

Obstetrical Performance in Private Sector

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Summary

We have collected data from 120 private clinics covering 41,998 confinements. The profile of women going to private clinics is different from the profile of women in public hospitals. The women in private clinics are educated, register early in pregnancy, make more antenatal visits, have better haemoglobin status and are well nourished. The caesarean section rate in private clinics varies from 16-52% with a mean of 25.2 percent. About 66 percent of breech presentations are delivered by caesarean section and 80.9 percent of previous caesar are delivered by repeat section.

Introduction

There are more than 20 million births every year in India. Unfortunately, only 50% of the pregnant women seek antenatal care and less than 15% are delivered in health care facilities. Therefore, we do not have much data on deliveries taking place in woman's home. Even among institutional deliveries the information reflects the obstetrical performance in public hospitals and teaching hospitals. Many private hospitals maintain some data of pregnant women under their care. However, there is no published data on obstetrical performance in private sector. Though services in public hospitals are largely free, some women from upper social class or professional class prefer to go to private clinics. The question is why women prefer to go to private clinics and pay the fees when

services are free in public hospitals. Women have to spend longer time in registration, clinical examination and finally for getting the medicine from hospital pharmacy in public hospitals. In contrast, the services in private clinics are prompt and there is less redtapism. The staff in private clinics is by and large responsive and sympathetic. Women perceive that their privacy and confidentiality is maintained. Finally, women perceive that going to private clinics has a status value in society.

The purpose of the present study is to document quality of obstetrical care and obstetrical performance of women delivering in private hospitals. It must be remembered that there cannot be uniformity in quality of care in private hospitals. This is because small nursing homes in peripheral and rural areas may be able to provide minimal obstetric care and may not have infrastructure to manage complicated deliveries. In contrast, there may be private nursing homes and Trust hospitals offering tertiary level care and can manage any obstetrical emergency. Just as there cannot be uniformity in health care in private clinics, there cannot be uniformity in quality of care in public hospitals. The facilities in primary health centres (PHC) are limited and cannot treat all obstetrical complications. Some public hospitals and teaching hospitals may be providing best tertiary level obstetrical services. We have tried to evaluate obstetrical performance in small nursing homes in urban and rural areas, Trust hospitals and large nursing homes throughout India. We expected some regional variations in obstetrical outcome. Therefore, we have analyzed some obstetrical parameters region wise. The North zone includes Haryana, Punjab, Himachal and UP states. The South zone includes Kerala, Karnatak, Andhra Pradesh and Tamilnadu. The Eastern zone includes Assam, Bihar, West Bengal and Orissa. The Western Zone includes Gujarat, Maharashtra, MP and Rajasthan.

Material and Methods

The study covers about 120 private sector clinics located in urban and rural areas throughout India. A simple one page proforma with 45 items was devised and

pretested in a few clinics before initiating the actual study. The instruction manual was prepared to guide the person filling the forms. The data was collected every month from all centres and checked at the headquarters. If there were any queries, the centre was asked to clarify. The data was fed in the computer after all scrutiny. The present study covers 41,998 confinements. The project report is getting finalized. We present here the salient features of the study. The complete details would be available when the final report is ready. We have analyzed the socio-demographic profile, past obstetrical performance, number of antenatal visits, main antenatal complications, mode of delivery, management of breech presentation and delivery in cases of previous caesarean section.

Analysis

Socio-Demographic Profile

The socio-demographic profile is summarized in Table I. The antenatal care is availed by 90% of the women in private clinics. However in rural areas only 84% of the women are booked. Private clinics also cater for emergency admissions and referred cases from other private and public hospitals. Complicated obstetrical emergencies from PHCs or smaller nursing homes are referred to private clinics who have facilities to deal with such complications.

Table I: Socio-demographic profile of women

Residence	Urban 75%, Rural 25%
Booking status	90.6% booked
Age	5.5% teenagers
Parity	43.7% are primi 2.1% para 4+
Literacy	9.2% illiterate 30.9% are graduates and above
Tobacco	3.6%
Alcohol	0.7%

There are fewer pregnancies in teenagers in private clinics. There were only 5.5% below the age of 20 years who delivered in private clinics. The teenage deliveries in public hospitals vary from 10-15 percent. More women above the age of 30 years deliver in private

clinics. Primipara is the largest group delivering in private clinics. There were only 2.1% women more than parity 4+. The women in private clinics are educated and only 9.2% were illiterate. In southern zone illiteracy rate is only 5.4%. Women registering in private clinics are also used to tobacco and alcohol. About 3.6% of the women were taking tobacco in some form. In Eastern India 24.2% women consume tobacco (mainly chewing). Only 0.7% of the pregnant women consumed alcohol.

Antenatal profile

The antenatal registration is 90%. Not only this but 75% of these register in the first half of pregnancy. The mean antenatal visits are 7.1 as compared to 4.6 in public hospitals. The maternal weight at registration was more than 50 kilograms in 70% of the women. About 3.7% of the pregnant women weighed more than 70 kilograms. The incidence of severe anemia is very low. Only 0.3% of the pregnant women had haemoglobin less than 5 grams percent. Only 36.5% of the women had haemoglobin more than 11 grams percent. This means that by WHO definition, more than 60% of the women in private clinics are anemic. Malaria, infective hepatitis and heart disease are the main medical complications in the antenatal period. (malaria 1.6%, infective hepatitis 0.3% and heart disease 0.4%). Pregnancy induced hypertension (8.2%) and antepartum haemorrhage (0.9%) are the main obstetrical complications during pregnancy.

