Chapter I

Introduction
CHAPTER I
INTRODUCTION

Health is characterised by complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health organisation, 1948). Some argue that health cannot be defined as a state at all, but must be seen as a process of continuous adjustment to the changing means given to life. It refers to a situation that exists in some individuals but not in everyone all the time; it is not usually observed in groups of human beings and in communities (Park and Park, 1995). In recent years, a new philosophy of health has emerged which states health as a fundamental human right, an integral part of development and is central to the concept of quality of life.

Health is the barometer of growth of the body as well as the economy. In developed countries the health status is far higher than that of developing countries. Quality of life and health services are also different among these countries. India being a developing country health facilities are quite inadequate, both in urban and rural areas.

1.1 Human Development and Health Status

Human development has been accepted as an important goal for all the developed and developing countries in which health is a crucial input of human development and consequently economic growth (World Development Report, 1993).

Health development is recognized as an essential and integral part of national socio-economic development, and every effort is being made to see that health and health related activities are systematically planned and coordinated at all levels. Being a source of enjoyment, health status is also a valid indicator of human development. Individual health status has multiple dimensions and so does the aggregate for society.
Health status is one of the indicators of the welfare of the people. An increase in the income per-capita, is associated with an enhancement in the health status of the people. The issue of ‘health’ is of great importance both from the point of view of individuals and the nation as well. In many countries it is the health status of the people that determines their well-being and the pace of economic and social development. A great deal of attention is being paid to investment in health, which is an important component of investment in human capital.

The provision of healthcare has important redistribution aspects as well as close inter-relationship between poverty and morbidity. The poor are more vulnerable to disease because they are malnourished, forced to live in an environment that is unsanitary, congested, lacking in adequate or safe drinking water and proper sanitation. Mal-nutrition is a major element in maternal and child morbidity and mortality. Poverty increases vulnerability to disease and at the same time restricts the access of the poor to health facilities and further deprives them of regular income due to non-reporting for work regularly.

Good health, as people know from their own experience, is a crucial part of well-being, but spending on health can also be justified on purely economic grounds. Improved health contributes to the economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that have been totally or nearly inaccessible because of disease; it increases the enrolment of children in school and makes them better able to learn; and it frees resources for alternative uses that would otherwise be spent on treating illness. (World Development Report, 1993)

1.2 Perspectives on Health

Health is viewed as a right, analogous to justice or political freedom. The WHO constitution states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social condition” (WHO Constitution, 1979).
Health is seen as an important individual objective, which is not comparable with 'justice', but rather with material aspects of life. Such a view often refers to health as consumption goods. The state here has no special responsibilities in the promotion of health, but leaves decisions as to its comparative importance to the individual. The State role under such a view might be limited to ensuring that the healthcare provided is of an adequate quality in the same way that it would monitor the quality of any goods or services, such as food.

Another view on health is that it is important, largely because it affects the productive ability of workforce. Illness may affect the overall production, either through absenteeism or by lowering productivity through its debiting effects (World Development Report, 1993).

At the level of political discourse, three schools of thought on healthcare can be identified; conservative, liberal and Marxist. The conservatives argue that healthcare is private good and is best left to the market to be distributed and price to be decided according to supply and demand. For the liberals, healthcare is both a private good and social good and therefore, there is a role for the government to play. This is in fact a part of the whole process of the rise of welfare state during which the state took on some social obligations and passed several legislations with regard to health, education, children, women and labour etc. The Marxists recognize healthcare as a social good and a right, which should be controlled by the state (Prasad, 1995).

1.3 Characteristics of Healthcare

Health is valued as an asset in the community and healthcare treatment is an investment in human capital. Better healthcare would increase the life expectancy and the number of potential man-hours for production, which sets the pace of social and economic development. Healthcare is considered as a 'Merit Good' in public finance parlance and considered to have the following characteristics:
a) The demand for healthcare is not regular unlike for food, clothing, etc., but irregular and unpredictable. It is hard to think of another commodity comparable to it.

b) Illness is associated with risk and that too a costly risk, potential for loss or reduction of earning ability. Illness cannot be avoided or overcome with income like other necessary things. If proper medical care is not provided, the risk will be costly and sometimes deadly.

c) Quality of the product is uncertain, that is recovery from disease is unpredictable as is its incidence. “In most commodities the possibility of learning from one’s own experience or that of others is strong because there is an adequate number of trials. In the case of severe illness, that is not true” (IBID).

