability of required healthcare services in the facility.

Thus, the finding that people in Hamirpur are 1.7 times more likely to use public healthcare facilities over private healthcare facilities as compared to Aligarh and Kushinagar should be read along with the finding that the density of primary and secondary care facilities in Hamirpur is at the desirable level whereas in Kushinagar both primary healthcare facilities have a density of about half of what should be, and in Aligarh primary healthcare density is even worse. Aligarh's better utilisation of public health services despite its lower primary healthcare density is due to a much better number of secondary and tertiary hospitals which respond to much of the primary healthcare needs. The outpatient clinics in each of these three facilities are full and overflowing, and this is despite the one minute per patient de facto standard of care, which reflects the fact that despite such a quality gap, if services are available, people come to utilise them. Clearly therefore, physical access is a determinant of greater likelihood of use of public facility.

Causes of Non-use of Facilities

Such an interpretation gains support from triangulating with causes of non-use of any care for an illness. In Kushinagar, where the density of facilities is lowest, the chances of non-use are 34.42% which is a 3.46 higher likelihood as compared to Aligarh and 1.42 times the likelihood of doing so in Hamirpur.

This would mean that a large section of population in need for services are staying at home, because they are unable to access or afford care even in the public sector. Kushinagar has the highest proportion of BPL households (44.7% as compared to Aligarh at 17.5% and Hamirpur at 36.7%). Kushinagar is not more privatised, but it is merely reflective of being the least developed public health sector. This could be not only in terms of density of facilities but in terms of what services are available and financial barriers in the form of user fees collected. In such an interpretation we could make sense of some of the other

findings. Urban residence correlates with almost a two-time higher likelihood of public sector use as compared to rural residence despite private sector being more readily available, since it is not an active preference of private provider but the access to public provider which is the greater determinant. Social category makes for only a small difference in choice of provider but there is a sharp gradient with income quintile. In the poorest quintile 71.7% would seek hospitalisation in public sector as compared to only 27% in the richest quintile. The multiple logistic regression shows that the SCs/STs are twice as likely and the poorest quintile 4.9 times as likely to not seek any care for an illness as compared to the general caste and highest income quintile respectively. This clearly brings out that for the poor with all its limitations the public sector remains the main choice but even this remains far out of reach to about one-third of all patients who “choose” not to go to any provider whatsoever.

The increased likelihood of using the public sector services where access is better and its correlation with social determinants should not give the impression that physical access is the only limitation. Even in Hamirpur, where the density of facilities is very much as per norms—80% of ambulatory care use and 69% of hospitalisation is in the private sector. The 20% who go to the public sector for ambulatory care are more or less equally distributed between the PHC/CHC at one end and the public hospital at the other. In Aligarh, 80% of ambulatory care and 65% of hospitalisation is in the private sector, but here only 4% of ambulatory care is at the PHC/CHC level and 16% is in the public hospital because there is lower density of PHCs, with only one per 78,167 population as compared to one per 26,933 in Hamirpur and one per 53,202 in Kushinagar; but, it has 1,850 beds at the district level as compared to only 100 beds in each of the other two districts. The site of most ambulatory care therefore shifts to the public hospital, which would be more expensive for both patient and the system.

One reason that we consider as contributing to decreased utilisation of public sector even where physical access exists is the basket of services available within the PHC/CHC. Thus, we find that women are 3.4 times more likely than men to use a public health facility because care in pregnancy and childbirth is one of the more commonly utilised services by women and its availability in the PHC/CHC level is much better. That utilisation is least in the elderly could be also because primary care for chronic illness is less available at the periphery. The fact that the educated would choose private sector more readily is also consistent with a greater knowledge of availability of services.

This explanation finds more support from our case studies. All that is available in the PHC/CHCs of Kushinagar and Hamirpur are services for conducting normal deliveries and services for treating some simple acute medical illness—notably fever, acute upper respiratory illness, diarrhoea and minor injuries—all the rest being referred away. There are very few diagnostics available and both drugs and diagnostics have to be purchased outside making for less differential between public and private even where care is available. It is only at the public hospital that a larger range of ambulatory care is available, but inpatient

range of services are still limited. In contrast, of those who go to private sector, 67% in Aligarh, 47% in Hamirpur, and 50% (Table 2) in Kushinagar are treated at the single-doctor clinic, implying that there is a much wider range of primary level curative care available in the private sector.

But the latter comes with a cost not only in terms of prices, but also in the perception of quality care that it creates. Thus, at least a part of the dissatisfaction with the public sector, beyond the lack of services, is the manipulated perception of what constitutes attentive care. Our case studies showed that irrational practices like intravenous drips, injections, and prescriptions of syrups is the norm in the private sector and the lack of these in the public sector is seen as a fault. When patients report a lack of credibility, they are in part responding to the time, effort, and expense they wasted in going to a public hospital only to be referred away, and partly to the fact they get the same limited range of drugs, many of which do not work (because they are mainly symptomatic treatment or inappropriate) and partly to a perception of care as set by the private sector.

