ETHICAL ISSUES IN THE ORGANIZATION AND DELIVERY OF WELFARE SERVICES

DR. D. SEETHA NAIK

FACULTY
DOS IN BUSINESS ADMINISTRATION,
B.N.BAHADUR MANAGEMENT SCIENCES,
UNIVERSITY OF MYSORE, MYSORE,
KARNATAKA, INDIA

ABSTRACT
This paper focuses on the new dimensions of ethical issues in organizations and delivery of welfare services in India. Ethical issues in health workforce development; The ethical considerations in answering five important illustrations on enabling health workers to deal appropriately with the circumstances in which they must work are described. The ethics of setting standards for the skills and care provided by traditional health care practitioners are discussed.

The theme of this paper has two dimensions, one is the dimension of values, and the other is the dimension of emerging ethical issues. Examining how our values and ethical issues are concerned with management, management covers a wide spectrum of organization. This paper looks at delivery of welfare services in the World Bank group, population, reproductive and child health and also national commission population in India. This paper also explores utilization of and expenditure on delivery care services and the link between uses of institutional facility for delivery care and cost of delivery care services in a population. Analysis is based on data on expenditure on delivery care services collected during a community-based survey on women's health.

KEY WORDS: Delivery, Ethical issues, Expenditure, Welfare services

Prelude
Ethics is concerned with the conduct of human beings. All scientific activities, including those by the social scientists, are conducted with the participation of human beings or have an impact on human beings or on the wider society and environment. Therefore, it is essential that scientist’s researchers understand ethical issues and the implications of their scientific work and act accordingly it is essential that researchers share and discuss the ethical issues in their work and evolve collective standards of their own.

The development of organizational mechanism for ethics in social science research in health has been kept as an open process to be evolved by the community of researchers and institutions. In their future efforts to increase the number of skill levels of their health workers, developing countries will have to confront a number of ethical dilemmas. These will be influenced by the fact that resources are limited in most developing countries, inequitably distributed between countries and, to varying degrees, within countries. Public health is the collaborative actions to improve population-wide health and reduce health inequalities, then the issue of equity will influence the ethics dialogue.
Declarations of human rights and other inspirational documents often speak of a universal right of the best possible health care. In the wealthiest countries, this is sometimes achievable with regard to availability of drugs, equipment and facilities. These same abundant resources make it possible to train doctors and other health-care workers to the full extent of their capabilities. In the developing world, even in the poorest countries, health ministries are urged to license and certify physicians and other health workers and to ensure that each person permitted to practice health care has had proper training.

The theme of this paper has two dimensions. One is the dimension of values, which are perceived to be eroding in Indian management and the other is the dimension of emerging ethical issues. Perhaps a good starting point for our exercise may be to begin by examining how our values and ethical issues are concerned with management. Management covers a wide spectrum of organization. Peter Drucker has pointed out that the principles of management remain the same whether it is a business enterprise or a non-profit organization. In the context of GAIL we should of course look at the issues of management from the point of view of a business enterprise.

India was among the first developing nations to recognize the threat rapid population growth poses to national development and to adopt policies to address the problem. India’s Family Welfare Program, launched in 1951, has contributed significantly to improving the health of mothers and children and to providing family planning services.

At present, only one-third of the deliveries in India take place in a health facility / institution, while the remaining are home deliveries. In fact, this is part of the problem faced by Indian women in relation to their access to basic and good quality health care services.

Mainly the Government and the private health sector provide health care services in India, with the private sector provision having a large share. Expenditure on inpatient and outpatient care is also expectedly higher in the private sector than the public sector.