d) In healthcare there is always information gap about the nature of the product sold between the producers and purchasers. But this is not usually the case with other commodities. For commodities, consumers have a fair idea of what constitutes quality.

e) Because of imperfect competition, suppliers of medical care acquired considerable monopoly power in pricing their products. Each doctor or hospital can operate as a monopoly, raising prices without fearing a substantial loss of consumers or discriminate prices as among different consumers.

f) The supply of medical care is strongly influenced by social and non-market forces. Firstly, entry to the profession is restricted by licensing in the name of guaranteeing a minimum quality, but the same is not the case of other professions, although licensing is done. Secondly, the medical education is highly subsidised.

g) Unlike other commodities, healthcare has certain external benefits or externalities associated with it. For example, certain types of healthcare, particularly those concerned with communicable diseases like, tuberculoses, malaria, small pox etc., can create external benefits. A hospital treatment that cures someone of particular communicable disease confers external benefits, since it reduces the probability of others contracting the disease.
h) In case of medical care, the product and its production activities are identical. The customer cannot test the commodity before consuming it. The restrictions on the part of doctors are much more than the sellers of other commodities. For example (i) in advertising and over-pricing, competition is eliminated among physicians, (ii) advice given by physician is supposed to be diverted from self-interest, (iii) there is an element of implicit trust in the advice of physician, and (iv) physician is relied on as an expert in certifying to the existence of illness and injuries for various legal and other purposes (Arrow, 1963).

The economic gains are relatively greater for poor people, who are typically most handicapped by ill-health and who stand to gain the most from the development of under-utilised natural resources.

1.4 Gain in Workers Productivity and Schooling Ability of Children

From the point of view of workers, one can analyse the possible gains. The sources of gain are fewer workdays lost due to illness, increased productivity, and greater opportunities to obtain better paying jobs and longer working lives with good health. Healthier workers earn more because they are more productive and can get better paying jobs. When illness strikes, an individual's lost output and earning often go undetected in economic statistics because they are borne by households. In many developing countries unemployment (or disability) insurance is rare, and the healthier member of the household works harder or longer to make up for the loss in income. In the long run the benefits of improved health are also likely to influence the way work is organised and carried out. With a healthy workforce, employers can reduce the cost of building slack into their production schedules, invest more in staff training and exploit the benefits of specialisation.
Schooling pays off higher incomes. Poor health and nutrition reduce the gains of schooling in three areas: enrolment, ability to learn, and participation by girls. Children who enjoy better health and nutrition during early childhood are more ready for school and more likely to enrol. Health and nutrition problems affect a child's ability to learn. Nutritional deficiencies in early childhood can lead to many lasting problems. In societies where girls' education is given lower priority than boys', girls miss school because they have to stay home to look after sick relatives.

Healthcare spending that reduces the incidence of disease can produce big savings in treatment costs. Preventing the incidences of disease can save the cost of treatment. For some diseases the expenditure on preventive care pays for itself even when all the indirect benefits such as higher labour productivity and reduced pain and suffering are ignored. Polio is one example.

1.5 Health Investments and Poverty

The goal of reducing poverty provides a different but equally powerful case for health investments. The adverse effects of ill health are the greatest for poor people, partly because their income depends exclusively on physical labour and they have no savings to cushion the blow. They may therefore find it impossible to recover from an illness with their human and financial capital intact. Investment to reduce health risk among the poor and provision of insurance against catastrophic healthcare cost are important elements in a strategy for reducing poverty. Spending on health is a productive investment, which can raise incomes, particularly among the poor, and it reduces the toll of human suffering from ill health. Good health is a fundamental goal of development as well as means of accelerating it. Targeting health as a part of development efforts is an effective way to improve welfare in low-income countries. Evidence gathered over last thirty years indicates that in health, unlike income, the gap between the poor and the rich countries has been narrowing.
The detrimental effects of poor health on individuals and households and on the use of resources suggest that better health should lead to better economic performance at the national level. A number of analyses have found a positive relationship between growth of income per capita and the initial national education stock.

Not surprisingly, the health status variable is strongly correlated with educational stock, but the significant association between income growth and health remains strong and of similar magnitude across time periods and for a range of model formulations. Although it is possible that unobserved factors such as government capacity to implement effective policies could explain the apparent association, the data do suggest that better health means more rapid growth (World Bank Development Report, 1993).

