CHAPTER II
REVIEW OF STUDIES

Theoretically, every researcher must undertake a review of research studies produced earlier basically (i) to know the background of subject of interest; (ii) to judge the efficiency of work done; and (iii) to explore new areas of research. The review of literature of previous studies not only contributes towards widening of outlook of the researchers and gives directions and impetus to move towards the desired goals, but also prevents the duplication/repetition of research and wastage of scarce resources. The survey of related studies also stimulates the imagination of researchers, enriches his/her mind or deepens his/her insights and experiences with regard to the subject of study.

Since the present study is basically concerned with the determinants, utilization, access and expenditure pattern of health services in Punjab, review of literature presented here has been strictly limited to the relevant studies related to field of study. As a part of review of literature, only important studies are reviewed here related mainly to the morbidity, socio-economic status, determinants of utilization of health services, factors affecting perception of diseases and utilization pattern both in the urban and rural settings. The present chapter is divided into three sections. Section I reviewed the studies related to utilization pattern and treatment cost of health services. Section II deals with the studies related to accessibility and demand for health care services. And, main conclusions have been included in the last, i.e., Section III.

SECTION I
2.1 UTILIZATIONS PATTERN AND TREATMENT COST

Theoretically, utilization of health services and treatment cost are closely interrelated with each other. The study by Yesudian (1988) found wide variations in the utilization pattern of health services in
urban India across the different socio-economic households. It showed that 100 percent high status and 84.9 percent middle status households preferred private health sector for curing the diseases, whereas 86.6 percent low status and 95.8 percent very low status households used public health sector for treatment of diseases. Regarding treatment type, the study found that almost all the patients (94.9 percent) preferred allopathic medicine for treating their illnesses, and the rest used Ayurvedic and homoeopathic medicines. Further, average expenditure of seeking treatment was much higher in case of the high and middle status households than that of the low and very low status households. Almost half of the high class households (49 percent) had medical expenditure above Rs. 750 and a nearly half of the middle class households (47 percent) spent Rs. 200 on health services. Similarly, about half of the low class households (49 percent) had medical expenditure of Rs. 50 or less. A majority of the very low class households (51 percent) had the same amount of medical expenditure and a good proportion of very low class households (41 percent) did not have medical expenditure. On the whole, the medical expenditure increased with the rise of social class position.

The research study of Duggal and Amin, 1989 found that a little more than three-fourth (76.86 percent) of patients utilized private health centres, whereas a very small proportion (12.23 percent) of patients used public health centres. Further, it showed that morbidity prevalence rate was higher in the rural areas (154.66 per thousand population) compared to the urban areas (141.85 per thousand population). The study also estimated that annual per capita health expenditure was higher in rural areas (Rs. 192.19) compared to urban areas (Rs. 170.97) during 1987. On the other hand, out-of-pocket expenditure made by the patients for treating their illnesses was 3.5 times more than that of what state government (including local bodies) spent. It was also found that cost per illness episode was directly proportional to the level of income and consumption expenditure.
A few other studies revealed that rising costs of seeking health services were generally followed by a precipitous decline in utilizing these services by the different income groups. For instance, the evidence from many countries such as Ghana (Waddington and Enyimayew, 1990), Kenya (Mwabu et. al., 1995), Swaziland (Yoder, 1989) and Zambia (Kahenya and Lake, 1994) reported a decline in utilization of public health clinics due to the imposition of user fees. Further, people having lower levels of income are more responsive to rising costs of health care. For example, doubling the price of public clinics and dispensaries in Tanzania had led to a decline in actual utilization of health services any care by 0.172 in the poorest quartile, while it remained less than 0.010 for the richest quartile (David, et al., 2002).

The estimates of 42nd Round of National Sample Survey Organization (NSSO, 1992) found that prevalence rate of hospitalization cases was much higher in rural area (28 per thousand populations) than that of in urban area (17 per thousand populations) of India during 1986-87. And, allopathic system of medicine was used in more than 98 percent hospitalized cases in both rural and urban area. Given the structure of health services in India, public health facilities were preferred by the household for in-patient care, whereas private health facilities were used for out-patients care. On the other hand, naturally, average expenditure made for the treatment of illness episode was higher in private hospitals (Rs. 733 per case) compared to public hospitals (Rs. 320 per case).

Another study (NCAER, 1992) showed that prevalence rate of treated illnesses in India was higher in rural areas as compared to urban areas as it was 79.06 per thousand population in rural areas and 67.70 per thousand population in urban areas during 1991. Further, morbidity prevalence rate across all states had declined when one moved from the low income to the high income households. It suggested that the people belonging to the lower income groups were more susceptible to various illnesses due to the poor living conditions
and lower nutritional status. An overwhelming majority of illness episodes in urban areas (80 percent) and rural areas (75 percent) were preferred allopathic system of medicine. And, 55 percent of the illness episodes sought treatment from public health institutions, whereas, 36 percent from private health institutions. Regarding household expenditure on health services, it was found that the average cost of treating each illness episode was higher in the rural areas (Rs. 151.81) compared to the urban areas (Rs. 142.60).

