PATTERN OF MORBIDITY AND ACCESS TO HEALTH CARE IN WEST BENGAL

Abstract

Access to health care is defined as the potential and actual entry of a given individual or population group into the health care delivery system. It is the 'degree of fit' between clients and the health system depending on acceptability, affordability, availability, physical accessibility and accommodation. It has been an issue of debate whether the recent reforms in economic as well as health care policies, coupled with the wave of globalization and privatization, have been successful in improving access to health care, lack of which can be taken as the 'unmet demand' for health care in general. Using unit level data of National Sample Survey (NSS) 60th and 52nd rounds on Morbidity and Health Care, the present study looks into the nature and determinants of both hospitalized and non-hospitalized health care in West Bengal, an Eastern state of India where people overwhelmingly prefer publicly provided health care facilities. The state is experiencing epidemiological transition with a sharp decrease in the prevalence of communicable diseases and increase in non-communicable diseases. Income, living condition and the social affiliation has come out as important determinants of incidence of communicable disease. Differences in morbidity prevalence and their determinants are observed across the regions of the state. Education and income appear to be crucial determinants on access to non-hospitalized outdoor health care, whereas intra-household discrimination against women in access emerges in the analysis of socio-economic ordering analysis. The preference for private providers among better off and more educated classes hints towards a perceived low quality of services in public sector. With the National Health Policy in India (2002) suggesting expansion of market based care for the affording class and subsidized care for the deserving class of the society, the benefit incidence analysis of the public support in health sector is important to study the welfare consequences of the policy. Analysis shows that though the rate of utilization of public hospitals is quite high, other complementary services like medicine, doctor and diagnostic tests are mostly purchased from private market, which leads to high out-of-pocket expenditure. Moreover, the public subsidies are mostly enjoyed by the relatively better placed patients, both socially and economically. As a result, nearly 30 percent of the households have to incur catastrophic health care, spending more than 40 percent of their annual income on health care. Thus in WB, the horizontal equity in access to health care cannot ensure enough benefits for the poorer section resulting in pro-rich distribution of subsidy, violating the concept of vertical equity altogether.