There are also demand side factors at work, and clearly many barriers to seeking any sort of medical care. Thus the finding that women are 4.85 times as likely to go without care as men could relate to two findings in our case study, that in the absence of an “escort” many women are unable to access care and that there are too few women doctors in the public health services. This may be in addition to other gender-related barriers described in literature, like a lower concern within the family for women’s health, or the inability to get away from domestic work, etc (Srivastava 2010). Our case studies note that health-seeking behaviour has changed where the ASHA has intervened, but since the ASHAs work (like the services in the primary centre) are very limited in scope the demand side barriers remain unaddressed for most healthcare needs.

In contrast, the general practitioner in private practice represents the main access to primary curative healthcare and this is easier because of more convenient timings, ease of access and the possibility of building up a mutual recognition and trust.

Implications for Policy

Much has been written about UP’s poor public health sector performance. The poor utilisation of the public sector, despite a five times higher OOPE in the private sector, has been interpreted to imply a public preference for the latter and therefore a reform direction that looks to shifting ownership of public facilities to private hands or promoting purchasing of care from private providers (Marriott 2009). There are two problems with this understanding.

First, the poor performance of the public sector is a consequence of both inadequate budgetary allocations for existing facilities and underinvestment and consequent underdevelopment of new facilities (Sundararaman et al 2016). Because UP has greater health challenges it should have called for a greater density of public healthcare facilities.

But what we find in our case studies, which is consistent with secondary state level data of state public health infrastructure is that the density of public health facilities is less than the national average and far less than the states with better health performance. In terms of densities we have only one sub-centre per 9,592 population in the state as against the recommendation of one per 5,000 population, one PHC per 57,154 population as against a norm of one per 30,000 population and one CHC per 2,58,489 against a norm of one per 1,20,000 population (computed based on facility figures from RHS, 2014-15 and UP population of 2011 Census). Further, there is a sharp underinvestment in the regular public health workforce. We find both from our case studies and from literature that sanctioned posts are less than required. Further, most of the newly added workforce is on contractual terms of employment, though there is no evidence that such terms of employment are in anyway beneficial and there is some evidence to the contrary.

Second, the highly selective nature of services in the district health system leads in effect to a withdrawal of other services from the public sector—a sort of creeping privatisation. This along with the introduction of user fees was dictated by policy changes. The state has been the site of action of almost every international aid agency with World Bank, United States Agency for International Development (USAID), Gates Foundation, UNICEF being the most active. The World Bank guided reforms in the 1990s persuaded governments to restrict public services to the limited health conditions which are the same ones currently available as seen in the case studies. The rest were to be left to private markets (World Bank 1993). UP was one of the few states that insisted that user fees collected by hospitals to be deposited in the treasury as revenues for the state (Dipankar and Peters 2007), a very perversely iniquitous arrangement of earning from the sickness of the poorest sections. This policy was reversed only in the last few years but even now user fees are collected for local use. We note that in Kushinagar district, which has the highest levels of poverty in the three districts we studied, and where the proportion of people who did not utilise any healthcare for ailments was highest, the user fee collection in the PHC studies in the previous year was ₹ 1.4 lakh as compared to ₹ 0.7 lakh in the other two districts.

The repeated visits where they are referred away for lack of services, user fees and having to purchase drugs and diagnostics from private facilities all contribute to a lack of credibility of the public health facility. Social determinants also affect poor public sector utilisation, reflected not so much in choice of a private provider, as the “choice” of not taking any treatment. Where relevant services are available, the facilities are overcrowded.

What policy discussions repeatedly emphasise are the rudeness and apathy of public provider staff which is perceived as a major factor in pushing away healthcare seekers especially those from poor and marginalised sections. There are without doubt many such complaints, and such complaints are also captured in the case studies, but it is unclear whether this contributes to a shift of provider and there is little evidence that these aspects of behaviour are better in the private sector. Policy discussions also emphasise poor accountability and high levels of corruption but these problems of governance would persist

even where the government shifts to purchasing care (Marriott 2009).

This discussion gains importance in the context of the push from the government, in particular the NITI Aayog, to shift to the path of purchasing from the private sector, and discourage further investment in public provisioning of healthcare (Sethi 2015). There is a recent move to hand over substantial control of district hospitals to private sector in the name of expanding care to include non-communicable disease (Nagarajan 2017). The Government of Uttar Pradesh with the Bill & Melinda Gates Foundation has also recently floated a tender to outsource public healthcare in two or three districts to consortiums of private providers (CHMI 2017). All of these seem to assume that the problem is in the ownership and financing, whereas what we have shown is that problems of access and design are much more central. We have also shown in our earlier paper that purchasing from private sector in UP in the form of government-funded health insurance is almost a non-starter.

Given that it is one of India's poorest states and its adverse social determinants lead to a higher burden of disease, it is important to advocate a much larger per capita public investment than the national average for public provisioning of subsidised or free services. This is required both for improving access to healthcare for the poor and as the main strategy of financial protection against further impoverishment due to healthcare costs. The problems of public service delivery and poor quality in Up are not to be minimised. A more comprehensive package of services, less ope with public services, better social accountability mechanisms, more institutional capacity in logistics, human resource management, and quality assurance systems, all of which have been successful in better performing states, are the way forward, and not a premature and ill-evidenced shift to purchasing from private providers.

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