Further, Ramamani’s analysis of NCAER data (1993) revealed that in 90 percent of illness cases, patients preferred allopathic system of medicine for treatment. For out-patient treatment, dependency was more on the private health facilities compared to the public health facilities as 52 percent and 59 percent illness cases in rural and urban areas respectively sought treatment from the private health sector. However, in the case of hospitalization, more patients preferred the public health services both in rural (62 percent) and urban (60 percent) areas respectively. So far as expenditure on health services was concerned, the study revealed that the poor households spent more than 7 percent of their income on treatment of diseases compared to 2.7 percent by the rich households.

The study undertaken by Devlin and Richardson (1993) had analyzed health expenditure incurred by households in New Zealand. The study used Annual Household Expenditure and Income Survey - 1987 and 1991 - to compare expenditure on health services across four categories: general practitioner fees, dental fees, optician and optometrist fees, and spending on all health services combined. The study found that spending on health care was unequally distributed across the income groups. In particular, the highest income households spend six times as much on dental care as the lowest income households. The difference between the high and the low income households with respect to the amount spent on all health services was greater in 1991 than that in 1987. For instance, high income households spent 3.6 times more on health services compared
to the low income households during 1987. The study concluded that high income households spend substantially more on health care than that of the low income households. Moreover, these households appear to assign a higher priority to the medical care than the dental care, although this may reflect the lack of any state subsidy on adult dental care.

George (1997) conducted a research study in two states of India i.e. Maharashtra and Madhya Pradesh and found that private sector was preferred by the patients in both states. However, dependence on private sector for health care needs was found to a greater in rural Maharashtra (79.8 percent) compared to her urban areas (73.45 percent) than in Madhya Pradesh where utilization of private sector was around 70 percent both for the rural and urban areas. Further, utilization of public health facilities was relatively more in the urban Maharashtra (16 percent) than in rural Maharashtra (10 percent). However, a reverse trend was observed in Madhya Pradesh as 17 percent rural patients and 14 percent urban patients preferred public health services. Among the in-patients, 38.6 percent cases in rural areas and 38.5 percent in urban areas depended on private health facilities. On the other hand, 55.4 percent in-patient cases in rural areas and 59.5 percent in-patient cases in urban areas used public health facilities. Per episode cost in both the states was higher in the rural areas compared to the urban areas. For instance, in rural Maharashtra, per episode cost was Rs. 103.56 compared to Rs. 100.44 in urban Maharashtra. The corresponding figures for rural Madhya Pradesh were Rs. 137.67 and Rs. 128.86 for urban Madhya Pradesh.

Another research study (Street, et al., 1997) surveyed households’ expenditure on medical care at two different locations in the Russia. It found that out-of-pocket expenditure on curing diseases was substantial high and growing in Russia. The proportion of households’ income spent on the prescribed drugs and over-the-counter (OTC) drugs together were 16.8 percent and 14.9 percent
respectively. Interestingly, twelve sampled households (0.8 percent) in Tula and 11 (1.3 percent) in Pskov reported more spending on the drugs than they were earning, perhaps by drawing out of past savings or contributions from the extended family.

Researches done by Boikov, et al. (1998) on households’ health expenditure in Russia, with a survey of 3,000 households, found that on an average, 14 percent of monthly expenditure of households was spent on drugs and other medical services. Out-of-pocket expenditure for health care was found to be regressive as the lowest income group spent 27 percent while the highest income group spent 9 percent. Drugs alone accounted for just over one-half of private health expenditures, or slightly more than 7 percent of total monthly household expenditure. The private health sector in Russia was very small and bulk of payments of out-patients and in-patients was made in government health facilities; some of these payments were official and some unofficial. Extrapolation of the survey results suggests that out-of-pocket payments constituted between 43 percent and 55 percent of total health expenditure in Russia. These findings suggest that a nation’s total health expenditure was between 6.43 percent and 8.13 percent of GDP rather than the official estimate of 3.49 percent attributed to government entities and mandatory health insurance.

The study done by Hotchkiss, et al. (1998) in a nationally representative sample survey of households investigated the level and distribution of out-of-pocket health expenditures of households in Nepal during 1996. The results indicated that sampled households spent about 5.5 percent of total household expenditures on health care treatment and these households accounted for 74 percent of total expenditure used to finance the health economy. In addition, rural households were found to be spent more on health care than that of urban households. Further, it stated that the wealthy as well as the poor households relied heavily upon health services provided by the public sector. These results were used to discuss and judge the feasibility of implementing alternative health care financing policies.
The work of Casey, et al. (2000) examined altogether different aspect of health services, i.e., utilization of preventive health services in the time frame work recommended by the nationally accepted guidelines in U.S. The study revealed that rural residents were significantly showed less preference than that of urban residents to obtain certain types of preventive health services (even after controlling for the demographic characteristics, health insurance status and health market characteristics). The study found several possible explanations responsible for the significant rural-urban differences in utilization pattern: First, there may be rural-urban differences in respondents’ out-of-pocket costs for preventive services that affect preventive services utilization; Second, there may be rural-urban differences in respondents’ access to medical care, cultural barriers that may also limit rural residents’ use of preventive services.