**Ethical Issues in Health Workforce Development**

Standards of Care to Which Health Workers are Trained

There are many paths to health and there is no point in insisting that all countries follow one model. At each level of economic development some countries are vastly more successful than others both in achieving good health for their populations and in delivering health care. Although people in developing countries must accept that they lack the resources needed for health care at the standards prevailing in the wealthiest cities, surely the citizens of a given developing country should receive health services comparable to those available in other countries that are at the same level of economic development. Comparisons can be made by looking at WHO's ranking of national health systems, which, for all its flaws, is a systematic attempt to assess the overall efficiency of national health systems with respect to the morally relevant criteria. The relevant comparisons would come from the answers to the following questions.

- How much health does a country produce in its population relative to the resources that are available?
- How equitably are these health benefits distributed?
- What is the extent and distribution of desirable attributes of the health system apart from maintaining and restoring health?
- Is the financing fair to the entire population?
WHO's rankings have been questioned, and appropriately so. In view of the paucity of data on which WHO sought to base some of its conclusions; moreover, its interpretation of certain data has been disputed. Nonetheless, the framework itself is a major step forward at the conceptual level in putting ethics to work in global public health. Countries are implicitly held accountable for the efficiency and fairness on the use of their resources. Theoretically, a poor country could do better than a rich one in this regard, and some have done so. Fairness is not an un-quantifiable attribute; WHO has provided an example of how it can be measured. This type of analysis has not yet been extended to health workforce issues, but the work could be a useful starting point. In research ethics there is still a contentious debate as to whether the participants in a study should have access to the best treatment in the world or to the best available and sustainable treatment in the country in which the research is conducted. Although each medical professional might wish to have the skills of the world's foremost practitioner, and the resources needed to provide the best possible level of care, a humane policy for health workers must accept the compromises that are dedicated by the overwhelming unmet needs of those who live in poverty in much of the world. It would be unethical - because it would have to be inequitable - to impose first-world standards in training health personnel, if the result were to limit access to care to a fortunate few.

Ensuring Appropriate Training for Health Workers

Ethical considerations apply to three of the most important issues: training of the health workforce, licensure and continuing education. Curriculum content has been alluded to in the previous section; many of the same considerations apply to postgraduate education. If the quality of training is below some international optimal standard, does this condemn the people - both practitioners and patients - to second-class medicine? Can one be a first-class practitioner of a type of medical practice that accepts compromises due to resource standards might justifiably be proud. One reason must be acknowledged explicitly; knowledge of the modes of health care suitable to the poorest and sickest populations will not help a medical graduate pass the Educational Commission for Foreign Medical Graduates (ECFMG) examination (an examination taken by physicians who want to be licensed in the USA, but have been trained in a country whose medical schools do not have reciprocity with USA institutions). Training to care for the poorest and sickest will not make graduates exportable. The notion of a developing country lavishing scarce resources on training a health professional so that she can practice in a richer country may seem indefensible, given what it may cost to train a physician. In India for example, it costs 70 times the per capita gross national product (GNP) to train a physician and in South Africa the cost is 70 times the per capita gross national product (GNP) to train a physician and in South Africa the cost 23 times the per capita. But practicing in comfortable surroundings with plentiful resources is an understandable preference of health professionals. Is the solution to this pattern of misallocation draconian restrictions on the freedom of practitioners or rather the kind of training that the society provides? It should also be borne in mind that many countries and states train far more health workers than can be locally employed. Countries that have an unwritten policy to overproduce human resources for health for export include Cuba, Egypt, India and the Philippines. Kerala State in India for example, has 3 per cent of the national population and 30 per cent of the nursing schools. The excess nurses who are trained in Kerala then work in other Indian states and overseas and send money back to their families.
Support from the Health System for its Workers
Is it ethically defensible for society to train people and then not support them at even the basic level? Or to support a system of medical training that focuses on resource-intensive procedures that will never be available to most of the country's people? Health authorities have an ethical obligation to determine the appropriate target standard for health care in their country, which requires making comparisons with similar countries at the same level of development, and to provide the best possible training for health workers who will work in that health care environment.

