OBS+
GYNAE

William Dooley **May 2011**

Elective Report

Objectives:

- Describe the prevalent Obstetric and neonatal complication and gynaecological disease in Southern India
- How are the O&G and neonatal services delivered in rural and urban settings in South India? How do they differ to the UK?
- To explore the methods used to monitor and manage complicated patients in labour in different healthcare environment
- To further explore a range of specialities in terms of potential career options.

List of hospitals visited and specialties observed:

- Fernandez Hospital, Hyderabad (O&G)
- Hyderabad Maternity Government Hosptial (O&G)
- Narayana Hrudalayala Hospital, Bangalore (O&G, General Medicine and T&O)
- Rural Development Trust (RDT), including visits to 3 village clinics (General Medicine)

Report:

The aims of my elective centred on a contrast in the healthcare provided in the UK and India and between the different levels of healthcare provided within India. I was particularly interested in the area of Obstetrics and Gynaecology although have had experiences in many different specialties. To achieve these aims I visited many different healthcare providers within India; from small village clinics with only 3 inpatient beds and one doctor, to a poorly funded Government Hospital and two contrasting privately run hospitals; the relatively small Fernandez Hospital and the vast health city in Bangalore.

The healthcare provisions differ greatly in the UK and India. The NHS in England offers a high standard of free healthcare to all citizens, with private medicine's role being supplementary to this offering quicker and sometime more specialist care at a cost. In India the government hospitals are of a very poor standard; the funding is much too low compared to the vast numbers attending and the quality of care and hygiene is poor. Private hospitals therefore have a very different role; there are vast numbers of private hospitals competing in price and standard which offer differing levels of healthcare standard at varying levels of price. The government funding the Britain is £122bn for a population 60 million whereas the Indian government provides only the equivalent of £3.2bn for its population of 1.2 billion. This is why India relies so heavily on the private healthcare sector.

With the level of poverty in India high when compared to UK many of the community are unable to afford the prices at the private hospitals and so are resigned to attending the government hospitals. My visit to the labour ward in the government maternity hospital was a shocking experience. There were 9 women in the "active" labour ward at any one time, with no level of privacy and on beds that would have been more suited in a butcher than a hospital. There was only 1 doctor on the ward at any one time and there is on average 30-50 deliveries per day, and so there had to be a compromise in the care of each mother. The level of hygiene in the hospital was appalling. The gloves used for examination and delivery were washed and re-used countless times, instruments were often clean but never sterile and artificial rupture of the membranes were done using the same needle used to pierce the saline drip and re-used for the whole ward without washing. The consideration for the mother's wellbeing was very much lacking; blunt scissors were used to perform the episiotomies which were subsequently often left for hours before being sutured.

Many women travelled very far to receive any sort of care for their delivery and often had had no antenatal care previously, and so the risk stratification usually carried out before labour was not able to be done here and so the rate of emergency caesarean sections was extremely high. The post-natal care was also often performed outside this hospital and so the rates of infection and complications were unknown, although I would imagine them being extremely high.

This was in complete contrast to the other hospitals I visited. The non-government hospitals had a far better standard of care, achieved by better staffing levels, equipment and hospital environment. Fernandez Hospital is a 130-bed maternity hospital, which offers step-wise private health care. The profit made from the highest and most expensive standard of care directly helps to fund the lower standards of care. This way women who cannot afford even the lowest care often have their care subsidised (and even free in some cases) to ensure that patients are only turned away in very rare situations. Their mission, "To offer affordable, quality healthcare for women and the newborn" is certainly met and is such a stark contrast to the environment of the government hospital that would often be the alternative.