Another paper (Rous and Hotchkiss, 2000) used Nepal Living Standards Survey, a nationally representative household survey of 1996, to investigate the determinants of households’ out-of-pocket health expenditures. The analysis uses a multi-equation joint estimation to control for endogeneity of sickness and provider choice. The results indicated several interesting findings. First, common unobserved factors (i.e. level of health knowledge, severity of health problem, community norms, availability and quality of public outreach services) were found to be statistically significant determinants of illness, choice of provider and health expenditures. Second, income elasticity of demand is estimated to be 1.10, with income level having both a direct effect on health expenditure, and an indirect effect through likelihood of illness and type of provider chosen. Third, housing and sanitary conditions were found to have a substantial effect on illness episodes, and as a result, out-of-pocket health expenditures affected. Fourth, despite the fact that urban patients who seek care, were likely to utilize more health care in more expensive settings, average health care expenditure of urban households was found to be substantially lower than that of rural
households, partly due to a lower likelihood of reporting illnesses and injuries and of using any type of health care provider.

The findings of study related to rural settings of Vietnam (Segall, 2000) revealed that opening hours of health care facilities both for the inpatients and outpatients is the main convenience of rural households. On the other hand, retail drug outlets and private practitioners were more available, especially at odd hours, and private practitioners were willing to make home visits also. Adding to it, over-the-counter drug purchases were relatively cheap and used frequently, especially by the poor households and in the case of simple or shorter illnesses. These retail outlets are often situated in shopping areas and are usually open outside formal odd hours. Private practitioners had advantages in the areas where community health services were weak: they were always caring in style, they were happy to provide care in odd hours and in patients' homes, and they were prepared to wait for payment or accept payment in kind also. Further, ambulatory care was mainly used by households, even in the non-poor category, in the event of more serious illness.

The study by Makinen, et al. (2000) summarizes the experiences of eight countries (Burkina Faso, Guatemala, Kazakhstan, Kyrgyzstan, Paraguay, South Africa, Thailand, Zambia) highlights inequalities in utilization of health care services and expenditure incurred by the patients. According to this study, richer people were found to have a higher probability of obtaining care when they fell sick, more likely to be seen by a doctor, and to have a higher probability of receiving medicines when ill than that of the poorer people. However, the poor people were found to be spending more in absolute terms on health care services.

Another study conducted in Rwanda (Nandakumar, et al., 2000) related to 348 HIV positive individuals examined the utilization pattern of health services and treatment expenditures. In Rwanda, HIV/AIDS is not only a health problem but has strong social and
economic dimensions, and is competing for limited resources with other urgent health care demands arising from other diseases such as malaria, diarrhea, and respiratory infections. The findings of this study indicate that less than 30 percent of households were able to meet costs of health services exclusively from their own resources. Most of other households resorted to multiple ways to pay for health care including receiving assistance, borrowings, and selling assets. About two-third of households (66 percent) received some kind of assistance, 18 percent had to borrow money, and 5 percent had to sell assets to make payments for seeking care. The high proportion of households that reported receiving assistance preferred community and church support systems that exist in Rwanda. In the absence of this assistance, impact of health expenditures would have been even more catastrophic for these families. The study highlights the need for more systematic research to develop better understanding of the impacts of HIV/AIDS on the households. The findings also highlight the role of gender, income, and place of residence to understand inequities in the utilization and expenditure patterns of health services as well as the ability to mobilize non-household resources to pay for care.

The research paper of Ghosh (2000) investigates the levels, differentials and determinants of morbidity in West Bengal during 1995-96. It found that overall morbidity prevalence rate was 67 per thousand population in rural and 70 per thousand population in urban areas of the state. The morbidity prevalence rate of females was slightly higher than for males both in rural and urban areas. Further, illness prevalence rate was higher among the children aged 0-4 and old people aged above 60 years compared to other age groups. Though the illiterates had experienced the highest rate of morbidity both in rural and urban areas, but no clear-cut relationship between education and morbidity was found. The morbidity prevalence rate increased moderately as household monthly consumption expenditure increased up to Rs. 4667 in case of rural and Rs. 6500 in case of
urban areas and then declines in both areas. The untreated illness was found to be higher for females than for males both in rural and urban areas.

Another study analyzed the use of health services by the poor in India (Mahal, et al., 2001). It states that that like most developing countries, publicly financed and delivered curative health services in India are benefitting the richer segments of population than the poor. Further, privately owned curative health delivery system in India is more skewed towards the rich people than the public sector’s health services. Interestingly, those below the poverty line continue to rely heavily on the public sector institutions (93 percent of immunizations, 74 percent of antenatal care, 66 percent for inpatient bed days, and 63 percent of delivery related inpatient bed days). Tertiary-level hospital services are more likely to be used by the richest quintile than the poorest both in the case of out and inpatient care. Moreover, public health services in urban areas used more equitably than those in rural areas. And, the private sector dominates in the case of outpatient care (82 percent episodes).

