Chapter I

Introduction

Health is perhaps the most crucial dimension of human well-being, no matter whether we view it through the human development lens or that of human resource development. While good health is of intrinsic value to the "doing" and "being" of an individual, a healthy educated population, favourably located in the stages of demographic transition can work wonders for a country's economy. At an individual level, alongside the inherent importance of health as a dimension of welfare, poor health can directly influence an individual's opportunities—his or her earnings capacity, performance at school, ability to care for children, participation in community activities, and so on. This important instrumental function of health implies that inequalities in health often translate into inequalities in other dimensions of welfare (WDR 2006). The causation however often operates in a reverse direction. One cannot disagree that health is unique and hence dissimilar to other dimensions of well-being because the general constitution of the human body is largely a genetic aspect i.e., one might be disabled, mentally challenged or simply more susceptible to morbidity since the inception of life. However, prevailing socio-economic arrangements often determine whether a person can recover from the congenital physical deprivations and lead a dignified healthy life. Therefore individual demand for health is highly variable, a fact that emphasises the importance of health equity or a need based access to health care. Equity, as is the case with any normative concept, means different things to different people. It is an essentially impalpable concept with a history of diverse interpretations varying by country and academic disciplines. Summarising such nuanced differences in interpretation is extremely intricate, but the common denominator of all these views is that equity relates to fairness, whether locally within households and communities, or globally across nations.
1.1 Health: State vs. Markets

The pursuit of health equity demands greater role of the state vis-à-vis the market in provision of the health services. Healthcare is characterised by the presence of externalities and asymmetries in information which lead to failure of the market, necessitating state intervention. Externalities refer to situations when the effect of production or consumption of goods and services imposes costs or benefits on others, which are not reflected in the prices charged for the goods and services being provided. If a good or service not only benefits those who purchase these but others as well, then there is said to be a positive externality in its consumption. Therefore the operation of market forces alone in such cases brings about a non-optimal consumption and production of the relevant good or service. This then requires an intervention by the State to ensure that adequate resources are directed towards this activity.

The field of public health has substantial manifestations of externality. An act of ensuring clean, safe water, immunising oneself against, or seeking treatment for, a communicable disease by a person generates direct health benefits for other individuals, through lower prevalence of morbidity. These positive externalities make government intervention essential. Government intervention can take the form of price subsidies to boost or restore balance in the consumption of healthcare services, or direct public provision of such services.

Asymmetric information reflects any situation in which one party involved in transaction (contract or exchange) with another, has more or superior knowledge and information than the other. Such information asymmetries, primarily between the service provider and treatment seeker are widely prevalent in the health sector causing market failure in both

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1 Public health services refer to interventions targeted at overall conditions of nutrition and sanitation that determine health, as well as communicable diseases which are passed either directly among humans or indirectly through the physical environment. They are designed essentially to enhance the health status of the population as distinct from the curative services which repair health dysfunction.
healthcare and healthcare insurance markets. For example, in any society, the sick knows best how enhancement in health, affects his own well-being, while both the causes of ill-health and the efficacy of alternative healthcare services in restoring health, or preventing the further deterioration of health, is best known to the service provider. Again, there are occasions when the concerns of the treatment seeker and the health service provider do not coincide, leading to the problem of "incentive incompatibility".

Both of these features related to health hints at the need for government intervention in the form of regulation. Such regulation can take the form of licensing of healthcare providers, limits on advertising, insistence on some professional norms that prohibit low quality, etc. The ulterior objective of these regulations would be to ensure balance between the need to increase welfare by improving or assuring quality, and the welfare reducing effects of inadvertently granting monopoly powers to providers. Therefore both the efficiency and equity arguments point towards the public provision of healthcare. Even for a private insurance based health system to succeed, increased public health spending and superior public health facilities are a necessity. The above account therefore constitutes a strong theoretical case for health expenditure by the government.

