In this study we have been concerned with understanding individuals’ health care seeking behaviour, especially the role of quality and price in their choice of health care. Earlier studies attempting to examine individuals’ demand for health care have found user fees/price of health care, travel distance/travel time, quality of health care, income as important factors determining the demand. Although the price of health care has gained conceptual refinement and methodological improvement in measurement over the years, such refinement and improvement has not taken place in case of quality of health care. Ambiguous definition of quality and confusing distinction between price and quality are the two main disturbing features in most of the studies. There are also other limitations such as inability of the behavioural model to incorporate price and quality in a way meaningful for demand/choice analysis, lack of suitable data sets, inappropriate proxies, not distinguishing outpatient and inpatient care, and questionable inferences found in most of the studies.

Although the scope of economists’ conceptualisation of quality and public health approach to quality assessment is limited in providing us a concept of quality suitable for understanding individuals’ health care seeking behaviour, they enrich our understanding about quality of health care to a great extent. Based on the lessons drawn from a critical review of economists’ view of quality and public health view on health care quality and by borrowing ideas from standard of living literature, it is possible to develop an alternative approach. The alternative approach, which views quality purely from an individual’s perspective seems to be more appropriate in understanding individuals’ health care seeking behaviour. The approach makes a clear distinction between quality and price of health care. Within quality it further makes a distinction between technical and functional quality and within price it also makes a clear distinction between direct price and access cost. The main advantage of this approach is it clarifies many conceptual ambiguities associated with quality and price of health care.

Another advantage of this approach is that it also fits into the framework of consumer behaviour of standard microeconomics and allows us to draw some theoretical insights about an individual’s possible responses to quality and price of health care. For example, the theoretical result shows that any change in price or quality of a particular health care provider implies a change in price per unit of quality to an individual. Whether an increase in price
coupled with improvement in quality will be acceptable to an individual depends on her trade-off between quality of health care and consumption of non-health care goods. The theoretical result shows that it may be inappropriate to consider the additional money an individual spends at private facility (over what she would have spent at government facility) as her willingness to pay for better quality at private facility. It may be a combined willingness to pay for better quality and lower access cost. An individual's willingness to pay for quality would depend on the price of non-health care goods and her rate of substitution between quality of health care and non-health care goods. The theoretical results demonstrate that whether absolute expenditure on health care will increase or not as a result of increase in price per unit of quality depends on the individual's price elasticity of quality. However, whether the individual's expenditure on health care as a proportion of income will change as a result of change in her income depends on her income elasticity of quality. For example, if quality is a luxury good, individual's expenditure on health care as a proportion of her income will increase with increase in her income. The theoretical results also show that when access cost is higher than direct price, demand for quality is expected to be more responsive to changes in access cost than changes in direct price.

We have used unit-record data from two large household surveys namely, NSS 52nd round and NFHS 2 data for the state of West Bengal. Both these data sets provide good amount of information on morbidity, utilisation of and expenditure on health care. In particular data provided by NSS 52nd round data on reasons for no health care and on reasons for non-utilisation of government health care facilities illuminates important aspects of individuals' health care seeking behaviour. NFHS 2 data also provides good amount of information on women's assessment of a few dimensions of health care quality. However the scopes of both the data sets are limited to allow us address all issues we are interested in and in most of the cases they provide us only with indirect evidences. Moreover, the data sets have other shortcomings too. For example, in NSS 52nd round data there are problems relating to classification of illnesses and health care providers, truncation of data, recall errors, large missing values on key variables, first stage stratification etc. Although such limitations do not prevent us from using the data, they keep us alert when we do the empirical analysis and interpret the results.

Analysis of outpatient care utilisation data from NSS 52nd round shows that economic status (or alternatively the price of health care) seems to an important determinant of utilisation of health care. However, information on reasons for 'no health care' does not support the
negative role of price in reducing utilisation of health care except for the rural poor. Although direct price may play a significant role in the choice between ‘health care’ and ‘no health care’, it seems to play an insignificant role in the choice of health care providers. It is the higher access cost (due to higher opportunity cost of time) and not the lack of quality, which is the main reason for individuals not utilising government health care providers. However, the relative importance of quality with respect to access cost is much higher for the rich compared to the poor. The multinomial logit analysis reveals individuals with lower opportunity cost of time are more likely to utilise government health care providers, when other relevant influential factors are controlled for. It is also clear from the results of multinomial logit analysis that as economic status increases, the probability of utilising non-government health care provider on better quality ground increases at higher rate than probability of utilising non-government on lower access cost ground. Further, as far as utilisation of non-government health care providers on lower access cost ground, the probabilities are much higher for individuals belonging to labour and self-employed compared to individual belonging to regular wage or salaried households.