The study (Marco, 2002) specifically addressed the differences in various types of health care services (primary care, medical specialties, emergency care, etc.) by those covered by the public and private health insurance and those having different family incomes. To determine whether there were some differences in the actual utilization and opportunity of utilizing different health services, logistic regressions were conducted. The study came with the results that those covered by the public insurance (FONASA) have 1.18 times more probability of not using health services when they need it in comparison to those covered by the private insurance (ISAPRE). Apart from it, family income was strongly associated with the use of health services in a timely fashion, as the people belonged to the poorest income quintile were two times more likely to utilize health interventions than the richer people of the highest income quintile.
Another study on Vietnam done by Berman (2002) assesses the role of private health care providers by examining utilization patterns and financial burden on households. The study found that private sector provided 60 percent of all outpatients’ contacts for treatment. There was strong evidence suggesting that rich people use private providers more than the poor. Also, the households with several sick members at the same time also relied more on private providers than the public ones, and those with severe illnesses tended to use less private providers than that of public health services. Regarding financial burden on households, the study found that cost of seeking private health services was roughly a half of that imposed by the public providers. Expenditure on drugs accounted for a substantial percentage of household expenditure in general and health care expenditure, in particular.

Another study done by Ramamani, et al. (2002) conducted in the urban slums and resettlement colonies of two metropolitan cities of India - Chennai and Delhi - showed that the proportionate share of private health facilities among total treated cases increased with the rise in per capita income of families. Regarding in-patient care, it had found that both slums and resettlement colonies’ residents used public health facilities in higher proportions (71 percent) rather than private health facilities (21 percent). Adding to it, morbidity prevalence was higher in the urban slums (111.7 per thousand persons) than that in resettlement colonies (86.0 per thousand persons). In relation to health expenditure incurred by the households for out-patient care, the study revealed that out-of-pocket spending by those who used public health services (Rs. 90) was much lower than those used private health services (Rs. 170).

Another study based on Vietnam Living Standards Survey data of 1997-98 done by Trivedi (2002) found that the care by self-medication and commune health centers were proved as the inferior goods as their demand declines with rising household incomes. Further, self-medication appears to be a normal good at low income
levels. In the aggregate, however, net effect of income on the pharmacist’s visits is estimated to be closer to zero. These results are consistent with the view that both self-medication and commune health centers are providing low-quality and risky forms of health care in Vietnam. On the other hand, health care provided by the private health facilities is found to be weakly related to income level overall, but may be positively related for the lower income groups. There was a strong positive relationship between income level and use of both in-patient and out-patient care provided at the public hospitals. Income, insurance status and age of patients were the three major determinants of in-patient care provided in public hospitals. There appears to be no evidence that health insurance had a significant impact on the total out-of-pocket health expenditures of households (excluding in-patient care at public hospitals) in either direction.

Another study done by Chaudhury, et al. (2003) conducted in Armenia state, where reduction in public financing of health services and decentralization in decision making were introduced along with rising trend of privatization of health provision. The study highlighted that due to these trends, private out-of-pocket contributions were increasingly become a significant component of health costs in Armenia. To help poor families, the Armenian government provided free-of-charge safety nets in the form of basic package of health services to eligible persons in vulnerable groups, such as the disabled and children from single parent households. Analyzing the Armenia Integrated Survey of Living Standards (AISLS) of 1996 and 1998-99, the authors estimated the impact of the fee-waiver program on utilization of health services, particularly among the poor. Although utilization rates of health services had indeed declined across the two survey rounds despite comparable levels of income, and this decline has occurred among both the poor and rich with average utilization falling by 12 percent between the two surveys, yet the families with four or more children, the largest beneficiary group under the vulnerable population program, have decreased their utilization of
health services in a disproportionate manner - 21 percent reduction in utilization between the two survey rounds.

In India, poor coverage of any health insurance programme and inadequacy of public health system has made the patients vulnerable to economic insecurity as out-of-pocket expenditure for seeking health care contributed to 75 percent of total health care expenditure in India. Such a high level of spending on health care drastically reduces the earnings and economic security of the ailing persons’ household. The researches done by Duggle and Dilip (2002) using the 52nd Round National Sample Survey Data tried to study the above phenomenon by analyzing the household level financing of hospitalization cases in urban India. The results of financing of 12,437 persons who were hospitalized during last one year prior to the survey date showed that about 25 percent of households were meeting expenditure on in-patient care of a member through sale of animals/ornaments/physical assets/borrowings. The percentage of households falling into debt trap because of incidence of hospitalization expenditure was 30 percent if treatment was sought from the private health providers and 20 percent if treatment was from the public health sector institution. Class differentials showed that proportion of households with ailing persons falling into debt increased between the richest and poorest subgroups from 17 percent to 26 percent if treatment was sought from the public sector and from 23 percent to 41 percent if treatment was sought from the private sector.