Teaching Students about the Ethics of Health Care
Health professionals take pride in their expertise; and most would think badly of a colleague who offered care that he or she could not deliver at the appropriate standard. But, it is inappropriate simply to adopt the professional standards of the developed world, because this world requires resources that are unavailable to most people in developing countries.

Eroding Values and Emerging Ethical Issues in Contemporary Indian Management
There are certain values, which are important in the context of business enterprise. The most important is the importance of the value of the enterprise for the customer. Peter Drucker pointed out a different context that the purpose of a business is to create a customer and retain him. The values, which are important to the customer, are ultimately the most important values for a business enterprise. The concepts of total quality management and delighting the customer etc., A business ultimately depends on the trust of the customer. Honesty is the best policy. Transparency and truthfulness are the fundamental values of any enterprise.

The second important set of values for an enterprise relates to finance. As Robert Townsend wrote years ago in his book "Up the Organization". "If you are not in business for fun or profit, get the hell out of it"! Very few an afford to be in business for 'fun'. Profit and finance therefore became important value for an enterprise. Recently the concepts of economic value added are attracting the attention. The third aspect of values of business relates to the wide spread impact of information technology. We are in the age of the Internet, e-commerce and e-business. This goes by the name of the "New Economy". In this new category, creativity has become the highest value.

In the Indian public sector and also in the traditional industries where the unions are strong, there is a high degree of stability and less of mobility. In the Indian context, the focus has been always on ensuring job security. Job security was also one method of ensuring loyalty so far as management is concerned. But, in a highly competitive environment where Indian industry has to face global competition, to what extent can loyalty as a value survive?

In fact, in addition to the loyalty of a person to an enterprise, is the loyalty to his profession. Loyalty to profession when it comes to values involves professional codes of conduct. There are professional codes of conduct for every professional like the chartered accountants, company secretaries or doctors or engineers. So, when we talk about values we can also talk in terms of values as cherished by a profession and which are expected to be upheld by a number of the profession.

Business is supposed to be an exercise in pragmatism. If corruption is taken as a part of the scene of doing business in a country, business enterprises factor this aspect also into account and arrange their action accordingly. In fact, the Germal NGO Transparency International publishes
annually the Corruption Perception Index of countries, which is based on the perception of the business enterprises operating in different countries.

The current debate in the Indian business community about ethics is based on the growing realization that ultimately the old adage, 'honesty is the best policy' may have not only a grain of truth but can be a practical guide to operations. The dramatic collapse of the currencies in the tiger economies of South East Asia, especially Thailand and Indonesia, which used to know for crony capitalism and corruption, brought home the fact that ultimately corruption may turn out to be a not good for business in the long run.

India is listed as 66th among 85 countries in the Corruption Perception Index by the Transparency International Corruption has been very much a fact of life for doing business in India. There have been, however, glorious exceptions of companies consciously adopting the ethical principle of integrity and honesty in doing business. One such developing country. There has not been adequate debate on what principles and standards should be taught and upheld in health systems in the poorest countries that would simultaneously uphold the health worker's sense of professional integrity and at the same time address the very difficult question of what constitutes optimal are under severe resource constraints.

It is surprising how little medical and public health ethics is taught in professional schools. Other than taking an oath at graduation most medical and nursing students receive no training in ethics. Yet it forms the backbone of professional guidelines and behavior. Until recently, St John's Medical College in Bangalore was the only one of hundreds of Indian health schools that required students to take a course in medical ethics. Is it an accident that physicians see no "conflict of interest" issues in sending their patients for medicines and tests at their own pharmacies and diagnostic laboratories? Should we be surprised when government doctors refer the day patients that they see in government hospitals to their private clinics after hours? Though one cannot ensure high ethical standards by requiring an ethics course, a good course in ethics can achieve the goal of engaging the student's attention as to the nature of the problems and the need to make a responsible choice between feasible alternatives. It can also remind the student that the health professions carry high expectations for integrity and responsibility. These expectations do not provide formal sanctions, as do laws and regulations, but they do create a climate of opinion in which the health professional will be judged by peers and by patients, and according to which the health professional feels entitled to self-respect.

illustrious company is the Chennai based Alacrity Foundation, which decided up front that they would not indulge in illegal actions and deal with black money even though they were in the business of building houses. The Urban Land Ceiling Act and the Income Tax Act had ensured that real estate became a gold miner for black money. In that sector, for a company to adopt ethical standards was unbelievable and the fact that they succeeded is really incredible. The question is, if Alacrity Foundation can afford to be honest, why not other companies?