1.1.1 Health Financing Arrangements

Health care all over the world however, is typically financed through a blend of the following sources:

a) The tax-based public sector comprising of Central, State and Local Governments, in addition to several public sector units.

b) The private sector encompassing the not-for-profit sector, financing directly or through insurance, the healthcare of their employees and target populations.

c) Households through out-of-pocket expenditures that include user charges paid in public facilities.

d) Other social and community based insurance, and

e) External financing through grants and loans.
While tax based financing might be considered as the most equitable system of financing, as taxes ideally mobilise resources from the richer segment to finance the health care needs of the poor, out-of-pocket expenses by households is considered as the most unjust means of financing health care. This is because the ability to spend out-of-pocket is essentially dependent on the general ability to pay of the household or individual. As such, the allocation of health services cease to be need based and health assumes the status of a luxury good. The effect that such a system has on treatment seeking is alarming. While the abject poor forego treatment, those who go for it are in danger of experiencing the economic burden of illness.

1.2 Economic Burden of Illness: A Review of Literature

Private out-of-pocket expenditures by households are considered to be the most inequitable means of financing health. The logic behind it is not hard to fathom. When people pay for a service out of their pockets it is generally dependent on their ability to pay rather than their need. So it is not unnatural that a society that relies on out of pocket payments for the health of its citizens, find the economically vulnerable sections out of the ambit of the health sector. In other words some forego treatment while the others remain in consequent danger of becoming impoverished on account of health payments.

1.2.1 Poverty and Illness: The Link

Poverty and ill health are mutually reinforcing. Studies compiled from the twelfth century onward show that the poor, quite simply, are sicker than the non poor and that this is invariant of the degree of economic affluence of a country (Farmer 1999). Scholars have examined poverty as a cause and consequence of poor health. Poverty is unfavourable to health because it restricts access to medical care and healthy living conditions. Moreover, since both prevention and effective treatment of adverse health events cost money, the poor are not only likely to suffer from ill health more often, but
also to have more severe sequel. The most immediate costs of illness to individuals and their households include the costs of treatment and forgone income due to lost work time.

A participatory poverty study in fifty countries known as Voices of the Poor (Narayan et. Al 2000) found that poor health and illness are universally feared as a source of penury, particularly owing to the costs of health care but also due to the income lost due to illness. Voices of the Poor documents the case of a 26 year-old Vietnamese man who has moved from being the richest man in his community to being one of the poorest as a result of the large health care costs necessitated by his daughter’s severe illness. Also recorded was the case of a 30-year-old Indian mother of four who has been forced to sell the family’s home and land, and has to walk 10 kilometers a day transporting wood on her head in order to finance the cost of her diabetic husband’s medical care.

Ill-health apart from reducing the earning capacity of a household, adds substantially to the household’s burden of expenditure, in the absence of accessible and affordable health-care facilities, thereby striking a double blow, which quite often results in a disaster. Evidence from several countries viz. Cambodia, China, Ethiopia, Haiti, Kenya, Peru, Sierra Leone, Senegal, and Vietnam, points unmistakably to the lethal consequences of healthcare costs upon household well-being (Asfaw & von Braun, 2004; Barrett, Reardon, & Webb, 2001; Deolalikar, 2002; Fabricant, Kamara, & Mills, 1999; Farmer, 1999; Krishna, 2004; Krishna et al., 2006; Strauss & Thomas, 1998; Xu et al., 2003). This phenomenon has been found to be prevalent in certain developed nations too. For example, more than half of all personal insolvencies in the United States of America are ascribable to medical costs (Himmelstein, Warren, Thorne, & Woolhandler, 2005).

1.2.2 Financial Burden of Health Shock

Major illnesses are widely acknowledged to be the most significant and least predictable shocks to the economic well-being of households. It entails both a direct cost, in terms of the price of accessing healthcare, and an indirect cost, in terms of the loss of income
associated with reduced labor supply and productivity. Since financing health care in most developing countries takes place through out-of-pocket payments, households are exposed to considerable financial risk. In the absence of an adequate system of social protection, illness can strain household well-being: resource-poor households may be compelled to forego the future welfare of all its members in return of current access to healthcare for one of them, or opt for inappropriate, ineffective and insufficient care, and in doing so, risk a vicious circle of poverty and illness (Gertler and Gruber 2002).