An another study of Dilip and Duggle (2003) conducted in a municipal ward (with no public health facility) in the greater Mumbai with a sample of 1035 households stated that the major source of health care treatment for in-patients was private sector as it accounted for more than 56 percent of the total illness episodes where treatment was sought. Moreover, the role of private sector in delivering out-patient care was also very high (79 percent). Regarding cost of health care, the study revealed that average out-of-pocket expenditure
for treating an ailment of in-patient category was remained higher in private sector (Rs. 13,206) than that in public sector (Rs. 4830). Morbidity rate was higher in the age group of over 60 years (71 per thousand population) compared to the morbidity in all age groups (29 per thousand population). Besides, morbidity prevalence was more in case of households with monthly income less than Rs. 2000 (86 per thousand population) compared to the households with monthly income Rs. 4000 and above (74 per thousand population).

Gupta and Datta’s research (2003) strengthened the belief that the poorer households especially in rural areas bore the greatest brunt of acute illness/es, and spent disproportionately more on acute illness compared to the richer households. Regarding choice of health facility, the study revealed that patients belonged to the vulnerable sections like SC/STs and labour were having a higher probability of visiting the government facilities, mainly because of the price differentials. The poor and uneducated also have a higher probability of ending up with unregistered practitioners. Also, it was a true fact that self-care was continued to be an important choice for a significant percentage of population, especially in the rural area. Other results from the econometric analyses revealed that economic status is negatively related to the probability of seeking care in the government facility. The no-care option continues to be negatively related to education, and positively related to social class. Also, individuals with high income ended up spending more, while the rural residents spending less.

Another study (Selvaraju, 2003) estimated the health care expenditure at macro level (state governments) and micro level (households) in rural India. The study revealed that during 1993-94, the health expenditure made by households accounted for a major share (70-80 percent) of the total health expenditure in India. As a percentage of income, rural households spent about 5.40 percent, while the government spent only about 1.09 percent for them (rural) in India during 1993-94. The structure of health spending revealed that
the state governments spent largely on the personnel’ salaries and wages, machinery and equipments, materials and supplies and other office expenses, whereas the households spent primarily on medicines, clinical charges, surgery, diet, rituals, transportation, etc. This suggests that health spending by government and households is complementary to each other and not substitutes.

Another country specific study of Australia (Australian Bureau of Statistics, 2003) highlighted that, for the year 2002, average household expenditure on health and medical care had increased steadily between 1984 and 1998-99. As a proportion of total household expenditure on all goods and services, health and medical care expenditure increased from 3.9 percent in 1984 to 4.7 percent in 1998-99. While the proportion of household health expenditure spent on health practitioner's fees has remained relatively constant since 1984, expenditure on other individual items needed for treatment had fluctuated. In particular, general practitioner doctor's fees had decreased from 3.8 percent of total health expenditure in 1984 to 2.4 percent in 1998-99, while specialist doctor's fees increased from 3.9 percent to 7.8 percent during the same period. The proportion of total health expenditure spent on medicines, pharmaceutical products and therapeutic appliances increased from 20 percent in 1984 to 25 percent in 1998-99.

The research work of Buor (2004) on Ghana’ health sector examined those factors which had impacted the accessibility and utilization of health services. The study had demonstrated dichotomy in the utilization of health services between rural and urban areas, although the urban residents had certain advantages over the rural residents. It also showed that in developing countries like Ghana, need for better health status was not as significant as pre-disposing, enabling and restrictive factors in determining the utilization. Education, distance and treatment cost were the most important factors influencing health care utilization in the metropolis; distance and income emerged as the most important factors in the rural areas.
Women were at a disadvantage position implying gender inequity, whilst the health insurance had a strong positive effect on utilization pattern of health services.

Similarly, in a case study of Zambia, Hjortsberg’s work (2004) empirically analyzed the determinants of household health care utilization and found that an average Zambian households’ expenditure on health care was closely connected to total monthly expenditure and monthly expenditures on other than food items. Besides, the size of household and age of household head were emerged as two significant variables impacting on total health care expenditures. The analysis also showed that there exist differences in utilization of health care between various socio-economic groups in Zambia. Poorer households do not seem to utilize health care to such an extent as the households of better-off do.

Peters’s study (2004) investigated the impact of a newly created integrated health facility in the UP (India) on the utilization of health services and patient satisfaction, especially in the case of poor and lower caste families. The study found that the relationship between utilization and satisfaction on one hand and vulnerable groups on the other is very complex; suggesting that new health centre in project mode may have less predictable effects on the poor parsons. Although the poor got some benefit from the project, yet gains were greater for the wealthier groups, supporting the ‘inverse equity hypothesis’ (Victoria, et al., 2000) that interventions tend to first increase the health inequalities. Regarding benefits of such projects, the study revealed that both utilization and patient satisfaction were greater at the lower level health facilities (CHCs/PHCs) than at the district hospitals. The project also improved absolute levels of utilization among the poorest people. The gains were largest for the rich people as they were found to increase utilization in larger numbers at all types of facilities, and most notably at the higher level of facilities (district hospitals). This supports the hypothesis that the rich people
are the first to benefit when general improvements are made in health care system.