In India corruption is an all embracing phenomenon. There are five elements - the corrupt politician, the corrupt bureaucrat, the corrupt businessman, the corrupt NGO and the criminal who are major players in the corruption scene. These five can easily be remembered in Hindi as the Neta, Babu, Lala, Ihola and Dada. In this, if the Indian business community were to 'adopt healthy principles of good corporate governance and avoid corruption in their transactions, India could really take a step forward to becoming a less corrupt country and improving its rank in the Corruption Perception Index.
Five principles of ethical for organizations were -

- **Purpose** - The mission of our organization is communicated from the top. Our organization is guided by the values, hopes and a vision that helps us to determine what is acceptable and unacceptable behaviour.

- **Pride** - We feel proud of ourselves and of our organization. We know that when we feel this way, we can resist temptations to behave unethically.

- **Patience** - We believe that holding to our ethical values will lead us to success in the long-term. This involves maintaining a balance between obtaining results and caring how we achieve these results.

- **Persistence** - We have commitment to live by ethical principles. We are committed to our commitment. Actions are consistent with our purpose. We make sure our

- **Perspective** - Our managers and employees take time to pause and reflect, take stock of where we are, evaluate where we are going and determine how we are going to get there.

The Work Bank Group, Population, Reproductive and Child Health in India

India was among the first developing nations to recognize the threat rapid population growth poses to national development and to adopt policies to address the problem. India's Family Welfare Program, launched in 1951, has contributed significantly to improving the health of mothers and children and to providing family planning services. Forty-six per cent of eligible couples now use some form of contraception, fertility has declined by about two-fifths, and immunization coverage of children is approaching 80 per cent. However, maternal deaths remain high at 437 per 100,000 live births, and the total fertility rate, while below replacement level in the states of Kerala and Goa, is as high as four or more children per woman in the poorer northern states of the Hindi-speaking belt. India's continued high fertility rate, combined with a two-thirds drop in the death rate and a doubled life expectancy, have resulted in substantial population increases, from 342 million in 1947, to 684 million in 1981, to 931 million people today. Each year, 16 million people are added to the population and by 2050, India's population is projected to reach 1.5 billion. Slow progress in the 1980s made it essential for India to devise innovative strategies to achieve greater dynamism in its Family Welfare Program. In the early 1990s, the Government of India began a paradigm shift from a system based on contraceptive method-specific and fertility reduction targets and monetary incentives to a broader system of performance goals and measures designed to encourage a wider range of reproductive and child health services. The Ministry of Health and Family Welfare developed an action plan to strengthen the program and made several recommendations consistent with the reproductive and child health approach. This approach, which was adopted by the Government of India when it initiated Child Survival and Safe Motherhood Program in 1992, is also central to the new vision of population policy that emerged from the 1994 Cairo International Conference on Population and Development. Reproductive health refers to a state in which people can reproduce and regulate their fertility, women go through pregnancy and childbirth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well-being, and couples are able to have sexual relations free of the fear of pregnancy and disease. In its transition to this approach, India is taking careful account of the links between family welfare and other health services. More emphasis is now placed on the private and voluntary sectors as they develop in the increasingly dynamic Indian economy.
World Bank Group assistance to India's efforts in population and Reproductive and Child Health (RCH) dates back to the earliest days of Bank involvement in the population sector. Between 1972, four population projects totaling about US$ 188 million were approved. Since then, Bank Group Government of India collaboration has been stepped up, with approval of five more population projects and a Child Survival and Safe Motherhood (CSSM) Project totaling about US$ 645 million, and preparation of a Reproductive and Child Health Project for some US$ 248 million. The objective of each of these projects has been to strengthen the capacity of the family welfare and health systems to deliver better quality services more equitably.

