

HEALTH SPENDING BY PEOPLE IN UNDERSERVED AREAS

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Policy Implication for Health Financing Reforms in India

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RESEARCH

This paper uses the data from a study of a representative sample of households in the tribal-sub plan (TSP) region of Rajasthan, a north-western State in India, to investigate health seeking behaviour and household healthcare expenditure. The utilisation and expenditure for different types of providers are presented in terms of rural/urban status. The results of the study indicated a high dependence on traditional practitioners in the rural areas. In addition, the rural households spent one and a half times more money on healthcare than the urban households. The study also revealed that rural people bore a significantly higher burden for almost all the components of indirect expenses for treatment. The results of this study are used to discuss the feasibility of implementing alternative healthcare financing reforms.

Introduction

Overall health spending in India is estimated at about 4.5 per cent of GDP, which is less than the average of 5.6 per cent for the poor and the developing countries. India also has one of the highest proportions of private health financing in the world—about 82 per cent. Only five countries—Cambodia, Congo, Georgia, Myanmar, and Sierra Leone—have a higher dependence on private health financing. (WHO 2000) The low spending and the dominance of private sources of financing make India unique.

In many developing countries, governments are facing increasing pressure to improve the efficiency and financial viability of health service delivery system, particularly in the light of renewed commitments to improve the living conditions of the poor. (World Bank 1993) The case of India provides an excellent example of this situation, as the governments of almost all its states are struggling to deliver adequate and appropriate healthcare to the mostly poor

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population. The situation is grimmer in the States with large special population groups such as Rajasthan, which has a significant tribal population that mostly lives outside the mainstream economy and culture and is, therefore, poor and has less access to healthcare.

Rajasthan ranks below the national average on many health indicators. It, therefore, needs a distinct, State-specific approach to improve the efficiency and financial viability of the health sector. The formulation of such customised health policies and programmes requires a better understanding of the peculiar healthcare seeking behaviour and expenditure on treatment by the local people.

To improve the status of health of the people of Rajasthan, the State government has initiated a number of policy reforms including the drafting of the 'Health Vision for Rajasthan 2025'. However, a lot needs to be known about the way households finance healthcare to address the issue. Only a few studies have investigated the level and distribution of household health expenditure in India. (Bhatia and Cleland 2001; Duggal and Amin 1989; George 1997; Hotchkiss, et al. 2000; NSSO 1992; NCAER 1992; Sodani 1997; Sodani and Gupta 1998). The objective of this paper is to understand morbidity profile, healthcare seeking behaviour, utilisation of healthcare services, household healthcare expenditure, and to investigate factors affecting household healthcare expenditure and discuss policy implications to design and implement health sector reforms.

Data and Methodology

The data used in this analysis comes from the doctoral research carried out by the author at the Department of Economics, MLS University, Udaipur. (Sodani 1997) This household survey collected information from a representative sample of 450 households—225 each from the rural and the urban areas of the Banswara, Dungarpur, and Udaipur districts, which have substantial scheduled tribe population. These three districts make up much of the tribal sub-plan (TSP) region of Rajasthan. The data was collected during the June-August 1996 period. It was a one-time survey and, therefore, could not reflect the seasonal variations in the morbidity pattern. Only those households were selected where at least one family member had sought treatment for some illness during the reference period of the survey. Untreated illnesses were not included in the study.

Results and Discussions

Choice of Source of Healthcare

There are various types of healthcare facilities available for the treatment of illnesses in the surveyed area. For the purpose of this analysis, the available

healthcare providers have been divided into five categories: public healthcare facilities, private healthcare facilities, traditional practitioners, chemist shops, and family and friends. The public facilities category included all the government-run healthcare institutions irrespective of the system of medicines. Private facilities included all the allopathic hospitals, dispensaries, and clinics run by private charitable institutions, non-governmental organisations, individual practitioners, and also the moonlighting government medical or para-medical personnel. Traditional practitioners included folk healers, registered medical practitioners (non-allopathic), herbalists, *vaidyas*, *hakims*, *bhagats*, etc. The chemist shops category covered the treatment taken on the advice of the chemists without consulting any qualified healthcare provider. The family and friends category covered the home remedies, self-medication, and healthcare measures taken on the advice of family members, relatives, and friends.