Intranatal profile

Table II: Antenatal profile

No. of visits & Booking time	Average No. of visits. 7.1 75% register in the first half
Haemoglobin status	Hb. Upto 5 grams 0.3% Hb. 7 G to 10.9 G 60.2% Hb. 11 G.+ 36.5%
Maternal weight	9.2% less than 45 kg. 70% more than 50 kg 3.7% 70kg.+
Medical complications	Malaria 1.6%, infective hepatitis 0.3% heart disease 0.4%
Obstetrical complications	PIH 8.2% APH 0.9%

The incidence of elective induction of labor is 15 percent. The elective induction of labor is higher in northern and eastern region (31.2 & 30.7%). In private clinics in rural areas incidence of elective induction of labor is only 11.5 percent. The consultant or his resident doctor conducts 90 percent of the deliveries and nurses conduct less than 10 percent of the deliveries. This is in contrast to public hospitals where nurses/medical students conduct most of the deliveries and consultant/residents conduct only operative deliveries and high risk deliveries. The incidence of spontaneous vaginal delivery with or without episiotomy is 61.3 percent. Caesarean section rate is 25.2 percent, it varies from 16 to 52%. The incidence of caesarean section in northern and southern region is 38.4% and 32.6%. Live births was the outcome in 96.1 percent, still birth was in 1.9% and 0.5% had neonatal death. The main causes of neonatal death were asphyxia, jaundice, infection and malformation. The baby weight was more than 2500 grams in 69% of the cases. Only 2.4% of the newborns weighed less than 1500 grams. Tube ligation during the stay in the hospital was performed in 6.8 percent of the cases. At least 40.2 percent of the women showed the desire to use some family planning method. There is a tendency for short hospital stay in private clinics. (29% were discharged within 3 days and

breech by caesarean section. In the present study 66% of breech presentations were delivered by caesarean section. In northern and southern region caesarean section was performed for breech presentation in 82.5% and 78.7%. In public hospitals the incidence of caesarean section for Breech presentation is 37.5%.

Management of cases with previous caesarean section is another issue which has raised more debate. The trend in private hospitals is to perform caesarean section in such cases. About 80.9% of women with previous caesarean section were delivered by caesarean section. Repeat caesarean section was performed in 56% of cases in public hospitals.

There is great uniformity in managing cases of placenta praevia. Nearly 60% of cases of placenta praevia were delivered by caesarean section in private clinic as well in public hospitals.

Maternal mortality

There were 13 maternal deaths. Pregnancy induced hypertension resulted in 3 deaths, eclampsia in 1 and jaundice (one had renal failure with jaundice) in 3. There were 3 deaths after caesarean section. Two of

Table III: Caesarean Section Rate in India in Percentage

Overall	Eastern Zone	Northern Zone	Southern Zone	Western Zone	Rural Private Clinics	Public Hospitals
25.2	23.4	38.4	32.6	20.8	18.4	19.7

Table IV: Incidence of Caesarean section for Breech in Percentage

Overall	Eastern Zone	Northern Zone	Southern Zone	Western Zone	Rural Private Clinics	Public Hospitals
66	56	82.5	78.7	58.77	50.78	37.5

Table V: Caesarean Delivery in Previous Caesarean Section in Percentage

Overall	Eastern Zone	Northern Zone	Southern Zone	Western Zone	Rural Private Clinics	Public Hospitals
80.9	85	87.7	78.3	81.77	75.47	56

48% were discharged within 4-7 days). The hospital stay was more than 8 days in 17.3 percent of the cases.

Management of Breech presentation is the issue of debate all over the world. There is a trend to deliver

these had severe anemia (haemoglobin less than 5 grams). There was anesthetic complication after caesarean section in the third case. One died due to PPH after twin delivery. The maternal mortality is 30.9/100,000 births. FOGSI-WHO (Bhatt, 1997) reported maternal mortality of 572

in teaching hospitals. The study did not include other public health care facilities like PHC and district hospitals. The maternal mortality in teaching hospitals is bound to be high because all complicated and high risk cases finally end up in teaching hospitals. The data includes maternal death in numerator but does not include deliveries in referring centres to the denominator. In spite of the discrepancy in data from teaching hospitals, there is no doubt that maternal mortality is very low in private institutions. The possible reasons are that women going to private clinics are more educated, coming from upper socio-economic class, well nourished and the complications are detected early because of more antenatal visits and promptness in health care.

Conclusions

There is not adequate data about obstetric performance in private clinics. The socio-economic profile of women going to private clinics is different from the profile of women going to public hospitals. The women going to private clinics register early in pregnancy, make more antenatal visits, have better haemoglobin status and are well nourished. They do not have transport and communication problems. There is no shortage of drugs or other life saving facilities. Of course there are small

private clinics where there is no facility to deal with high risk obstetric problems. But such patients are referred to better health care facility in time by the practising doctor

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