The development of this lending program has been based on a number of analytical efforts and on a continuous dialogue between the Bank Group and the Government of India, which has allowed the Bank to support India's transition to a reproductive and child health approach. The Bank has focused an increasing share of its attention on those features of the Family Welfare Program that constrain it from being more effective, including reorienting management focus from contraceptive targets to client-responsive quality service. The Bank Group also continues to emphasize assistance to the national immunization program, programs in safe motherhood, and the control of acute respiratory infections and diarrheal disease.

The Ninth Population Project, which became effective in September 1994, is being implemented in three states viz., Assam, Karnataka and Rajasthan and is financed through an IDA credit of US$ 88.6 million. The project supports improved access to demand for, and quality of family welfare services, particularly among poor, remote and tribal peoples.

The project aims to
- Strengthen family welfare service delivery, including establishment of first-referral units;
- Improve the quality of family welfare service;
- Strengthen demand-generation activities through improved information, education, and communications planning and activities;
- Strengthen program management and implementation capacity; and
- Provide funds for innovative schemes to improve service delivery.

Improving Women's Health in India provides a comprehensive overview both of women's health issues and the government's programs to improve them. Despite considerable progress, the report argues that India still has a large, unfinished agenda in the areas of reproductive and child health. The report emphasizes women's reproductive health and the factors underlying excess female mortality at early ages, especially in the northern "Hindi belt" states of Bihar, Rajasthan, Madhya Pradesh and Uttar Pradesh. These states account for almost 40 per cent of India's population and exhibit well-documented unfavorable demographic trends compared with the rest of India.

The book also points out the needs of women in rural areas where mortality levels are substantially higher than in urban areas and access to care is limited. Its focus is on the measures necessary to address existing policy and implementation constraints and improve the quality, acceptability, and use of services essential to women's health. Further progress and more resources are needed.

Meeting the Health Care Needs of Women and Children in the New Century
Population stabilization and sustainable development are critical determinants of human development and quality of life. India, the second most populous country in the world, has no more than 2.5 per cent of global land but 1/6th of the world's population. The prevailing high maternal, infant, childhood morbidity and mortality, low life high fertility had been a source of
concern for public health professionals right from the pre-independence period Committee Report (1946), which laid the foundation for health service planning in India, gave high priority and health status of women and children. This report, which emphasized the importance of providing integration, primitive and curative primary health care services to all based on their needs preceded the Alma Ata declaration decades. Under the Constitution of India elimination of poverty, ignorance and ill health are three important basic goals.

**Utilization of and Expenditure on Delivery Care Services**

Despite growing attention to women's health needs the world over, the maternal mortality figures due to pregnancy and childbirth have been a cause of concern. One major reason for very high level of maternal mortality levels in India is that of lack of medical attention at birth. At present, only one-third of the deliveries in India take place in a health facility / institution, while the remaining are home deliveries. In fact, this is part of the problem faced by Indian women in relation to their access to basic and good quality health care services. Their age, education, earning, occupational status, and role in the family, coupled with the cost of health care services, often govern women's access. It must be added that the lack of medical attention at birth does not only adversely affect maternal healthy / mortality, but also increases the risk of neonatal mortality in the population. Despite five decades of implementation of the official family welfare programme, the progress of institutional deliveries has been far from satisfactory. Perhaps it might have got sidelined because of massive investment required for its promotion and due over emphasis on other relatively cheaper components of the programme like family planning and immunization.