Health care can be expensive depending on the system of financing prevalent in a particular country. In the absence of insurance cover, households with severe and immediate medical needs can be forced to spend a large fraction of the household budget on health care. Such spending is generally accommodated by cutting back on consumption of other goods and services, by accumulating debt, by running down savings or by selling assets. Regardless of the financing strategy adopted, the household suffers a cost that may be labeled "catastrophic". The concept of catastrophic payments has been propagated by defining them as occurring when out of pocket payments exceed some threshold share of household expenditure and is considered as a major concern in the health financing system of any country. (Berki 1986; Wyszewianski 1986; Whitehead, Dahgren et al. 2001; CMH, 2001; Pradhan and Prescott 2002; Kawabata, Xu et al. 2002; Meesen, Zang et al. 2003; OECD and WHO 2003; Wagstaff and Van Doorslaer 2003; Xu, Evans et al. 2003 World Bank 2004). While the choice of threshold is somewhat arbitrary, 10% of total expenditure has been a common choice (Pradhan and Prescott 2002; Ranson 2002; Wagstaff and Van Doorslaer 2003); with the rationale that this represents an approximate share at which the household is forced to sacrifice other basic needs, sell productive assets, incur debt, or be impoverished (Russell 2004).

Other negative economic effects also accompany high medical expenses. Poor health, a lower life-expectancy and lost income from illness correspond to reduced wealth and savings due to lower lifetime earnings. Higher the level of medical utilisation lower is the labor force participation which transforms into lower future income (Smith J, 1999). Furthermore, while many traditional cost of illness studies have sought to quantify the
costs of lost work time due to illness, workers who do not deliberately change their work habits in response to illness can also be expected perform sub-optimally during the term of their illness (Schultz and Tansel 1996). Several studies have highlighted this aspect of burden of illness internationally. For example, one study finds that treatment of a single episode of malaria in Tigray, Ethiopia costs the affected household $0.80 to $1.60, and results in about 12-26 days of work lost. Therefore, the annual private cost of malaria in this region amounts to an average of 5-8% of household income (Cropper et al. 2000). Mead Over (1992) and others estimate the average total cost of treatment and foregone productivity in Tanzania resulting from a single HIV infection to be about $2462-$5316 in 1985 dollars, or about 8.5%-18.3% of per capita income (Over 1992). Similarly, a study of multiple sclerosis in the United States suggests an annual cost in terms of lost earnings and treatment expenses to each affected household of $5336 per year in 1976 dollars; aggregated, these costs amounted to about 0.04% of total US GDP in 1976 (Inman).

Most previous estimates of the impact of OOP payments on living standards in developing countries have been based on small-scale health survey data that are not nationally representative, often being restricted to rural areas (Parker 1986; Berman et al. 1987; Ensrud and Pham 1996; Sauerbrun, Adams et al. 1996; Pannarunothai and Mills 1997; Wilkes, Y. et al. 1998; Fabricant, Kamara et al. 1999; Ranson 2002; Skarbinski, Walker et al. 2002; Russell 2004; van Damme 2004). However over the past decades there has been growing evidences of an interest in effects of healthcare expenditure on consumption and poverty even at the national level in low- and middle-income countries. Health shocks are gradually being perceived as one of the greatest concerns by the poor themselves: “loss of income coupled with cost of treatment and the transformation of a wage-earner into a dependent make injury and illness common triggers of impoverishment” (Narayan et al. 2000). Gertler and Gruber (2002), for instance, studied the impact of health shocks on households’ consumption patterns in Indonesia, providing evidence that illness reduced labor supply and household income. Similarly Wagstaff (2005) finds evidence that health shocks are associated with a decline in consumption in Vietnam, in particular for the uninsured and better-off households. A relatively recent
series of participatory studies in Kenya, Uganda, India and Peru found that "healthcare is overwhelmingly the single-most important reason for households descending into poverty" (Krishna 2006). In addition, estimates are available for at least six Latin American countries (Baeza and Packard 2005), China (Lindelow and Wagstaff, 2005), Thailand (Limwattananon 2007), and fourteen Asian countries and territories (Van Doorslaer et al. 2007) on the economic burden of morbidity. A recent WHO article, using survey data from 89 countries, finds that 3% of households in low-income countries, 1.8% of households in middle-income countries and 0.6% of households in high-income countries incur catastrophic health expenditures (Xu et al. 2007).