The study conducted by PHRplus (2005) in Suez governorate (Egypt) focused on the effectiveness of health insurance on utilization pattern, treatment seeking behavior, out-of-pocket payments, satisfaction with care, and willingness to insure. The study revealed that individual health insurance was mandatory only for certain groups, which led to exclusion of socio-economically weak sections of society. Further, insured and uninsured individuals had similar utilization rates for out-patient, hospitalization and pharmacy cares. Health insurance did not decrease barriers in accessing basic health care, as the richer still able to use more care than the poorer individuals, which had raised serious equity concerns about the health delivery system in Egypt. Also, there were significant differences in utilization pattern health services when the patients sought out-patient and in-patient care with respect to their insurance, socio-demographic, and economic background. Such differences were happened despite the fact that public health services were being provided almost free of charge and the patients did not prefer option for out-patient care. A greater majority of patients sought out-patient care of private sector providers, even when the care was not covered by the insurance. Uninsured patients were likely to be hospitalized more in private clinics than the insured ones because the satisfaction level associated with in-patient care was the highest in the private hospitals. Satisfaction level of out-patient care was significantly higher among the patients who went to a private provider because of short waiting periods at the provider and he/she spent 15-60 minutes service time with the provider.

Based on a household survey conducted in Tbilisi (Georgia), Gotsadze, et al. (2005) examined pattern of health seeking behaviour and extent of out-of-pocket payments made by the households. It revealed that utilization of health services meant an additional financial burden on the households, and in fact, high private
payments create financial barriers for the poor in accessing health services. The poor households adopted many strategies to overcome these financial barriers, but these strategies contributed to declining economic status and worsening health outcomes. In light of these, the study suggested that first, the state should prioritize public financing of health services for the poor; second, it should promote the quality and utilization of primary health services; and third, it should mobilize out-of-pocket payments on a pre-paid basis through the formal or community based risk pooling schemes.

Another study (Ager and Pepper, 2005) examined the utilization pattern of health services across the rural population of 66 villages living in four districts of Orissa through sample survey. Sampled households found to be utilized a wide range of health providers, although the hospitals were preferred by them compared to the PHCs. Private practitioners (qualified and unqualified) were preferred by majority of people, especially by the SC/ST families. Key factors that determine the utilization pattern were the reputation of provider, cost and physical accessibility. Further, services provided by the local health provisions through ANMs and MHWs were generally perceived of poor quality.

The report prepared by Kilbreth, et al. (2005) examined more than 1.06 thousand health plan beneficiaries from a subset of employers few trends in costs of health care during 1995-2001 and use of approximately 1,06,000 health plan beneficiaries in the Maine Health Management Coalition (MHMC). The study showed that average per capita health costs rose from $128 per month in 1995 to $172 per month in 2001 – a 34 percent increase. Among the most striking findings of this analysis was the contribution of hospital outpatient costs to overall cost growth rates. Out-patient costs per person increased by 92 percent and in-patient costs rose by 20 percent over the six years of study. Average charges per in-patient episode rose to 64 percent.
The study done by Gangadharan (2005) conducted in Kerala, identified that the socio-economic status of households was found to be an important determinant in explaining utilization of health services and its severe impact on urban morbidity pattern. Utilization pattern of health services varied widely across the socio-economic classes. For instance, 75 percent of those households who were living in better urban colonies preferred private clinics/hospitals for treatment, whereas for the households living in slums, this proportion was very meager (12.5 percent). Further, only 11.25 percent of the households from the slums preferred immediate treatment of illness, whereas it was 57.5 percent in the case of better urban colonies reflecting the impact of high per capita income. This implied that as the income increases, not only the stage of treatment of illness became immediate, but the frequency of treatment also increases. Regarding the satisfaction of patients about the utilization of in-patient services, the study found that 92 percent of slum households and 78 percent of better urban colonies households were totally dissatisfied about the services rendered by the government hospitals. The analysis also showed that as the socio-economic status improved, the proportion of households who utilized private health services also increased. As far as the medical expenditure was concerned, the study found that average annual expenditure on health services as a proportion of total household expenditure was 2.4 percent in the case of upper income classes and it was 10.44 percent in the case of lower income classes. The study also revealed that the rapid but unplanned urbanization is the root cause of all urban health problems of the state.

Two research studies published by Majumder during the year 2006 were related to rural and urban areas of Cooch Behar and Jalpaiguri districts of North Bengal. The first study (Majumder, 2006) revealed that patients’ or households’ preference for a particular type of system of medicine had an important bearing on the use or non-use of different types of health care services especially in Indian context. The study indicated that in rural areas, people utilized public health
facilities mostly because of their high availability in rural areas or no other option (no presence of private clinics) was available to them. On the other hand, people living in urban areas preferred public health facilities because of financial reasons: either price of a care or affordability of households. The main reason behind choosing the private sector’s care both in rural and urban areas was the quality aspect of health care provides by them. Moreover, patients belonged to rural and urban areas preferred allopathic treatment for the quick relief, reliability of treatment, etc. and the homeopathic treatment as it was cheaper, good for children and as it did not have any side effect.