Evidence from NFHS 2 data on women’s assessment of quality shows that women are more satisfied with the non-government providers than the government providers as far as indicators like ‘time spent by the doctor/health staff’ and ‘privacy was respected’ are concerned. When we focus on the indicators like ‘time spent’, ‘behaviour of the doctor/health staff’, and ‘privacy’, there is evidence of discrimination against the poor women when they visit government facilities but except ‘privacy’ such discrimination is not observed with the non-government providers.

Analysis of inpatient care utilisation data from NSS 52nd round shows that economic status (or alternatively monetary cost of inpatient care) and access cost are the most important factors determining the utilisation of inpatient care. The higher access cost faced by the rural individuals seems to be the major reasons for the huge rural-urban difference in utilisation. The main reason for the higher access cost faced by the rural individuals seems to be the higher time required to utilise inpatient care and not the higher opportunity cost per unit of time. Unlike outpatient care, the degree of substitutability between government and non-government inpatient care is very low due to the high price differentials. Between rural and urban sectors, the degree of substitutability is much lower for the rural individuals, since the concentration of non-government inpatient facilities in the urban areas makes them face
higher access cost of non-government inpatient care compared to the urban individuals. Since there is no evidence that access cost of non-government inpatient care is lower than that of government, individuals seeking inpatient care from non-government facilities must be doing so on the ground of better quality. The negative relationship found between access to and utilisation of inpatient care is probably due the reason that higher distance substantially raises the non-monetary access cost. The observed almost negative relationship between access-utilisation confirms that spatial inequality in utilisation is rooted in the spatial inequality in access.

In the light of our conceptual discussion and empirical findings, we attempt to clarify a few commonly discussed policy options whose aims have been to improve the quality or/and reduce the price of health care:

1. Improving the Quality of Care

First, since there can be two pure perspectives from which the quality of health care can be viewed (Chapter 3), any measure aiming at improving the quality of health care must be clear whether it wants to improve the quality from biomedical perspective or from individuals' perspective. Improvement in quality from biomedical perspective may not mean quality improvement to an individual.

Secondly, as far as the notion of health care quality from an individual's perspective is concerned, we have made a distinction between technical and functional quality. Although it can be debated how much importance one should pay to the assessment of technical quality from individuals' point of view, such dilemma does not arise in the assessment of functional quality from individuals' point of view. As far as functional quality is concerned, an individual who receives the care is the ultimate judge, as functional quality can only be evaluated from an individual's perspective. However, the same cannot be argued about an individual's assessment of technical quality. ¹ The important question that arises then is if we want to improve the technical quality of care, should we go with the assessment of technical quality from individuals' perspective or from biomedical perspective? Assessing technical

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¹In health care there exists an asymmetry of information regarding the knowledge of health care between health care providers and individuals. Although such an asymmetry is unnatural and totally expected, the information asymmetry relevant here is the difference in information as a consequence of a purchase of medical care. There is always an inequality of information as to the production methods between the producer and the purchaser of any commodity, but in most cases the consumer may well have a good or nearly a minimal understanding of the utility of the product as the producer. It is evident that in case of health care the asymmetry of information is different from that in case of other economic goods and services (Arrow 1963).
quality from both the perspectives have their own merits and demerits. While an individual’s assessment of technical quality influences her choice behaviour, assessing technical quality from biomedical perspective is also important to improve the benefit of health care on an individual’s health outcome. One might argue that it is more appropriate to assess the quality of health care from biomedical perspective and improve individuals’ awareness about quality to the possible extent. However, it is more reasonable to argue that quality improvement measures based on the assessment of quality from both the perspectives are likely to be more effective than measures which incorporate the views either from biomedical or individuals’ perspective.

Thirdly, while designing measures to improve the quality of health care there is a need to distinguish between providers who are providing outpatient care and those who are providing inpatient care. Our empirical analysis shows that individuals’ health care seeking behaviour is different for outpatient and inpatient care due to difference in quality-price tradeoff. Whereas access cost and quality seem to be more important in the choice of outpatient care, direct price and access cost determine the utilisation of inpatient care to a great extent. Moreover, in a geographical setting (especially in the semi-urban and rural areas), generally the number of inpatient care providers is smaller compared to the number of outpatient care providers. Therefore, it is much easier to monitor and regulate the activity of inpatient care providers but monitoring and regulating large number of outpatient care providers are difficult. It also became evident from the empirical findings that spatial inequality in utilisation could be reduced to a considerable magnitude by reducing spatial inequality in access to government inpatient care.