The catastrophic effect of OOP payments may prevail in the short run as well as the long run. In the case that OOP payments are fully financed out of current income, a large OOP budget share implies the sacrifice of other consumption. If the household can draw on savings, credit, assets or gifts, then the short-term consequences of OOP payments will be reduced but there will be longer-term effects on household living standards that could possibly be catastrophic. With the cross-section data typically used to examine the issue, short and long term consequences are not distinguishable. Nor does the definition of catastrophe by reference to a given share of household (one-period) resources restrict attention to short or long-term effects. A high share of a fixed budget implies sacrifice of other consumption. But a high budget share could also indicate that the household has depleted savings / assets or borrowed to cover the costs. The budget share alone does not tell us what financing strategy has been adopted.

1.2.3 Health Shock and Impoverishment

Paying for health care may push households into, or further into, poverty. Standard measures of poverty however are unable to capture this aspect since they compare total household resources, including those exhausted by health care, with a poverty line that reflects needs for food and possibly those for other basic necessities but cannot take full account of health care needs. The variability and unpredictability of health care costs means that they cannot be reflected in a given poverty line. If expenditures on health care
were completely non-discretionary, constituting resources that are not available to meet other basic needs, then it would be appropriate to assess poverty on the basis of household resources net of payments for health care. Of course, not all expenditures on health care are made without discretion. There is ample evidence that such expenditures demonstrate an income and price gradient. Nonetheless, it is likely that households make great sacrifices in order to meet needs for vital health care. It seems inaccurate to categorise a household as non-poor simply because high medical expenses raise its total spending above the poverty line, while spending on food, clothing and shelter is below subsistence levels.

A static definition of poverty (having an income below a certain threshold, usually the poverty line) therefore does not capture an important dimension, which is vulnerability. "Many households, while not currently in poverty, recognize that they are vulnerable and that events could easily push them into poverty — a bad harvest, a lost job, an unexpected expense, an illness, a lull in business." (Pritchett 2000). Vulnerability is often understood as the expected poverty of an individual, household or group. Households are vulnerable when they are not able to smooth consumption, despite various formal and informal coping mechanisms. Thus vulnerability is the net effect of three processes. It reflects, first, non-stochastic poverty determinants such as education of the household members, secondly, the households' exposure to shocks (e.g. health shock) and thirdly, its ability to cope with shocks (e.g. through insurance). Moreover, vulnerability and poverty reinforce each other. Indeed, poverty is a source of vulnerability (poor people are more likely to fall badly sick or to be affected by political events) and repeated exposure to downturns reinforces poverty (Morduch 1999). The recent emphasis in the poverty literature on vulnerability is based on the recognition that a household's current poverty may be a bad guide to its future economic prospects (World Bank, 2001).

The difference between poverty estimates derived from household expenditures gross and net of OOP payments for health care provides a rough approximation to the poverty impact of such payments (Wagstaff and van Doorslaer 2003; Gustaffson and Li 2004). A study that needs special mention was the one conducted for South East Asia-Pacific
countries by the EQUITAP team that analysed data from nationally representative household expenditure surveys that recorded both OOP payments for health care and total household expenditure in detail and so offered accurate estimates of the magnitude of OOP payments relative to the household budget. (Van Doorslaer et al. 2006b). Catastrophic impact was measured by the prevalence and intensity of high shares of OOP in total spending and in non-food expenditure. Impoverishment was measured by comparing poverty headcounts and gaps before and after OOP health payments. In fact this study presents the first cross-country comparisons of the impoverishing effect of OOP payments measured against the international poverty standards of $1 and $2 per person per day. Their baseline poverty estimates were quite consistent with those of the World Bank (Chen and Ravallion 2004). At the $1.08 poverty line, subtracting OOP payments from total resources resulted in a 3.8 percentage point increase in the headcount in Bangladesh, equivalent to almost 5 million people, a 3.7 percentage point increase in India (over 37 million) and a 2.6 percentage point increase in China (32.4 million). The total estimated increase in the poverty headcount was 78.25 million people, or 2.7 per cent of the population of these eleven low/middle-income Asian countries. They infer that Bangladesh, China, India and Vietnam stand out in relying heavily on OOP financing, having a high prevalence of catastrophic payments and a large poverty impact of these payments. In most low/middle-income countries, the better-off are more likely to spend a large fraction of total household resources on health care. This reflects the inability of the poorest of the poor to divert resources from basic needs. It also seems to reflect the protection of the poor from user charges in some countries. Despite the concentration of catastrophic payments on the better-off in the majority of low-income countries, OOP payments still pushed as many as seventy-eight million people in the eleven low/middle-income countries included in this study, or 2.7% of the total population, below the very low poverty threshold of $1 per day.
Thus illness leads to poverty through two major pathways:

A. The first is through the death or disability of a household income earner. This reduces future income generation and may jeopardize basic household consumption. Depleted of wealth, the household may invest less on children’s education creating a vicious intergenerational poverty cycle.

B. The second pathway is through prohibitive treatment cost. When a member falls ill, the household faces several different costs (treatment cost, transportation cost, opportunity cost of care giving etc.) and takes recourse to diverse strategies to finance the same. These coping strategies very often turn out to be potential poverty traps.

This chain of events has often been termed as the “poverty ratchet” (Chambers, 1983) or the “medical poverty trap” (Whitehead et. al., 2001). The mechanism of a medical poverty trap is demonstrated in detail with a help of a flowchart below. While direct cost of illness is more observable and hence better documented, it is the indirect cost of illness that has been ignored. It includes the time cost of the ailing person as well as his attendant and their consequent loss of work days and income. Some of the strategies for coping with these costs might include measures as drastic as withdrawing children from school, sending children to work or reduce consumption of food.
The health system prevailing in a particular country therefore emerges as the most important macro parameter in this regard. A health system comprises all organizations, institutions and resources devoted to producing actions whose primary intent is to improve health. Most national health systems include public, private, traditional and informal sectors. The four essential functions of a health system have been defined as service provision, resource generation, financing and stewardship. In what follows we discuss the health system prevailing in India from an evolutionary perspective.
1.3 The Health System in India: Past and Present

Private providers, both modern and traditional, have historically been the dominant players in the health care market in India instead of the State per se. While in pre-colonial India, health services were largely within the domain of a caste based occupational assignment system\(^2\), later on with the advent of modern technology and pharmaceutical research, health care was transformed into a commodity. Inpatient care however has been predominantly provided by the State and its agencies right from the pre-colonial times, through the colonial period and the post independence period up to the mid-seventies. Since then, the medical education system witnessed a significant overhaul whereby post graduation, specialisation and super-specialisation started to be offered. Though this was an encouraging development as far as its potential to deliver state-of-the-art medical services is concerned, it arguably changed the character of medical practice as well—private nursing homes were set up by the specialists and the corporate sector with their corpus of capital and access to modern technology, started expressing their interest in entering the health care market in general, and hospital care in particular (Duggal, 2007). Public health expenditure as percentage of total government expenditure as well as a proportion to gross domestic product subsequently declined and reached some of the lowest levels after the setting in of the structural adjustment program.

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\(^2\) Better known as the \textit{jajmani} system. According to the Encyclopedia Britannica, the \textit{jajmani} system refers to reciprocal social and economic arrangements between families of different castes within a village community in India, by which one family exclusively performs certain services for the other, such as ministering to the ritual or providing agricultural labour, in return for pay, protection, and employment security. These relations are supposed to continue from one generation to the next, and payment is normally made in the form of a fixed share in the harvest rather than in cash. The patron family itself can be the client of another whom it patronizes for certain services and by whom it is in turn patronized for other services. The hereditary character allows for certain forms of bond labour, since it is the family obligation to serve its hereditary patrons.
Recent studies on India’s health sector have reported substantial variation in the delivery and financing of health services across India (MOHFW, 2005; Peters Rao, & Fryatt, 2003; Peters et. al., 2002). Persistent underfunding and abysmal performance characterises the rather large public health services delivery infrastructure in the country. The private sector on the other hand is even larger and fractured. The services however have been found to favour the better off over the poor, irrespective of the type of service provider. Nationally, curative care, both as an inpatient as well as an outpatient, is predominantly addressed by the private sector (NSSO 2006, Report No. 507) and the utilisation rates are much better among the well off vis-à-vis the poor. For example, Naylor et al. (1999) provides evidence that the share of private health care in outpatient care increases with a rise in economic status of the population. Preventive health care, on the other hand is mostly through the public sector. About 90 percent of immunizations and 60 percent of antenatal care is provided publicly, with the distribution of both services disproportionately favouring the poor (Peters et al., 2002). Arguably the most extensive study of spending and utilisation of public resources in health revealed that nationally, public spending is about three times greater for the wealthiest quintile of Indians as against the poorest and this difference exhibited substantial variation at the sub-national level (Mahal et al., 2001).