The second study (Majumder, 2006) highlighted how the utilization pattern of seeking health services is affected by different socio-economic, demographic, and other relevant factors. Among these characteristics, demographic factors like age, sex and family size were found to be important determinants of utilization of health care services. And, the probability of utilization of health services was seen higher in the small-sized families. It also found that those households, whose heads made frequent trips, have a tendency to utilize health care more compared to others.

A longitudinal research done by Pohar, et al. (2006) compared the health care utilization, costs and mortality among the diabetes patients in the province of Saskatchewan (Canada) during 1991-2001. The study found that, in 2001 those who resided in large urban centres had 3.1 visits for seeking treatment compared to 1.5 visits for those residing in rural areas. The average number of prescriptions dispensed each year was lowest for those living in large urban centres and highest for those living in small urban centres, yet prescription costs were the highest for large urban centre dwellers. While the average number of diabetes patients hospitalized in rural areas was highest, but average length of stay for these patients was shorter than for those belonged to the small and large urban centres. Further, in 2001, costs of getting treatment for large urban centre residents were
more, in fact doubled, than the costs of getting treatment for rural area residents ($291 vs. $119, P value < 0.001).

Another study (Rost, 2007) showed that patients suffering from depression in rural areas showed greater odds of hospitalization than their urban counterparts. Although the national level studies reported that all-cause hospitalization rates were comparable for the rural and urban populations, rural patients with depression symptoms in this study had greater odds of hospitalization both due to the physical and emotional problems compared with their urban counterparts, suggesting that the potential for reducing hospitalization rates among rural patients with depression should be addressed by depression care management programs serving this population.

SECTION II

2.2 ACCESS TO AND DEMAND FOR HEALTH CARE

As far as the accessibility of health infrastructural is concerned, the study prepared by NCAER (1992) found that people residing in rural areas had to travel longer distance compared to their urban counterpart because of rural areas had very low level of health infrastructure facilities. Mishra's study (1994) analyzed the demand for health services in Bihar state in India. According to this study, increasing demand for health services is a process that varies with economic, socio-cultural, and facility-related factors. In such a scenario, people residing in rural region where such infrastructural facilities are scattered need more emphasis to improve their well-beings. Demand for health care depends largely upon the many factors such as adequate supply of trained health personnel, leadership initiative, adequate and regular visits of people as a feedback mechanism. Quality of health care increases confidence of the potential user community. The study also stated that the strong and long violence and power conflicts in Bihar create an unfavorable effect on demand for health services. This is largely due to the primarily emphasis on the survival and secondarily on the health and
nutrition, dependence on wages and an inability to lose wages for seeking health care, lack of empathy among health personnel for the poor, and the vested interests of the rich to prevent the poor from receiving medical care.

Gupta and Dasgupta (2002) analyzed the data gathered by the National Council of Applied Economic Research (NCAER) to explore the possible effects of an increase in users’ fee on the demand for getting treatment from the health providers. The study concluded that there may be some scope to increase the price from zero or almost zero levels to a level that would not reduce demand for health care. Given this scenario, most of those who accessed a government provider did not pay any price indicates that a low level of users’ fee can safely be levied. However, it must be remembered that this has to be accompanied by quality improvements and a good referral system. In rural India, where individuals may not have a wide range of choice, a higher price may not reduce demand because of the limited options; this may not be a good option especially since it will hurt the budget of poorer households. But an increase in price accompanied by improvement in quality may, in fact, bring forth an increase in the demand for health care. The study also indicated that demand for government facilities was low as compared to private providers because of quality and accessibility problems. Only 23 percent of the respondents visited a government provider, while slightly more than 35 percent of the respondents visited a private qualified provider. At the same time, low or no user fee makes the situation worse in terms of both efficiency and equity as well as from the revenue point of view.

Another research work (David et al., 2002) estimated health care demand for Tanzania by using a multinomial logit model. The findings of study showed that quality and availability of doctors/nurses, drugs, and clinical environment were important determinants of demand for health care in Tanzania. The demand for health care will increase if people have the option to see a better doctor/nurse, get access to pharmaceuticals, and attend a health center, clinic and dispensary
that is cleaner, has a toilet and water facility, and a roof. The second important message from this study is that consumers in Tanzania were highly responsive to the price of health care, and that this responsiveness was greater for the individuals at the lower end of the income distribution. The study also examined other characteristics of the households and individuals that affected their health care choices. The role of education, age, illness duration and so forth, provide important insights into the potential opportunities and limitations of public policy to affect patterns of demand for health care services.

Another study (Htjortsberg and Mwikisa, 2002) analyzed equality in accessing health care in Zambia. The study found that cost of accessing health care varies between different socio-economic groups, i.e., individuals in rural areas pay a high price relative to their income for accessing primary health care, while individuals in urban areas pay the lowest price for accessing health care relative to their income. Along with the user fee, travel cost and cost of time spent in reaching the health facility also contributed to the inequality in the cost of accessing health care services. The poorer are more susceptible to illnesses living in areas with inadequate infrastructure and thus bear the higher travel and time costs. Accessibility to health care services seemed to vary inversely with the need for health care services. It was also concluded that the poor have a higher prevalence of illness and yet utilized health services to a lower extent than the non-poor.