Finally, designing effective measures to improve quality (from individuals’ perspective) we need to systematically look into the factors, which contribute to lack of quality. Discussions carried out in Chapters 4 and 5 clearly show that there are two sets of factors which determine individuals’ assessment of quality: (1) characteristics of the health care provider and (2) characteristics of the individuals. Besides improving quality through changing certain characteristics of the health care provider in a desired direction, it is also possible to improve the perception of the individual about quality by influencing some of the individuals’ characteristics (e.g. making them more aware of quality of health care).
2. User Fees and Exemption for the Poor

All the empirical studies and policy papers which have argued in favour of either introducing or increasing user fees as one of the means to generate more resources for carrying out quality improvement initiatives have taken a safeguard by suggesting to exempt the poor from paying user or any other fees.

Although the poor are very sensitive to direct price of health care, direct price is just a part of total price of health care. Our empirical analysis clearly shows that apart from direct price, access costs play very important role in individuals’ health care seeking behaviour. An important determinant of access cost is household’s opportunity cost per unit of time. As a result if the direct price of health care is reduced to zero, it encourages utilisation by the individuals with lower opportunity cost of time and not necessarily the poor individuals. Therefore, there is a need to reduce access cost too along with reduction of direct price if we want to make health care free to the poor in a real sense. Unfortunately reduction of access cost has not received enough attention in most of the policy papers in terms of concrete policy suggestions.

Discussion carried out in Chapter 3 clearly shows that many of the determinants of access costs are beyond the scope of the health sector and health policy cannot influence them. It is not difficult to see that access costs are determined by three group of factors: (1) individual/household-level factors (e.g. opportunity cost per unit of time of the household); (2) health care provider-level factors (e.g. waiting time, timing of the facility); and (3) factors outside the purview of either individual or health care provider (e.g. connectivity). It is reasonable to suggest that improving village connectivity, transport system, changing the timing of the outdoor hours in government facilities\(^2\), introducing some kinds of protection in case of income loss due to illness for the people engaged in informal economic activities can reduce the access costs to a considerable extent. Moreover measures like mobile health care centres in the rural areas especially during agriculture season can reduce the access cost of health care for the individuals belonging to agricultural labour and self-employed agriculture households. In other words, by moving health facilities closer to population either by improving transportation or locating health facilities closer by establishing satellite clinics around central facilities access cost can be reduced.

\(^2\) Keeping the government outpatient facilities open during morning and night hours can reduce the access costs of government outpatient care for the people with higher opportunity cost of time during working hours.
Another practical difficulty in exempting the poor from paying user or any other fees is 'identification of the poor'. It is often practically difficult to assess an individual's financial condition to qualify him as poor. The method which is followed to identify a below poverty line (BPL) household is not appropriate in case of health care because an individual's or a household's need or requirement for health care cannot be decided in advance with certainty. Which makes it impossible to draw a line showing minimum quantity of health care or minimum expenditure on health care, which will be applicable to all individuals.

In the absence of a proper mechanism to identify poor, a certificate from a public representative is often used to qualify an individual as poor. Such a practice could lead to bias and political favours on the part of public representatives. The motivation for short-run political gain may give the local representative enough incentives to issue/deny indigent certificates to an individual on the basis of his political interests. Based on our empirical findings it can be suggested that area targeting and giving exemptions based on household's occupational category can be effective in avoiding the above problem to a considerable extent.

The available scattered evidence on the generation of funds by 'user fees' and 'cost recovery' does not provide an impressive picture. It seems that to increase the revenues the utilisation of government facilities by the rich needs to be increased. To achieve this objective we need to compartmentalise each government facility by offering different services to individuals with different sensitivity to quality and price. For example, to attract more rich people to government facilities we need to improve those dimensions of quality to which rich are sensitive. However, this is not meant to penalise the ailing rich by charging a higher price for subsidising the ailing poor. The price discrimination mechanism needs also to be coupled with progressive taxation.

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3 As Arrow (1963) pointed out in his seminal paper that the most obvious distinguishing characteristics of an individual's demand for medical services is that it is not steady in origin, but irregular and unpredictable.