1.6 Healthcare – Its Accessibility

Healthcare is always felt to be intimately related to the health and the very life itself of individuals. Healthcare means services provided by the physician or indirectly by others under the direction of the physician to individuals for maintenance and restoration of health and for prevention of disease (Bryan and Smith, 1979). The concept of disease usually refers to some deviation from normal functioning that has undesirable consequences because it produces personal discomfort or adversely affects the individual’s future health status. In an era of scientific medicine, it is not surprising that many patients expect cures or at least relief to be available for many of their health problems (Many K. Beyrer 1977).

With the scientific and technology advances, there has been a rapid growth and development of specialization within medicine. Healthcare costs have soared up high. The ability to distribute the improved medical technology equitably throughout the population has not kept pace with technological advances themselves. Attempts have been made to provide maximum health at minimum cost. The proportion of gross national product being spent on medical care is steadily increasing.
The utilisation component of healthcare is a complex phenomenon and utilisation of care depends on both external and individual factors. While the poor have a greater prevalence of illness, disability and restriction of activity, because of health problems than do those of higher status, they have less accessibility to many types of health services and receive lower quality care in many respects (Mechanic, 1978).

1.7 Demand for Healthcare

In Economics, demand for health is defined as want of health service for a person linked with ability and willingness to pay for it. Demand is seen to reflect both the strength of the persons' desire to receive the service, that is the value placed on it, and the amount that will have to be sacrificed in order to do so. An individual's demand for healthcare treatment is to be considered in terms of money, time, inconvenience and incidental cost incurred. The utilisation of health services does not depend solely upon demand, rather than it is the result of the interaction of demand and supply, of consumers and providers. They need not necessarily interact on equal terms. This leads to increase in the individual's cost of healthcare treatment as demand for healthcare is always greater than its supply in a developing economy like India (Lee and Mills, 1995).

1.8 Healthcare Facilities and Expenditure in India

The Indian constitution charges the states with "the raising of the level of nutrition and the standard of living of its people and the improvement of public health". Central government efforts at influencing public health have focused on the five-year plans, on coordinated planning with the states, and on sponsoring major health programs. Government expenditures are jointly shared by the central and the state governments. Goals and strategies are set through central-state government consultations of the Central Council of Health and Family Welfare. Central government efforts are administered by the Ministry of Health and Family Welfare, which provides both administrative and technical services and manages medical education. States provide public services and health education.
By any reckoning, the healthcare facilities for an overwhelming majority of people in India are poor, both quantitatively and qualitatively. As per recent estimates, urban areas have only 4.48 hospitals, 6.16 dispensaries and 308 beds per one hundred thousand of urban population. For rural areas the situation is much worse, with 0.77 hospitals, 1.37 dispensaries, 3.2 public health centres and just 44 beds per one hundred thousand of population (Duggal, 2002). For the country as a whole, the number of beds per one hundred thousand population, which increased from 32 in 1951 to 83 in 1982, was only 93 in 1998 (Praveen, 2003). The curative services are primarily located in urban areas whereas the rural institutions mainly provide preventive and promotive services. The curative care facilities are very less in rural areas, resulting in a massive proliferation of quacks in many parts of the country.

One of the main reasons underlying the poor state of healthcare facilities in India happens to be very low levels of public expenditure in health sector, which happens to be among the lowest in the world (WHO). During the decade of 1990s the public investment on health as a percentage of Gross Domestic Product (GNP) declined from 1.3 in 1990 to 0.6 per cent in 2002. Currently the aggregate annual expenditure on health is 5.2 per cent of GDP. Out of this, about 17 per cent of aggregate spending is coming from state, the rest being out of pocket expenditure borne by the people directly (CSO, 2003).

In 1983 healthcare expenditures varied greatly among the States and Union territories, from Rs.13 per capita in Bihar to Rs.60 per capita in Himachal Pradesh and Indian per capita expenditure was low when compared with other Asian countries outside South Asia. Although government healthcare spending progressively grew throughout the 1980s, such spending as a percentage of the Gross National Product (GNP) remained fairly constant. In the meantime, healthcare spending as a share of total government spending decreased. During the same period, private sector spending on healthcare was
about 1.5 times higher than government spending. In the mid-1990s, per capita spending on health was around Rs320 per year with the major input from private households (75 per cent). State governments contribute 15.2 per cent, the central government 5.2 per cent, third-party insurance and employers 3.3 per cent, and municipal, government and foreign donors about 1.3, according to a 1995 World Bank study. Of these proportions, 58.7 per cent was towards primary healthcare (curative, preventive, and promotive) and 38.8 per cent is spent on secondary and tertiary inpatient care. The rest was for non-service costs.