In the rural areas of the region, the most commonly approached source of healthcare was the traditional practitioner (50.7 per cent), whereas in the urban areas it was the public health facility (45.1 per cent). The percentage of illness episodes for which medicines were directly purchased from medical shops was 3.1 for the rural population and 5.2 for the urban population. The percentage of the treatments sought from family and friends was low, albeit it was marginally higher in the urban areas (0.5 per cent) as compared with the rural areas (0.3 per cent). The traditional practitioners and the private sector seem to play an important role in providing healthcare in the studied areas. The major implications of these findings are that efforts are needed to encourage public-private partnership. The private—formal and non-formal—healthcare providers need to be tapped for better services in the tribal areas.

Health Care Expenditure by Households

The study divided the total healthcare expenditure per illness episode between direct and indirect costs incurred to recover during the reference

Table 1: Percentage Distribution of Sick Individuals by Choice of Source of Care in Tribal Areas of Rajasthan

Type of Healthcare Facility	Rural Area	Urban Area
Public facility	27.3	45.1
Private facility	20.3	30.2
Traditional practitioners	50.7	18.0
Chemist shops	1.4	6.1
Family/self	0.3	0.6
Total sample	355	295

period. The direct costs included expenses incurred on providers' fees, medicines, diagnostic tests, hospitalisation charges, and expenses related to surgery. The indirect costs included collateral expenses such as the expenses incurred on transport, food, and lodging when patients had to travel far for treatment; tips given to hospital staff to get better care; religious rites done for the sole purpose of alleviating the suffering of the sick; and loss of earnings to the sick individual and the accompanying person.

There was a substantial rural-urban differential in the average expenditure per illness episode during the reference period (Table 2). On an average, rural people incurred an expenditure of Rs. 931.70 per illness episode, whereas the urban people incurred an expenditure of Rs. 610.80. Thus, the rural people spent one and a half times more on treatment of illness than the urban people. However, this differential was more pronounced for acute illnesses (1.5 times) as compared to chronic illnesses (1.09 times).

The study revealed that average expenditure per illness episode was higher for chronic illnesses compared to acute illnesses in both the rural and the urban areas. The expenditure on the treatment of chronic illnesses exceeded the expenditure on acute illnesses by 2.5 times in the rural areas and by four times in the urban areas. Possibly, the treatment of acute illnesses was relatively less expensive than the treatment of chronic illnesses in the urban areas compared with the rural areas. Also, the people in the rural areas had a higher incidence of acute illnesses. They were mostly tribal and usually approached health facilities only after their ethnic rituals had failed to help and when the diseases became aggravated. That meant they had to eventually seek more intensive and frequent consultation.

Table 2: Average Household Healthcare Expenditure Per Illness Episode in Tribal Areas of Rajasthan

Average Healthcare Expenditure	Amount (Rs.)	
	Rural	Urban
By nature of illness		
All type of illnesses (acute & chronic)	931.70	610.80
Acute illnesses	714.30	465.60
Chronic illnesses	1817.10	1655.50
By source of care		
Public health facility	621.10	304.40
Private health facility	2051.00	1384.80
Traditional practitioners	679.20	293.10
Chemist shops	13.00	230.00
Family/ friends	116.40	26.10

As expected, people paid much more for private health facilities than any other source of care (Table 2). In rural areas, people spent 3.3 times more for treatment at the private facilities than at the public facilities whereas the urban people paid spent 4.5 times more. The average expenditure on healthcare was considerably lower when people purchased medicines directly from chemist shops. The study also brought out that the so-called 'free' government health facilities are actually not free. Those who sought healthcare from public health system incurred substantial costs, as only the consultation was free and they had to source diagnostic services and medicines from the private sector.

Table 3 shows that direct health expenditure accounted for about two-thirds of the total health expenditure. The direct expenses accounted for 63.3 per cent of the total healthcare expenditure in the urban areas and 59.6 per cent in the rural areas. This is probably because in the rural areas the financial burden on households is more because of special diet and higher opportunity costs compared to urban areas. This can be explained by the analysis presented in Table 4.

