

How Expensive is Public Health Care to the Patients ?

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1 INTRODUCTION

The fact that the government shoulders the main responsibility to provide health care which, by and large, is free, does not mean that people do not spend, directly or indirectly, while availing of these services. On the contrary, even while availing of public health services, people do spend considerable amounts. This is owing to (i) non-availability of medicines at the public hospitals (ii) indirect expenses required for travel, diets, board and lodging and (iii) income lost in the process of receiving treatment. It is quite pertinent to get an idea of the resources being spent by patients in availing of the so called "free" health care. Such an estimate could be useful in establishing the feasibility or viability of mobilising resources through a health insurance initiative.

2 THE PRESENT STUDY

The present study is based on a sample of 96 inpatients and 280 outpatients, selected from two public hospitals in Rajasthan. Based on 10 per cent coverage of total indoor and outdoor patients, the information collected between December 20, 1990 and March 19, 1991 comprised 54 per cent and 46 per cent respondents from the two public hospitals situated, one each in Sikar and Kota districts.

Though there are considerable intra-state regional disparities in health services in Rajasthan, the districts in which our study hospitals are located depict certain common features of low level of development (Purohit & Siddiqui, 1993a). For instance, the analysis of available information for the two districts, for the period 1981-90, indicates: (i) high population growth (32.33 per cent) with the proportion of rural population as much as three times its urban counterpart, (ii) low literacy level (4.6 per cent, (iii) SC and ST comprising nearly 16 per cent and 29 per

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cent of the urban and rural populations respectively, (iv) very low level of transport facilities (only 24 registered vehicles per thousand population), (v) low level of overall filled vacancies (59 per cent) and (vi) low utilisation of government health facilities, which ranged around 68 per cent and 2.32 per cent of the population respectively for OPD and Inpatient care.

In this context of low economic development, the estimate of cost per illness episode borne by patients in availing of public health facilities may partly reflect the potential margin of premium to raise resources for health insurance coverage in the area.

In this regard, presumably there tend to exist differences across socio-economic levels *(Purohit & Siddiqui, 1994). Bearing this in mind, we classified the respondents by means of a composite index encompassing income, education and occupation. (See Purohit *et al* 1992) Simultaneously, the differentials in characteristics and composition across the inpatients and the outpatients, as well as across the districts, were also borne in mind. The majority among our respondents (nearly 78 per cent) comprised lower-middle or upper-middle socio-economic strata. Among others, respondents from the lowest and the upper socio-economic strata comprised only 20 and 2 per cent respectively. This composition remained almost similar among the outpatients as well as the inpatients. Some of the major findings emerging from our study, incorporating these various aspects, are summarised in the next section.

3 MAIN FINDINGS

Observations from our sample composition indicate that it is not only the poor who utilise the government health care facilities. A substantial number of patients from other strata (78 per cent) were found to be users of these facilities. A major impediment in utilisation of these health facilities appears to be the distance factor. For instance, in case of inpatients, on an average, the distances from the study hospital, any other nearest hospital and the PHC were 25 kms, 10 kms, and 4 kms respectively. The comparable distances, in case of OPD respondents, were 8.89 kms, 7.71 kms and 3.8 kms respectively. Across the socio-economic levels, the distances varied and were comparatively more for the lower socio-economic levels. As a

majority of the respondents did not have any kind of medical insurance, the household burden of medical treatment was substantial. The direct expenditure includes the amount spent on diagnostic tests and medicines. The indirect expenditure comprises expenses incurred by the patients and their relatives/attendants on travel, diet, board and lodging and the loss of income on account of being away from work during the illness.

On an average, an inpatient respondent had direct spending in the range of Rs. 32 to Rs. 81 per day across different socio-economic levels. This, in effect, amounted to an expenditure of 6.22 per cent, 1.93 per cent and 1.29 per cent of the household income in the lowest, the lower-middle and the upper-middle socio-economic strata respectively per illness episode. Thus, contrary to general impression, a respondent from the lowest socio-economic level had to incur expenditure of a larger proportion of his income in relation to those for the two higher categories.

In line with other public hospitals in Rajasthan, the scarcity of medicines prevailing at the study hospitals was reflected in the nearly 90 per cent of the direct expenditure that was being incurred by inpatient respondents on purchase of medicines alone (Purohit & Rai, 1992 a, b).

Likewise, the distance to the hospital and the inadequate provision for diet and board and lodging had their bearing on the indirect expenditure. The latter expense per day per patient, across the lowest to the upper-middle strata, varied between Rs. 113 and Rs. 193. In terms of income, it comprised 2.95 per cent, 1.36 per cent and 0.62 per cent of the household's income for the lowest, the lower-middle and the upper-middle categories respectively. Further, the composition of the indirect expenditure suggested a major share (43 per cent) on travel. Diet and board and lodging accounted for nearly one-fourth of the indirect expenditure. The loss of income, due to absence from work on account of the illness, comprised another 30 per cent.