In the midst of this, a few years back the government decided to introduce/increase user charges for various services provided through government hospitals. Given the fact that a large majority of users of public facilities, especially the non-super specialties are the poor, this was a major setback to the poor.

Table 1.1
Trends in Health Expenditure in India - 1961-2003

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(In Rs. Billion)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td>1.08</td>
<td>3.35</td>
<td>12.86</td>
<td>27.15</td>
<td>50.78</td>
<td>82.17</td>
<td>126.27</td>
<td>178.54</td>
<td>209.41</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td>2.05</td>
<td>6.18</td>
<td>29.7</td>
<td>90.54</td>
<td>146.98</td>
<td>279</td>
<td>459</td>
<td>981.68</td>
<td>1200</td>
</tr>
<tr>
<td>per cent of GDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td>0.71</td>
<td>0.84</td>
<td>1.05</td>
<td>1.32</td>
<td>0.92</td>
<td>0.95</td>
<td>0.81</td>
<td>0.87</td>
<td>0.91</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td>1.34</td>
<td>1.56</td>
<td>2.43</td>
<td>3.63</td>
<td>2.88</td>
<td>3.04</td>
<td>3.3</td>
<td>5.12</td>
<td>5.22</td>
</tr>
<tr>
<td>per cent to govt total expenditure</td>
<td></td>
<td>5.13</td>
<td>3.84</td>
<td>3.29</td>
<td>3.4</td>
<td>2.88</td>
<td>2.13</td>
<td>2.7</td>
<td>2.9</td>
<td>3.0</td>
</tr>
</tbody>
</table>


These increased user charges invariably came as conditionalities under health sector reform projects which a number of state governments undertook through multilateral and bilateral support. There is clear evidence, not only in India, but across the world that user fees, especially in developing countries, is a regressive measure and it reduces access of the poor to healthcare. (Duggal, 2003)
1.9 Systems of Medicine

Private healthcare cost incurred by an individual in treating a disease differs with different healthcare systems of allopathic and non-allopathic Indian systems of medicines such as Ayurveda, Homeopathy, Siddha and Unani. Some of these systems are indigenous and others such as Homeopathy have over the years become a part of Indian tradition. Prior to the advent of modern medicine these systems had, for centuries, catered to the healthcare needs of the people and are widely used even today because their practitioners are acceptable both geographically and culturally, are accessible and their services and drugs are affordable.

The Department of Indian Systems of Medicine and Homeopathy was set up as separate department in 1995 to formulate policy for development and propagation of Ayurveda, Siddha, Unani, Homoeopathy, Yoga and Naturopathy systems including cooperation with other countries for collaborative efforts in the development of traditional system of medicine. Indian system of medicine has a long history of almost 5000 years. The knowledge of the system is scattered in the age old classical texts codified or in manuscript forms.

Ayurveda, the knowledge of life, advocates the means of promoting health through various ways. World Health Organisation has also recognised Ayurveda as alternative system of medicine and realised that such traditional system of medicine can contribute a lot in solving the problems of healthcare delivery by traditional practitioners through readily available drugs. The aims of Ayurveda are two-fold. Firstly, the maintenance of normal drugs as foods, supplements to food or medicines. Secondly, preventive aspects are elaborated through personal and hygiene under daily routine, seasonal adaptations, good behaviour etc. This system of medicine is widely adopted in Kerala and neighbouring states in India.
Siddha system of medicine was considered as a branch of Ayurveda with advanced specialities in respect of a few selected medicinal products and was known to be evolved by Sadhus (sages) in South India. It was with this kind of medicine a lot of superstitions; myth and miracles were associated and prevalent. This system is popular in rural areas of southern India.

The Unani system of medicine was supposed to be a contemporary to Siddha type of medical system developed by Muslim physicians during the Mohammedan rule.

The Allopathic medicine originated in Europe and was improved by Hippocrates, (460 BC) a Greek physician and became dominant in India with the establishment of British Empire. However, both Homeopathic and Allopathic systems of medicine had things in common with the principles of indigenous system (Reddy, 1995).