Available studies also show a very high out of pocket expenditure on delivery care. For example, a normal delivery with a skilled attendant tends to range between 3 -7 time higher in Africa and Latin America than in poor countries, where it is quite low. Similarly, it is to be noted that caesarean section that costs much more than vaginal deliveries, both in terms of number of hospitalization required as financial costs, is being misused for profit purposes in private sector in several states. In India, estimates of pregnancy-related expenditures are available through various household expenditure studies. This expenditure varies across the country and time periods. A study in Madhya Pradesh found the total average costs per delivery in urban areas to be 1.4 times higher than rural areas. Another national level survey 8 shows that the average expenditure per delivery in urban India is 1.6 times higher than in rural India. But here, if one had to calculate only institutional deliveries, then the total cost may be higher in rural areas due to costs relating to physical access.

This paper examines differentials in out of pocket expenditure incurred for childbirth in order to assess the validity of the hypothesis that cost of health care services is a significant factor in choice of the institutional facility for delivery care. Since there is a huge difference in expenditure incurred on deliveries in public and private institutions, the paper is extended further to find out sector-wise variations in cost of treatment by certain key variables.

Overall, it can be seen that the majority (67 per cent) had been home deliveries, as found elsewhere in India. These home deliveries might be attended by skilled health providers, trained birth attendants, friends, relatives and other persons and cost of delivery could vary according to assistance during home delivery also, which could not be explored due to limitation in availability of data. Remaining 22 per cent and 11 per cent of deliveries had taken place in the public and private health care sector respectively. The below table also gives average pocket expenditure on delivery care, which includes expenditure on doctor, fees, medicines and beds
spent during the time of delivery. For home deliveries, expenditure on person attending the delivery (if charged) and other medicines taken after delivery was taken into account. The average expenditure incurred per delivery in this population was Rs.512. The expenditure varied from Rs.193 if it was a home delivery of Rs.423 and Rs.2,613 if the delivery had taken place in public and private institutions respectively. This wide differential in costs was definitely a critical factor influencing the decision on source of delivery care sought.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Expenses in Rupees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public sector</td>
</tr>
<tr>
<td><strong>Place of residence</strong></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>14.6</td>
</tr>
<tr>
<td>Urban</td>
<td>42.6</td>
</tr>
<tr>
<td><strong>Order of Pregnancy</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>30.0</td>
</tr>
<tr>
<td>2</td>
<td>20.8</td>
</tr>
<tr>
<td>3+</td>
<td>13.3</td>
</tr>
<tr>
<td><strong>Nature of delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>20.1</td>
</tr>
<tr>
<td>Complicate</td>
<td>63.6</td>
</tr>
<tr>
<td>(Caesarean episiotomies)</td>
<td></td>
</tr>
<tr>
<td><strong>Earning Status</strong></td>
<td></td>
</tr>
<tr>
<td>Earner</td>
<td>16.4</td>
</tr>
<tr>
<td>Non-earner</td>
<td>29.0</td>
</tr>
<tr>
<td><strong>Occupation level of Household</strong></td>
<td></td>
</tr>
<tr>
<td>Unskilled and casual labour</td>
<td>26.4</td>
</tr>
<tr>
<td>Skilled and semi-skilled workers</td>
<td>22.3</td>
</tr>
<tr>
<td>Professional</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22.2</strong></td>
</tr>
</tbody>
</table>

* Denotes mean is based on less than 10 cases

**Place of Residence**
Rural urban differentials were marked. In rural areas, 77 per cent of deliveries were home deliveries, in contrast to only 39 per cent in urban areas. Relatively high level of institutional deliveries in urban areas had taken place in public institutions. The mean expenditure was more than double in urban areas than that in the rural areas.