Table 4 shows the break-up of total healthcare expenditure by various cost components for the rural and urban areas. The components included the costs on accounts of consultation, medicines, tests, hospitalisation, surgery, special diet, transportation, accompanying persons, tips, rituals, and opportunity costs to the ill persons and their attendants.

Analysis shows that rural people spent 1.6 times more on consultation and 1.5 times more on medicines per illness episode than the urban people. These two items accounted for the major share of the direct expenses for the rural people. Also, the rural people incurred seven times more expenses on special diet for the sick person than the urban people. This is because of the difference in perception regarding special diet; for example, milk may be considered a special diet in the rural areas but not in the urban areas.

Again, the rural people incurred higher expenses on attendants than the urban people, as the sick person was typically accompanied by more than

Table 3: Household Healthcare Expenditure per Illness Episode by Direct/Indirect Expense Category in Tribal Areas of Rajasthan

<i>Components</i>	<i>Rural</i>		<i>Urban</i>	
	<i>Amount (Rs.)</i>	<i>Percent</i>	<i>Amount (Rs.)</i>	<i>Percent</i>
Direct Expenditure	555.1	59.6	386.5	63.3
Indirect Expenditure	376.6	40.4	224.3	36.7
Total	931.7	100.0	610.8	100.0

Table 4: Break-Up of Household Healthcare Expenditure per Illness Episode in Tribal Areas of Rajasthan

Components	Rural		Urban	
	Amount (Rs.)	Percent	Amount (Rs.)	Percent
Doctor's/ Provider's fee	86.4	9.3	52.1	8.5
Medicine	409.6	43.9	279.6	46.0
Test Charges	34.6	3.7	31.6	5.2
Hospital fee	8.0	0.9	11.1	1.8
Surgery	16.3	1.8	11.8	1.9
Special diet	51.7	5.5	6.7	1.1
Transport	71.6	7.7	94.5	15.5
Accompanying person	68.0	7.3	47.9	7.8
Tips	1.4	0.2	0.08	0.01
Rituals	1.5	0.2	0.2	0.03
Loss of earning to sick person	105.7	11.3	53.2	8.7
Loss of earning to accompanying person	76.5	8.2	21.5	3.5
Total	931.7	100.0	610.8	100.0

one person. They spent 1.4 times more on accompanying persons than the urban people. Consequently, they suffered greater wage losses than the urban people—about 2 times in the case of patients and 3.5 times in the case of accompanying persons.

Factors Affecting Household Healthcare Expenditure

We have discussed in detail the determinants of the demand for healthcare by taking health expenditure as the dependent variable. The results are drawn by formulating demand for healthcare in rural and urban areas of the TSP region. The readers may see Sodani (1999) for further statistical analysis. Here, the important variables affecting the household healthcare expenditure are discussed based on simple statistics only.

Time Gap Between Onset of Disease and Contact with Source of Care

It was found that when the people fall sick, a higher percentage of the people in urban areas contact the source of care on the same day than the people in rural areas (Table 5). In rural areas, only 9.8 per cent of the ill persons contacted the source of care on the day of the onset of illness. Moreover, only about 13 per cent of the sick individuals contacted any source of care even after 10 days of illness. The delayed reporting thus

Table 5: Percentage Distribution of Sick Persons by Duration of Time-Gap between Onset of Disease and Contact with Source of Care in Tribal Areas of Rajasthan

Percentage distribution of sick persons	Duration (days)	
	Rural	Urban
Same day	9.8	38.3
1-3	48.9	49.3
4-6	15.8	2.4
7-10	18.2	8.4
10+	13.3	4.3
Total Sample	388	298

allowed the illnesses to aggravate and this required frequent consultation and more treatment, which directly increased the healthcare expenditure in rural areas. Efforts are needed to educate the tribal communities to report sickness as soon as possible. This requires the health services to be easily accessible to the tribal communities.