Homeopathy may be defined as the therapeutic method of symptom similarity. In the field of medicine, Homeopathy deals only with therapeutics i.e., treatment of disease. This homeopathic treatment of disease is further limited to the use of certain pharmacological preparations prepared according to certain well-defined principles laid down by the founder Samuel Christian Friedric Hahneman (Iyer, 1992).

In the modern Allopathic medical system, treatment of disease has several steps such as Physical examination, Clinical laboratory tests, Diagnosis based on physical examination and laboratory test, Hospitalisation, Prescription of medicines, Monitoring nutrition intake and medicines, Periodic observation, Surgical or other correction and Convalescence.

A characteristic feature of health services is that the person who needs them does not know the exact type and amount of services. It is the physician who, after diagnosis, prescribes the treatment. Further, health services are wide ranging from indispensable
services for survival to marginally beneficial services that promote positive health. No patient, however much educated and informed he/she is, would be able to demand the health services he/she is in need of. Health services are highly person specific. The cost to a patient of receiving health services includes the cost of transport of the patient to and from the place of health service and the same for persons accompanying the patient, fees and other charges paid to medical and paramedical staff, cost of medicines and charges for diagnostic services and surgical operations. In addition, the income foregone by the patient and the attendant need to be considered the cost of treatment.

The place and type of treatment a patient chooses would depend not only on his awareness and preference but also on his economic status. Poor patients usually prefer to approach free treatment centres such as Government hospitals and NGO managed hospitals rather than approaching private sector institutions.

More than user costs, it is the non-price factors such as physicians' attitude towards the poor and deserving patients, pressures on the physicians by the patient's kinsmen, bureaucracy and political leadership and competition from non-profit organisations that have great influence on physician's decisions and which influence the demand for health services. In fact health services provide an example of a service in which allocation of resources is determined prominently by non-price factors (Fuches, 1986).

It is said that affluent urban population increasingly shows disease patterns similar to those better-off urbanites in western countries. They demand increasingly sophisticated and high cost medical care for such problems as cardiovascular disease or cancer. Private sector plays a major role in the delivery of healthcare services. In India more than 70 per cent of the hospitals and more than 90 per cent of the hospital beds are located in the urban areas even though the population in these areas is only about 25 to 30 per cent. The urban bias is seen in all the sectors, government, private and voluntary.
The 42nd Round of National Sample Survey report states that on the overall, public hospitals dominated the use of hospital services, accounting for roughly two-thirds of all hospitalisation. However for the treatment of acute illnesses, private practitioners are dominant in both urban and rural areas, accounting for about two-thirds of the illnesses treated (Krisnakumar and Kanbargi, 1994).

1.10 Cost of Healthcare Treatment

The payment made for treating an illness or a disease by an individual is known as the cost of treatment of disease. Any treatment for illness involves cost and the benefit of averting the illness is the cost avoided. The costs are both direct and indirect.

The direct costs are the resources such as physicians and pharmaceuticals that are employed to treat a patient. These costs include consultation charge, cost of medicine, charges for clinical tests, diagnostic tests such as X-ray, ECG and scans, surgery charges, equipment charges, room rent, food expenditure etc.

The indirect cost is the loss of earnings to the afflicted person resulting from inability to work. Since labour – income measures the value of a person's contribution to the output of society, the patient's loss of income is a social as well as private cost (Ward, 1975).

1.11 Source of Financing for Healthcare Services

Healthcare systems are financed by many sources, public and private. These funds are managed by public and private entities and spent on both public and personal health services, which benefit only the individuals.

1.11.1. Public Sources

As health is a merit good, the role of government in providing health services plays preventive and curative role to the community and is of vital importance. Particularly in low income group it is the government which has to deliver the health services. Such provision warrants heavy resources and the government has to augment it through
different public finance sources as well as by collecting user charges from the beneficiaries of health services, receiving assistance from intermediate agencies and by receiving grants from upper layer of governments within the country.

Individuals pay **user charges** for a publicly provided good or service. User charges are an important source of revenue in cases where it is difficult to find more funds through government finance. Household surveys in a number of countries indicate that people are willing to pay for services that benefited them, making user charges a less coercive way than taxation to raise revenues to finance public services.