In OPD, the average expenditure by patients on purchasing medicines is estimated at Rs. 266.67. Across an average prescription of four medicines, the range per medicine varies from Rs. 41 to Rs. 68. Similar to the case of the inpatients, it was found that patients in the lower socio-economic strata spent relatively more, 3.93 per cent of their income, on medicines. By

contrast, the lower and the upper-middle strata spent only 1.69 per cent and 0.98 per cent respectively of their incomes.

The indirect average expenditure by OPD respondents comes out to be as much as Rs. 133.14. One fourth of this comprised travel expenses; 41 per cent was on board and lodging and diet and the rest amounted to the income lost by the patients and their relatives/attendants. The indirect expenditure by the lower socio-economic strata, 1.11 per cent of their income, was observed to be higher than for the two higher categories. The corresponding amounts spent by the lower and the upper middle strata were 0.70 per cent and 0.55 per cent respectively of their incomes.

Evidently, the availability of diagnostic tests seemed to be better for both the outpatients and the inpatients. Only 10 per cent of the direct expenditure by inpatients was on diagnostic tests. It was remarkable that none of the OPD respondents in the lower socio-economic strata had gone to avail of diagnostic facilities outside the hospital. Even among the other strata, a majority availed of the diagnostic test facilities at the public hospitals themselves.

The general responses, however, indicated a low level of satisfaction, especially among the inpatients, with regard to availability of medicines and beds, diet, wards, toilets and waiting time.

4 POLICY IMPLICATIONS

Our findings suggest a strong potential for initiating suitable health insurance schemes in the study region. Despite the low economic development and the "free" public health facilities, the financial burden borne by the respondents in getting treatment at the public hospitals is substantial. Combining the direct and indirect expenditures, it is observed that inpatients across the three lower to upper socio-economic strata spent, on an average, 9.17 per cent, 3.29 per cent and 1.91 per cent of the households' income respectively per illness episode. Likewise, outpatient treatment per illness episode involved expenditure of 6.28 per cent, 2.62 per cent and 1.89 per cent respectively for the three socio-economic categories.

Considering these estimates of expenditure as reflecting partly the ability and the willingness of the households to spend

on health care, it could be suggested that public or private health insurance initiative in the region could be successful, provided the rates of premium were optimally set in accordance with the estimates. With large scale coverage of a health insurance scheme in the region, even the premium set at the lowest of the above mentioned per capita expenditure may considerably enhance utilisation of available public health facilities. Besides attempting the insurance initiative, the development aspects, especially housing and transport, also demand adequate attention to overcome some of the causes of morbidity and certain impediments in accessibility to existing health care facilities, (Purohit & Siddique, 1993b)

REFERENCES

- Purohit, Brijesh C. & Rai, Vandana (1992a) *Measurement of Operational Efficiency in Institutional Public Health Care*. Mimeo., Indian Institute of Health Management Research, Jaipur
- Purohit, Brijesh C. & Rai, Vandana (1992) 'Operational Efficiency in Inpatient Care: An Exploratory Analysis of Teaching Hospitals in Rajasthan, India' *International Journal of Health Planning and Management*, Vol. 7, 149-162, U.K.
- Purohit, Brijesh C., Juyal, R.K., Siddiqui, A. Tasleem, Pulikkal, A. (1992), *Socio-Economic Case-Mix of Patients Utilising Public Health Services*, Mimeo, Indian Institute of Health Management Research, Jaipur
- Purohit, Brijesh C. & Siddiqui, A. Tasleem (1993) *Degree of Utilisation of Health Care Facilities Vs. Health Policy*, Mimeo, Indian Institute of Health Management Research, Jaipur
- Purohit, Brijesh C. & Siddiqui, A. Tasleem (1993a), 'Intra-State Regional Disparities and Health Care Utilisation in Rajasthan, India'. Paper presented at EWCA Okinawa Regional Conference on Regional Development in the 21st Century: Think Globally Act Locally, Nov. 5-7, 1993, Okinawa.
- Purohit, Brijesh C. & Siddiqui, A. Tasleem (1994) 'Socio - Economic Correlates of Outpatient Care in a factor Analytic framework' *Journal of Health & Social Policy*, Vol.6, U.S.A. (Forthcoming)
- Purohit, Brijesh C. & Siddiqui, A. Tasleem (1993b) 'Economic Development and Health Care : A Non - Parametric Approach', paper presented at XVII conference of the Rajasthan Economic Association, March 12-13, 1993, University of Rajasthan, Jaipur.