**Order of Pregnancy**
It is also clear that the preference for institutional deliveries was higher order of pregnancy than the higher order ones. Infact, none of the pregnancies of order 3 and above had taken place in private institution. Women are most likely to get care for their first delivery than others that follow, as there are factors like fear of the unknown or excitement that is probably associated
with the first child. On the other hand, the percentage undergoing home deliveries systematically increased from 46 per cent in first order to 71 per cent in second order births 9 87 per cent in pregnancies of order 3 and above. Women tend to incur decreasing expenditure pattern in the public facilities, with higher order of pregnancy, whereas the expenditure pattern for the home deliveries shows a consistent increasing pattern with decline in order of pregnancy. Average out of pocket expenditure on delivery care was Rs.763 for women delivering for the first time, while it was Rs.244 for women delivering for the second time, while it was Rs.244 for women undergoing deliveries for the third time or more.

**Nature of Delivery**
The chances of going for an institutional delivery are higher if the woman is experiencing health problems during pregnancy. All complicated deliveries (caesarean / episiotomies) had taken place in institutions; data does not show any public - private differentials in the same. It also shows that women prefer to undergo institutional delivery in case of complications. Average expenditure on a Normal delivery was Rs.413 and that for complicated delivery was as high as Rs.2,628. Average expenditure on a normal delivery was four times higher in the private sector, while the expenditure on a caesarean delivery was almost 12 times higher in the private than in the public sector.

**Earning Status**
Though the variable earning status was included as an indicator of pregnant women's autonomy and economic status, the results indicate that it is the non-earners (44 per cent) who are more likely to go for institutional delivery and capable of seeking delivery care from public sector than private sector, than earning women (24 per cent). Again, the women who were non-earners tended to spend more on delivery care than their earning counterparts. The utilization pattern by the non-earners who were more likely to go for institutional delivery, explains this expenditure pattern. The difference in expenditure in the private sector is comparatively larger between the earners (Rs.1742) and non-earners (Rs.3193). The negative relationship involving earning status with both utilization of institutional delivery as well as expenditure on delivery care observed above is mainly due to the above income inequalities between earners and non-earners in this population. Poor women in the population were involved in earning activities than the rich and hence their low utilization of institutional facilities was due to the high cost involved in it.

**Occupation Level of Household**
Occupational level of household was considered as an indicator of the economic status of pregnant woman. This variable is based on the highest level of occupation attained by any member on her household. Overall, the about 50 per cent of the economically well-off 'professional traders' category were having institutional delivery. There was not much differential in utilization of institutional facility for delivery care between the 'unskilled and casual labour' category and 'skilled / semi skilled' category. As can be expected, the chances of undergoing institutional delivery are very high in the highest occupation category than in the other two categories considered, which underscores the role of economic background of pregnant women while selecting source for delivery care. Further, it can be seen that delivery care services in the private sector are mostly accessible to professional/traders category (38 per cent than the others, where only less than 7 per cent had gone in for the same).
Occupational level shows that average expenditure on delivery care varied from Rs.1945 in 'professionals / traders' category to Rs.228 in 'unskilled and casual labour category'. Similar differentials were found in the public and private sectors, which strengthens our argument that potential to pay for delivery care is one major factor that limits women from utilizing institutional facilities delivery care services.

Decision Implications

- Nowadays all scientific activities and social scientists need ethics in their work.
- Especially, developing countries women's health should improve.
- Indian health care facilities, service centers need more technological advances.
- We need strict family planning and immunization.
- In India, morbidity and mortality is high that should be limited.
- Health workers need technical training.
- Low cost treatment should immediately remove, from India.
- We require quality of health professionals.
- In the future as societies seek to address their health workforce needs, they will have to address the ethical issues that have been raised.
- India yet to require skill-full labour to improve the economic development.
- Expenditure on delivery care services are high in private sector, and it should be fixed by the Government.

References

- CIOMS (Council for International Organizations of Medical Sciences) and (WHO) World Health Organization (1993), "International Ethical Guidelines for Biomedical Research Involving Human Subjects". Proposed
- ICMR (Indian Council of Medical Research) (1980), "Policy Statement on Ethical Considerations Involved in Research on Human Subjects ". New Delhi: ICMR.