When fiscal constraints are tight and market failures preclude public provision of a particular benefit- such as **health insurance-government mandate** to require provision of such benefits, either by employers or by individuals, can help government achieve its policy goals. Employer and individual mandates can be evaluated using the same criteria used to evaluate alternative revenue-raising sources. In fact, under certain conditions mandates are more efficient than taxes, though they tend to be less equitable. The main problem with mandates related to equity, since the valuation of the benefit and the subsequent wage adjustments generally bear no relationship to ability to pay.

1.11.2 Financing of Healthcare Services of Households

There are different methods with which individuals meet their expenditure on healthcare services. Some major sources prevailing in various contributions have been identified as out-of-pocket payments, informal risk-pooling arrangements, medical savings accounts, charitable contribution, private health insurance, etc. (Schieber, 1997).

Consumer **out-of-pocket payments** for health services are private expenditures. But such expenditures can take a variety of forms, including direct purchase of private services, direct purchase of publicly provided services (for example, public user charges), and cost sharing for publicly or privately financed services.
Informal, generally rural, and usually voluntary risk-pooling schemes are one variant of the health insurance model common in developing countries. These schemes generally encourage prepayment of individual premiums into an identifiable fund, provide some notion of entitlement to benefits, and work with a defined set of service providers.

Medical savings accounts are individual savings accounts from which individuals pay for healthcare, coupled with a backup financing mechanism. The source of the savings account and the backup financing can be public or private. One of the biggest advantages of a medical savings account is that individuals have a strong incentive to be prudent consumers of medical services, since they can use any unspent funds in a variety of ways. Unspent savings can be used for non-medical consumption.

Charitable contributions can be domestic or foreign. Foreign charitable contributions are the same as foreign grant assistance that has few or no policy conditionalities attached. There are no efficiency or equity costs in obtaining these funds. Domestic charitable contributions do have an opportunity cost—the alternative domestic use of the funds raised by the charity. If such contributions are encouraged by the tax system, there will be efficiency and perhaps equity costs to the economy.

The non-poor may have several reasons to prefer using private health insurance to finance personal health services. First, by pooling risks, overall risks are reduced. Second, consumer sovereignty in choosing an insurance package that best fits that individual's preferences maximizes welfare. Third, by relying on private markets rather than government coercion, the benefits of risk pooling and consumer choice can be achieved while the efficiency costs of taxation are avoided. Fourth, private insurers can negotiate with providers over cost and quality more effectively than individual consumers.
Out of the above methods referred here, we observe the following methods are followed in financing the healthcare expenditure by order of priority in our sample viz., out of pocket, borrowing from relatives and friends, sale of asset and receiving assistance from charitable organisations.

1.12 Need for the Study

Health is basically a humanitarian cause, literally a matter of existence. One naturally tends to get alarmed when questions of cost, price effectiveness and priorities are raised where lives are concerned. Economics, has since become an inevitable instrument and as time passes it has acquired a positive role (Krishnakumar and Kanbargi, 1994).

Individuals take efforts to improve the health status. Governments also, from social sector point of view, take efforts to promote the health services available to the people by focusing on preventive and curative services in both rural and urban areas. Besides the government, NGOs and private sector also play important role in the delivery of health services.

Both policy makers and researchers have directed considerable attention to the question of how broad the access to health services for people can be ensured. Early policy and research initiatives focused on the need to improve physical access through an expansion of the network of facilities. A growing literature on healthcare demand has, however, pointed out that supply is not sufficient. Actual consumption of healthcare depends on factors influencing the demand for healthcare such as income, cost of healthcare, education, social norms and traditions.

Following a growing literature on healthcare demand, it is necessary to investigate the determinants of access to public and private healthcare provisions and of health seeking behaviour of people broadly. Hence a detailed study is needed to estimate
the choice model of healthcare demand, where demand is understood as the probability of seeking different types of healthcare providers and systems of medicine for illness, given the relevant characteristics of the individual, the household and the community.

So to deliver health services to the rural public it is necessary to understand the factors which influence the rural household decision-making of health related issues in India. A number of studies, which examined health behaviour in rural Third World settings, identify several factors, which determine treatment choices (Young 1980; Stock 1983; Okafor 1983; Mwabu 1986; Kloos et al. 1987; Csete n.d.). These include the seriousness of the illness, knowledge and indigenous categorization of the illness, degree of confidence in home remedies and traditional medicine for treating the illness, and expenses associated with seeking western treatment. So far no specific study has been made to find out the choice of healthcare provider and systems of medicine among the rural households in Tamil Nadu.