4 A clear association between access and utilisation found in the case of inpatient care suggests that for increasing utilisation of inpatient care it would be effective to target population sub-groups which have poor access to inpatient care.

5 See Bhat (2000) for a detailed discussion on management issues in the implementation of user fee policy in public facilities.

6 However, improving those dimensions of quality which rich are sensitive to may crowd out the poor, provided we fail to compartmentalise the health care facility for the rich and the poor and charge the rich a higher price.
3. Measures to Improve Quality and Reducing Price: Striking a Balance

Since quality and price are the two main factors determining individuals' choice of health care, any change in quality and price would ultimately affect the distribution of health care across different population sub-groups. For example, if there is an improvement in the quality of health care in government facilities, it will attract individuals with higher sensitivity to quality. On the other hand, if there is an increase in price, it will adversely affect those with high sensitivity to price.

As far as outpatient care is concerned, the empirical findings show that it is the higher access cost (and not the poor quality) of government health care which is the main factor responsible for lower utilisation of government facilities. The empirical evidence further shows that the relative importance of access cost with respect to quality is substantially higher for the poor and for households whose major source of income is from informal economic activities. Therefore, to increase the utilisation of government facilities by the poor, the access cost of government outpatient care needs to be reduced. Since rich are more sensitive to quality than the poor are, an improvement in quality in the government facilities would result in higher utilisation of government facilities by the rich. If quality is improved and price is hiked, then utilisation by the rich might increase at the same time leading to a fall in the utilisation by the poor. There seems to be evidence to this effect in Indian context. Therefore, while allocating resources to improve quality and reduce access cost, a government facility needs to strike a balance between these two competing objectives keeping in view their potential impact on the utilisation by different individual groups.

The empirical evidence from NFHS 2 shows that there seems to be a discrimination against the poor women on some important dimensions of quality, while such discrimination is not present in case of private health care providers. Therefore, if we want to increase the utilisation of government facilities by the poor women, special measures should be taken so that poor women do not feel discriminated at the government facilities.

4. Need to Collect More Information

The major problem we faced in analysing individuals' health care seeking behaviour empirically was the lack of appropriate data set that our conceptual-theoretical framework

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7 By distribution of health care we mean distribution of government and non-government health care (outpatient and inpatient) between individuals belonging to different socio-economic groups.
8 See Mahal and Veerabhariah (2005).
demanded. As a result we were forced to present only indirect evidences in most of the places. It is essential to have detailed data on price and quality of health care to empirically analyse individuals' health care seeking behaviour. This requirement can be met to a great extent by collecting more information on quality and (exogenous) price\(^9\) in surveys like NSS and NFHS.\(^{10}\) However, information about quality should be collected from the individuals both as their descriptions and evaluations, which would be highly useful as it will allow us to examine the association between the values of quality objects and individual's satisfaction with those objects. It is also needed to explore the possibility of whether such surveys can collect some information about the health care providers the individuals do have access to.

As far NSS data is concerned the following specific suggestions can be made to make the data more amenable for empirical analysis: (1) In classifying the disease or illness NSS needs to follow the classification which is internationally followed so that comparison become easier. (2) There is a need to make the classification of health care providers uniform in village and household questionnaires so that the researchers can link the data on access and utilisation. (3) There is a need to have provision for recording multiple responses for some questions. (4) Truncation of data on expenditure and severity of illness can be avoided while still following a fixed reference period. (5) More care needs to be taken to avoid large missing values on important variables. (6) There is need to rethink on the present way of first stage stratification of villages if getting unbiased estimates of rate of utilisation of inpatient care for the rural sector is of more concern. (7) Quality of private health care is a neglected aspect which needs to be addressed in the future questionnaires.

Before close we must admit that we have not succeeded to give satisfactory answers to all the questions raised at the outset. Lack of appropriate data and limitations of the present data sets are of course one of the reasons for it. However, by providing various direct and indirect evidences we have attempted to get rid of some limitations of the available data.

\(^9\) Due to data limitations most of the studies on demand for health care were forced to use endogenous price information which is not well suited for estimating demand models. Use of endogenous explanatory variables may lead to biased estimates of the coefficients in the model.

\(^{10}\) In fact, in their study Gupta and Dasgupta (2000) also felt the need for a high quality data for policy makers to enable them to understand the intricacies of demand for health care. They argued that facility-level data that measures quality of providers must be linked up with household level variables. These can then be used to measure the effects of price changes on demand for health care more minutely and can be a very useful tool for policy guidance on health care financing.