Though the private sector remains the mainstay of curative health care in India, doubts have been expressed about the quality, costs and accessibility of care provided by this sector (Nandraj, Muraleedharan, Baru, Qadeer, & Priya, 2001; Peters et al., 2002). Primary sources of concern were regarding the possibility of needless services, high prices and low quality. For example, studies have shown excessive caesarian section rates (Mishra & Ramanathan, 2002; Muraleedharan, 2000) inappropriate drug treatment (Yesudian, 1994) etc. Nevertheless, public policy in India has largely preferred to overlook these issues and as such the expansion of private health care continues unabated. Regulation of these institutions is all the more difficult thanks to the lack of basic data on the number of such facilities within the country. Even if data is available, the inherent asymmetry in the relationship between the provider (the agent) and the patient (the principal) prevents an automatic measurement of costs, quality and quantity.
of care and therefore it is not possible to demonstrate the opportunistic behaviour of agents, even by independent regulatory bodies (Peters & Muraleedharan, 2008).

1.3.1 Sources of Health Financing in India

The National Health Accounts of India, 2001-02 which was the first systematic analysis of the distribution of health spending in India by source of funds confirm the widespread perception that private households in India account for the bulk of health expenditure. According to this estimate, households accounted for more than two-thirds of health spending in the country, and around three times the amount of all government expenditure taken together, by the Central, State and local governments. Employers (firms) account for only 5 per cent, but what is especially notable is the negligible role played by both external sources and others, including NGOs. Despite the reported increase in foreign aid for dealing with HIV/AIDS and similar issues, all external sources taken together accounted for only 2 per cent of total health spending, while NGOs accounted for only 0.3 per cent. (However, some foreign aid — that portion going directly to governmental sources for defined programmes of the government — is included in the health expenditure of Central and State governments.) More recent estimates suggest that the role of households has increased even more substantially in the most recent period. According to the Report of the National Commission on Macroeconomics and Health, 2005, households undertook nearly three-fourths of all the health spending in the country. Public spending was only 22 per cent, and all other sources accounted for less than 5 per cent. The exceptionally high burden placed upon households in the Indian context reflects the inadequate quantity and quality of public health service delivery.
1.3.2 A Review of Studies on Health Financing and its Impact in India

Information on health care expenditure has been collected in a number of studies in India. Average expenditure on medical care was invariably found to rise with monthly per capita consumer expenditure or household or per capita income of household (NSSO, 1992; Visaria and Gumber 1994; Rajarathnam, et al. 1996; Visaria, et al. 1996; Satya Sekar, 1997; NSSO, 1998). At the same time the medical care expenditure made by a poor household in comparison to its expenditure/earning potential is much higher than that of rich household (Kannan, et al. 1991; Krishnan, 2000). In India, where OOP expenditures are over three quarters of the total health expenditures (National Health Accounts, 2006), it is expected that a large number of households face poverty as well as catastrophic impacts of OOP payments. O'Donnell and Doorslaer, et al., (2005a) in fact estimated that as per the $1 norm of the poverty line, more than 37 million people in India go below poverty line in 1999-2000 because of OOP payments. This is in addition to those, who are already below poverty line and are further pushed into acute poverty because of OOP payments. This estimate is 32.5 million as per the Indian official poverty line (Garg and Karan, 2004). Another analysis on health expenditure by household (Shariff, et al. 1999) showed that about 6 percent of household income is being spent on curative care which amounts to rupees 250 per capita per annum. Estimates show health expenditure as a percentage of annual income was found to be varying from 3 percent in the richest 20 percent of the households to 12 percent in the bottom 20 percent of the households (Gumber 2002). A retrospective study in 35 villages in Rajasthan, India found that health and health expenses were one of three main causes that lie behind 85% of all cases of impoverishment (Krishna 2004). One-half to two-thirds of all households falling into poverty mentioned ill-health and health expenses as a contributory cause. Such impoverishment is of even greater concern given evidence from another detailed study in Rajasthan that shows the health care purchased is often of poor quality, even harmful (Banerjee, Deaton et al. 2004).