The selection of service provider depends also on the household healthcare expenditure due to the fact that public healthcare system is provided at subsidised rate when compared to other channels. Both preventive and curative public health services in Tamil Nadu have been provided free of cost or at very low price. However, public healthcare is not all that ‘free’ after all; there are many incidental expenses that consumers have to bear on their own. If all the quality and access differentials between public and private healthcare were to be wiped out, there would still be some financial burden on the consumers.

Information about Public Health Expenditure is fairly well documented. In contrast to this, information on private healthcare expenditure is very poorly documented. The National Sample Survey’s (NSS) earlier rounds (nineteen fifties) have recorded fairly reliable information, but later rounds have not reported on this category of consumer expenditure. NSS probably has this kind of data but it has not been publishing
it regularly. The large volume of private health expenditure in India is probably one of the largest in the world when viewed as a proportion to total health expenditure (Duggal, 1991).

Health problems arise for people unexpectedly. It is important to consider the sources through which the people faced such contingencies. It is said that when the expenditure happened to be at higher side above the capacity to meet out of pocket, then they borrowed money from various sources including friends, relatives and saving societies. People pay informal fees in the nominally free public sector, despite the generally low quality of services. Many have lost confidence in public services and turn to private healthcare providers. The range of private providers is broad and includes public health staff practising privately, often in direct competition with the public facility where they are posted. Often private health service providers are private practitioners, private hospitals under corporate structure, non-corporate hospitals run by trusts or NGOs and religious bodies. Now a trend has set in south India where practitioners who are treated as demigods with large number of followers collect donations from the followers and run super speciality hospitals and provide healthcare treatment for many patient’s complaints including diseases like cancer, heart problems at free of cost or at very low cost.

One of the major problems faced by the health sector in India is shortage of finance. In the midst of competing demand for funds from other sectors, governments have been allocating funds less than what the health sector needs. Generally, it is realised that most of the conventional healthcare financing sources (tax, user fees, foreign aid and private insurance) do not solve the problem of health sector in developing countries particularly that of the poor. As a result, there is a growing worldwide initiative to find additional sources of finance, which are broad based, sustainable and suitable to the socio-economic conditions of the rural population to provide basic health services for
socially excluded and disadvantaged groups of the population. According to the World Health Report 2000, India’s health expenditure was 5.2 per cent of its GDP. The public and private health expenditure is 13 and 87 per cent respectively. Health insurance is extremely marginal.

In a country like India the experience of health insurance hardly exists in urban areas let alone in rural areas. Market prices for health insurance could not be examined to estimate the preference of households. As a result, very little is known either about factors that affect the decision of households to join such schemes or their revealed preferences. At the same time, very little is known about the healthcare demand behaviour and the costs of illness in the rural areas that could have been used to estimate the potential benefit of insurance schemes and the willingness of households to pay for such insurance schemes. This study tries to bridge the existing research gap in these areas.

The way healthcare expenditures are financed has important implication on healthcare systems. Only a small percentage of total health expenditure has been found to be reimbursed by employers in the organised sector in India. It has also been observed that people borrow to finance their health expenditure. Insurance coverage in India is very limited.

In the context of wide disparity in income and sizable population living below poverty line particularly in rural areas, household expenditures on health deserve special focus. So far no study has focused on combining the health services covering choice of healthcare provider and systems of medicine, source of financing of health treatment and awareness of health insurance among the rural households in Tamil Nadu. Due to these reasons, “Health for all by 2000 AD” has not been achieved. In this context, it is necessary to understand the health seeking behaviour, which will help to evolve suitable policy to achieve the new goal in the sector “Vision 2020”. Hence the need for this study.
1.13 Objectives

Following are the major objectives of the study;

1. To examine the choice of curative healthcare provider and systems of medicine among the various rural households.
2. To estimate the healthcare expenditure by the households.
3. To assess the sources of financing for healthcare treatments and the awareness of health insurance among the rural households.

1.14 Methodology

To achieve the above objectives the data from rural households was needed. So the study used the data generated by IDPAD project on healthcare control by 600 rural households of Tamil Nadu. The sample households were spread in three revenue districts (Coimbatore, Erode and Thanjavur). In each district, the project covered 4 villages and in each village 50 households were randomly selected following NSSO sample selection pattern.

In analysing the data our study made tabular analysis by using simple statistical tools. For finding factors which determine the rural households' choice of healthcare provider and choice of system of medicine Multi-Nominal Logit (MNL) model was used. OLS regression method was used to study the factors which determine the healthcare expenditure of the households.