Narayana Hrudayalaya Hospital (NH), has been branded a "health-city" due to its enormous size (5000 beds) and exponential growth (it aims to have 30,000 nationwide in 10 years). NH is a for-profit, corporate hospital that makes profits that are more than the average private American hospital; it has an aim of "Caring with Compassion" and making health care affordable for all. There are several insurance "schemes" for farmers and other low-income families, however these only pay for surgery, and payment for the remainder of care must be made before any significant treatment is carried out. For those who don't fall into these schemes or for the long list of "exlusion conditions" (for example medical conditions, nursing and food costs) there is no subsidy. It is therefore a frequent occurrence that patients are turned away, or in emergencies not treated purely based on the financial situation of the patient. I feel that this common situation is a major

limitation of corporate private hospitals in a country where 25% of the population is below the poverty line and a much higher proportion unable to afford the bills.

The Rural Development Trust is a different model again. It was founded by the motivated Spanish Father Vicente Ferrer as part of his mission to improve the education, healthcare, women's rights and ecology of one of the poorest areas of India. There are now 3 hospitals in the area offering healthcare that is affordable for all. With patients at most paying for their medications, the poorest people in the area receive it completely free (including treatment costs at tertiary centres such as NH for complex treatment). A substational daily nutrition programme has also been set up for the young, elderly and those with chronic illness, delivered to their villages, with very impressive results. This project is funded by fundraising in Spain and the Spanish Government and has been hugely successful.

There are very different pressures on Indian women than their UK counterparts. The average age of marriage is 21 in India compared with 29 in Britain and the "demand" for a family to be started soon after marriage is very apparent in India. Gynaecology outpatients had its range of conditions similar to Britain, although sometimes presenting much later and therefore in more advanced disease. These conditions however were diluted in each clinic by vast numbers of patients regarding their fertility. Patients would frequently come after 6 months of marriage and demand interventions and investigations to determine the reasons why she has not become pregnant. These unrealistic expectations must be countered by the doctor, although investigations do begin at 1 year compared with 2 years in Britain due to these demands and the increasing stress that the woman is put under by the family and the husband.

Cervical cancer is another vastly contrasting area of obstetrics and gynaecology. India contribute 100,000 of the 350,000 new cases of cervical cancer across the world each year, making it the most common female cancer in India. There was a screening programme in both the private O&G hospitals that I attended, however due to the cost and the lack of health awareness the uptake was low. This is in contrast to the UK where 78.9% (4 million) of the target group (18-49 yo women) did partake in the screening in 2010.

The rates of maternal and neonatal mortality also bared significant contrast. The maternal mortality in the UK and India are 8.2 and 253 per 100,000 live births respectively, while the infant mortality rate is 5 and 53 per 1000 live births respectively. The rates of infant mortality rates in both countries have reduced almost equally by about 40%, which shows that progress is being made.

For a country that has such vast levels of healthcare demand due to its disease profile and population size the ideal model for improving this burden needs to be sought. The government hospitals in this country are so poorly funded that providing quality healthcare to the masses falls upon the private hospitals. The care provided by the RDT is inspirational and has helped so many of the very poorest people in India not only have quality free healthcare but also has helped them in so many other aspects of their lives.

This however is a unique situation with the Spanish funding and support which ensures doubt over whether this model could be repeated without further funding from elsewhere. NH Hospital is very successful in bringing down the treatment costs of some of the highest quality of care in India. However, the limitations of such as for-profit organization are clear to see and do not universally help the poorest sections of the population. From my varied experiences of private hospitals in this country I believe that the system that Fernandez Hospital has is one that seems the best at offering the highest quality of care to those who can afford it whilst ensuring that the poorest people are given all the help they can to ensure that few are rejected help. Admittedly, this is a relatively small hospital caring only for maternity patients and so whether this method would be generalisable in a large multispecialty hospital such as NH is debatable.

During my elective I spent much time experiencing O&G, but also spent time on general medical wards, neonatology, respiratory medicine and trauma and orthopaedics. This has allowed me to further explore my career options to get a better idea on what specialty I am interested in. Spending time experiencing, especially O&G, at vastly differing standards of care has allowed me to appreciate good care and better understand particular areas of the specialty that will positively influence my future career options.

WORD COUNT: 1597