These studies also mention that expenditure on drugs play a major role in impoverishment of households. It has been argued that, in general, low income of
households and distance of health care facilities has constraining effects on OOP payment. In spite of this, the proportion of poverty as well as catastrophic headcount-is much higher in India in comparison with many other countries where general income level of households is higher and health care facilities are accessible. This is because, in India, those who have better ability to pay have to pay much higher for availing health care services. The burden of health care affects the already thin household budget in India in terms of payments made for treatment as well as through inability to earn during the period of illness.

Prevalence of this alarming phenomenon is invariant of the place of residence of the poor households - rural or urban. However, it might be contended that the extent and severity of the burden of disease is more in the case of the urban poor vis-à-vis his rural counterpart. Though urban areas are comparatively much better than rural areas in terms of health indicators, survey based information shows wide inequalities in accessing services within the urban context (IIPS and ORC Macro 2001; Sundar and Sharma 2002). Apart from the higher cost of living and an extremely competitive informal job market, the burden of disease among the urban poor is enhanced, thanks to unhygienic living conditions, deplorable status of basic necessities like water and sanitation, increased exposure to accidents and poor environmental condition that increases the vulnerability to indispositions and hence the economic burden. High rate of growth of urban population and consequent increase in population residing in slums has lead to over straining of infrastructure and deterioration in public health and wide inequalities in accessing services. Such hostile circumstances coupled with the lack of social network and fall back options, arguably leads them to the “medical poverty trap”. Though there is a substantial literature on the causes of urban poverty (Pryer, 1989; Amis, 1997; Benjamin, 2000) available literature specifically on the impact of health shock on urban households in India is woefully limited. Among these, the work by Noponen on a panel data set of female headed households in Madras is very significant. The study is concerned with the responses (labour, non labour and “other”) to stress or shock events. The most frequent was ritual celebrations; the most expensive event was marriage and dowry; the most devastating event was the loss of a major income earner; however the event with the
greatest impact in terms of frequency and magnitude was illness to a major income earner. The dominant responses were to increase female employment and/or for them to take a second job. While the overwhelming non labour response, especially over time, was indebtedness; thus “taking loans from a variety of sources” was the dominant adjustment pattern over the study period for 80% of the households. Within this, approaching a money lender was the most common response (Noponen, 1991).

1.4 The Current Study

In light of the discussion made in the preceding sections and in the specific context of urban India, the current study conducts an in-depth analysis of the direct cost of treatment separately for hospitalised and non-hospitalised ailments. It computes the catastrophic and impoverishing effects of out of pocket health expenditure on the urban households. It also examines between group and within group variations in the incidence of the economic burden in order to isolate the vulnerable groups. At the end, by means of a suitable econometric exercise the study estimates the determinants of the ‘medical poverty trap’. The study consists of a secondary data component as well as a case study. The secondary data sources are the unit record data from the 52nd (1995-96) and 60th (2004) round of the National Sample Survey on Morbidity and Treatment of Ailments. This data is supplemented by a case study of two urban slums in Delhi to examine the incidence of the phenomenon of economic burden of illness specifically on the urban poor.

The chapters are organised as follows. Chapter II provides a socio-economic profile of morbidity and health service utilisation in urban India. Chapter III deals with the economic burden of direct as well as indirect cost. Chapter IV analyses the concept of ‘medical poverty trap’ and applies the same to urban households in India. Chapter V presents the socio-economic correlates of morbidity, health service utilisation and health expenditure within the slum. Chapter VI computes the economic burden of illness for the sample of urban poor households living in slums. Chapter VII applies binomial logistic
techniques to arrive at the household level determinants of the medical poverty trap while Chapter VIII concludes with few policy recommendations.