1.14.1 Data Collection

One project investigator stayed in each of the 12 villages for 14 months and collected different set of data from the randomly selected 600 households during 1998-99. One such data set was related to health. The data were collected from a sample of 50 households in each village by the interview method.
1.14.2 Enquiry Schedule

As our study was designed to analyse the household healthcare expenditure and choice of curative healthcare, three relevant schedules used to collect data during the project fieldwork have been utilised. They are, Schedule pertaining to village profile, schedule consisting of household characteristics and pattern of Consumption of health by households.

A set of probing questions were put to individual members of the selected households to ascertain whether they had suffered from any ailment during the reference period and whether they had taken any medical treatment for it. As far as possible, all the adult male members of each sample household were interviewed personally. For the female members, interviews were conducted through intermediaries in some cases. For the children, particularly the young, attempts were made to get the required information from their mothers. For hospitalised treatment, however, information was collected for every event of hospitalisation of a member during the 365 days preceding the date of enquiry.

1.15 Concepts and Definitions

The important concepts and definitions as used in this study are given here.

**Household** is defined as a family consisting of persons living together and taking food from a common kitchen, pooling their earnings and drawing their requirements.

**Ailment i.e, illness** or injury, is defined to be any deviation from the state of physical or mental well-being.

A person is regarded as having been **hospitalised** if he/she has availed of medical services as an inpatient (for indoor patient) in any medical institution. However, hospitalisation of female members for child-birth was not considered to be hospitalisation for the study.
A person is considered to have received **medical treatment** if he consults a doctor anywhere and obtains medical advice for ailment.

Total **expenditure incurred for medical treatment** received during the reference of 365 days for both hospitalisation and non-hospitalisation includes expenditure on items like fee for medical and paramedical services, medicine, bed charges, charges for diagnostic tests, operations, therapies etc.,

A person owning land and whose primary occupation is cultivating was called **agriculturist**.

A person who works in other’s land for wages (in cash or kind or both) in agriculture was treated as **agricultural labourers**.

People who have their own non-farm enterprises with small or large or no investment were defined as **self-employed**. There are different types of self-employed persons with or without capital. Likewise some may carry on their enterprises with or without hiring any labour. Activities like maintaining petty shops, vending household consumables, weaving, etc. are some of the jobs they choose. Other self-employed may work on their own but occasionally hire a few labourers. The next category of self-employed may regularly operate their enterprises by hiring labour.

All those persons living in rural areas and doing physical labour in non-agricultural occupation in return for wages (regular work) either in cash or kind were considered as **non-agricultural labourer**.

Persons employed in private sector or public sector enterprises and drawing regular monthly salary with some security of job or continuity of job have been considered as **salaried class**. In our sample villages all state and central Government
employees such as Teachers, Village Administrative Officers, Postmen, Electrical Department employees, Health department employees, Private Industrial employees were all considered as salaried class. Many of these were residing and working in the same villages. A proportion of them are residing at the village and working in urban areas or in another village. They commute daily for their work.

Instead of treating workers like Carpenters, Smiths, Washerman, Barbers, Masons and others who have special skills as one among the Non-Agricultural labour, we have classified them as rural artisans. The artisan employs his mental skill and carries out physical work. So we have differentiated them into rural artisans, which will reflect on many of our economic variables like earnings, allocating time on various activities, preferences and investment in human capital.

Households in villages earn income in monetary or non-monetary (or real) terms either as payment for the work performed and as yield in farming activities. The non-monetary value estimated by the market value of product. Household income is the pooled income of all the members of the households as well as market earnings and non-market income.

We have classified the educational attainment of the respondent into levels of education such as primary, secondary, degree and illiterate.

1.16. Organisation of the Thesis

Chapter I presents the Perspectives on health, Importance of health, objective, Methodology of the study and organisation of the thesis.

Chapter II is devoted to the discussion of theoretical framework of the study and review of empirical studies.
Chapter III reveals the development of Healthcare Services in India and Tamil Nadu

Chapter IV deals with Profile of the sample villages and the socio-economic background of the sample households.

Chapter V presents the analysis of Choice of Healthcare provider and systems of medicine.

Chapter VI analyses the Household Healthcare Expenditure

Chapter VII examines the source of financing for healthcare treatments and the awareness of health insurance

Chapter VIII presents summary and conclusions.