The research paper produced by Kaspar (2003) is based on the experiences of the Swiss Agency for Development and Cooperation (SDC) in the urban poor settings in N’Djaména (Chad), Dar es Salaam (Tanzania) and Douala (Cameroon). The study showed that the poor people tend to be disadvantaged in many aspects in urban settings including to access to health care. There is no universal explanation that applies to urban places and the determinants of access are not the same across different contexts. However, experiences from N’Djamena, Douala and Dar es Salaam shows that access to health
care for the poor is restricted due to a series of factors. These include: high diagnostic and treatment costs; direct and indirect financial costs for transport, waiting time, income losses, etc; cultural and organizational barriers. Moreover, there are discordances between health planners and beneficiary groups; weak and deficient communication between health providers and users of public health services and a de-personification of relations.

Another study done by Buor (2004) examined the factors that had highly influenced an access to health services in Ghana. The study showed that the income level followed by distance of health facility found to be the most important factors influencing the utilization of health services in the rural settings. It is strongly recommended that a national health insurance scheme be introduced as a mechanism for addressing the under utilization problems of health services. Hjortsberg’s study (2004) also suggests that access to health facilities is most important factor in determining the utilization of health services in Zambia. Those households having a motor vehicle have easy access to health facility but have to spend higher amount of expenditures than those without a vehicle. Moreover, the distance to the nearest health care facility also affects the expenditure level of patients. However, non-poor households are not affected by distance. Rural households have lower health care expenditures compared to urban households. This may be a reflection of the less developed infrastructure in rural areas.

Lindelow’s researches (2004) analyzed how different dimensions of health care quality affected the decisions about out-patient visits. The general conclusions of study showed that quality of health care is a significant and important factor in households’ choice of outpatient health care location. The analysis also suggested that along with the quality, other determinants such as physical access, education, and economic variables were also remained significant determinant in decisions about out-patient visits. While it is unrealistic to bring basic facilities closer to the home of every member of the population, yet
these findings point at the importance of outreach activities and transport services. Overall, the results indicate that improvements in certain dimensions of measured quality can substantially reduce spatial differences in utilization of health services.

The accessibility problems of public medical facilities as an important hurdle in the urban setting of Kerala were also studied by Gangadharan (2005). The study found that as the major chunk of government health budget was earmarked for paying salary and allowances, a very meager amount was left for purchasing medicines. In these circumstances, government hospitals and health centers are not able to meet even the requirements of people belonged to the lowest socio-economic class.

Lindelow’ paper (2006) investigated the determinants of access to public health care facilities in Mozambique. And, the study provided some quantitative evidence on the importance of individuals, households, and community characteristics on individuals’ care-seeking decisions during episodes of illness. These results suggested that even relatively a small price changes would have a substantial impact on access to public health care, particularly for the poorer households. Further, primary education had a very strong positive effect on the probability of individuals seeking care at a health centre/hospital in the event of illness. Conversely, results also indicated that the eradication of income poverty, independence of improvements in physical access to health care or the education, had only a negligible effect on health care choices. In the absence of information on the costs of different policies aimed at improving access to health care, their relative merits cannot be evaluated. Nonetheless, results of the study offer some strong indicative trends that can motivate future research to analyze these trends. Majumder’, study (2006) also stated that demands for public health facilities are tremendously high compared to the private health facilities in rural areas. Thus, the privatization or plan of leasing out the primary health care system to private operators can not be justified.
The research done by Habbani, et al. (2006) analyzed the extent of willingness to pay for good quality public health services in relation to the demographic and socio-economic characteristics of respondents in Khartoum (Sudan) during 2001. The results, based upon a logistic regression model, showed that overall percentage of people who are willing to pay for good quality public health services form greater majority (up to 80 percent). All these aspects were depending upon whether the respondents had already paid for these services (group 1) or not (group 2). They show that although the two groups are willing to pay for good quality public health services, the demographic characteristics that affect the willingness to pay differ between the two groups. The results of logistic regression analysis for each group had shown a remarkable similarity. The paper concluded if the quality of services is improved, reasonable fees could be set. This supports the continuity of policy to recover costs because virtually the majority of the households would be willing to pay reasonable fees.

SECTION III
2.3 MAIN CONCLUSIONS

All the studies reviewed in this chapter are related to household health surveys, which throw light on the accessibility, utilization pattern and household expenditure on health services in India and abroad. These studies tried to capture the major trends in utilization pattern and household expenditure in India and other developing countries. The gist of these studies regarding utilization pattern reveals that (i) morbidity prevalence rate was higher in rural areas compared to urban areas; (ii) People generally preferred allopathic system of medicine for the treatment of their illnesses both in rural and urban areas; (iii) For in-patient care, people suffering from serious diseases/illnesses were largely dependent on the public health services for treating morbidity, and for out-patient care, especially in case of minor ailments, on the private health clinics; and (iv) differentiation in utilization pattern of health services were subject to
the socio-economic status of the households. (v) With regard to expenditure on utilizing health services or treating illnesses by the households, these studies highlight major variations in estimating the average expenditure made by the households due to adoption of different methodology and regions.