Duration of Illness Episode

The second most important factor affecting the household healthcare expenditure is the duration of illness episode. The duration of an illness episode can be considered an indicator of the seriousness of the illness. However, a prompt curative intervention can moderate the period of illness. Table 6 shows that in the rural areas the majority of sick individuals suffered a longer duration of illness compared to the urban areas. The longer duration of sickness contributes to the higher healthcare expenditures by the rural people. Efforts are required to reduce the duration of disease/sickness in the community. Reforms need to focus on making available early treatment to the tribal community.

Table 6: Percentage Distribution of Sick Persons by Duration of Illness Episode in Tribal Areas of Rajasthan

Duration (days)	Percentage distribution of sick persons	
	Rural	Urban
1-3	6.5	25.4
4-6	18.3	28.8
7-10	29.8	21.4
11-15	13.2	8.8
16+	32.2	15.9
Total Sample	355	298

Table 7: Percentage Distribution of Sick Persons by Number of Visits Made to Source of Care in Rural and Urban Areas of Rajasthan

Number of visits	Percentage distribution of sick persons	
	Rural	Urban
Up to 2 times	63.4	74.9
More than 2 times	36.6	25.1
Total Sample	335	297

Visits to Source of Care

The frequency of visits to providers also contributed to increases expenditure on healthcare. Table 7 shows that the number of patients visiting providers more than twice was two times more in the rural areas than in the urban areas.

The higher frequency of the rural patients visiting healthcare providers might be due to the fact that in the rural areas people approached the traditional practitioners for the initial treatment, which proved to be less effective and of poor quality, and that eventually proved to be more costly as people had to access other sources of care later on. Moreover, the people in the rural areas sought care late, when the disease became aggravated, which required more number of visits to health facilities.

Policy Implications for Health Financing Reforms

The healthcare expenditure indicators, as brought out by the study, are simple yet crucial indicators for estimating the nature and extent of direct and indirect healthcare expenditure borne by households. The households in India spend rather portions of their incomes amounts on healthcare. To reduce the financial burden on households on account of healthcare and simultaneously improve the availability of quality healthcare in the 'underserved' areas, special efforts are needed to strengthen public sector health system with increased responsiveness, accountability, funding.

The study yielded a number of findings that are relevant for making health policies. For example, despite the lower availability of healthcare in rural areas, the rural population spends more on healthcare than the urban one that has much easier access to healthcare. Another crucial fact yielded by the study is that the population outside the mainstream of society, the tribal people, tend to resort to traditional medicines and superstitious rites for healing due to not only sparse availability of proper healthcare but also a lack of understanding of health.

Such findings put a question mark on the state's intent and ability to place affordable healthcare services where they are needed. The state claims that

the poor, especially those living below the poverty line, are exempted from paying the user charges at public health facilities and they can avail of 'free' care, but the facts don't bear out this claim. Given the findings of the study there is a need for a drastic improvement in the network of public health facilities from district level to sub-centre level. Also, there is a need for optimal utilisation of public health resources so that their benefits actually reach the intended beneficiaries.

Another major finding of the study that is relevant for policy making is that medicines account for a rather large portion—44–46 per cent—of the overall healthcare expenditure. In fact, medicines are the single large component of healthcare expenditure. Another issue highlighted by the study is that the public health facilities mostly limit themselves to consultation and hospitalisation and their users have to buy their medicines in the open market. A health policy could ensure that the public health facilities offer medicines also.

For the purpose of formulating a health policy for the State of Rajasthan with a high priority for serving the disadvantaged population, the authorities could look at the following suggestions:

Rural households, particularly among tribal communities, are paying a lot of money on healthcare. Therefore, it is urgently required to provide some community based health insurance (CBHI) schemes to them. A CBHI may have very high potential if designed keeping in view the needs of the target communities.

- b. There is need for formulating and implementing a fair drug policy as households are spending high amounts on medicines. The drug policy may favour rational use of drugs by practitioners, prescription audit by independent panels of experts to reduce over prescription, etc.
- c. There is a need to enhance the efficiency of public health interventions.

While such policy options are available, more research is clearly needed to monitor the response of the disadvantaged groups to health sector reforms. Reform strategies may first be tested through pilot projects. The reforms that prove effective in pilot projects should be taken up for general implementation.

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