Chapter VIII

Summary of Findings and Conclusion
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The health status of the people is an important indicator of the level of economic development of a country. Individuals take efforts to improve their health status. Governments also take efforts to promote the health services available to the people from social sector point of view by focusing on preventive and curative services in both rural and urban areas. Besides the government, NGOs and the private sector also play an important role in the delivery of health services. Both policy makers and researchers have restored considerable attention on the question of how broadly the access to health services for people can be ensured. Early policy and research initiatives focused on the need to improve physical access through an expansion of the network of facilities. A growing literature on healthcare demand has, however, pointed out that supply is not sufficient. Actual consumption of healthcare depends on factors influencing the demand for healthcare such as income, cost of healthcare, education, social norms and traditions.

The theoretical frame of the study is New Theory of Household Economics. Household economics assumes that households derive satisfaction from the non-market goods and services provided within households by combining the market purchased goods and services with the time of members of the household. In order to maintain good health status, in general, the households face constraints of time and monetary resources. The studies on new household behaviour have focussed researchers’ attention on the field of health economics (Pollack and Wales 1981, Russo et al. 1993, Deaton 1987; Deaton et al. 1989, Parker and Wong 1997).

Earlier studies have used the household theory to explain the decision making process and the investment on the members of household in the form of health and education which the healthcare component of household members belong to. Such investment leads to demand for health services.
With this backdrop, we formulated the problem with due following objectives

1. To examine the choice of curative healthcare provider and system of medicine among the various rural households.

2. To estimate the healthcare expenditure by the households.

3. To assess the sources of financing for healthcare treatments and the awareness of health insurance among the rural households.

To achieve the objectives, the study used the data collected for IDPAD project on healthcare in 600 rural households of Tamil Nadu during 1998-99. In analysing the data our study has made tabular analysis by using simple statistical tools. For finding the factors which determine the rural households' choice of healthcare provider and choice of system of medicine, the Multi-Nominal Logit (MNL) model was used. The OLS regression method was used to study the factors which determine the healthcare expenditure of the households.

In the following paragraphs, we present a summary of findings of the present research work and explain how our findings are similar and/or different from other studies on the aspect of research.

8.1 Healthcare Seeking Behaviour of Households

In the event of illness, individuals require curative care. Some of them may opt out of treatment because, in their perception the ailment may not be severe enough to warrant medical attention or they cannot afford to pay for treatment or even to take treatment at government hospital without fees. Others might seek care from different providers and from different systems. Past researches reveal that the curative healthcare demand depends upon the severity of illness, the healthcare facilities available, the access to these services, cost of the treatment, the economic condition of the household, demographic characteristics of the individual and a host of socio-economic factors that
could influence the healthcare seeking behaviour. There is another category, which
relates to getting cure by invoking the blessings of the family deity or favourite God and
seeking the blessings of religious healers.

There are various types of healthcare facilities available for treatment of illness in
India. An array of healthcare providers, are accessible to the people from varied socio-
economic categories. At one end of the spectrum there is an informal sector, comprising
faith healers, or religious healers, who dispense certain forms of indigenous medicines.
The non-allopathic streams such as homeopathic and ayurvedic medicines are also
popular, and in fact, often find a place within the formal setup such as government
organisations. At the other extreme are the qualified allopathic providers, dispensing
health services in both government and the private sectors, constituting the formal sector.

In the event of illness, a majority of individuals seek some kind of treatment and
very small proportion (2.5 to 5.4 per cent) of the people are not opting for any kind of
healthcare services. A greater proportion of females ignore healthcare when compared to
the males. Almost all the children up to 15 years were provided with healthcare, while
people above 15 years marginally ignored healthcare.

The studies by Ramamani Suraar, (1992), NCAER (1991) and NSSO, (1992) had
revealed that there was a remarkable gender difference in treating illness. But a study by
Deppti and Gupta (1997) had revealed that there were no gender bias as far as the
treatment seeking behaviour was concerned.

A small proportion of illiterates (3.4 per cent), primary level (7.4 per cent) and
secondary level (2.17 per cent) educated had not sought healthcare. Among the
occupational groups about six per cent of the agricultural labourers and self-employed
household individuals and artisans avoided healthcare. Almost the entire upper and
middle-income groups sought healthcare services while only about 7 per cent of low-income group had not sought the healthcare services. This has proved that household income influences the healthcare seeking behaviour.

The study by Mishra, Pandy and Sinha, (1988) had pointed out that the probability of seeking treatment was higher for literate persons.

Comparatively more (14 per cent) Christians avoided healthcare than Hindus (3 per cent) or Muslims (4.3 per cent). About seven per cent of the socially deprived, SC/ST population and around three per cent of BCs were not seeking treatment.

Around eight per cent of the patients belonging to joint families were not seeking healthcare, while only half that much of nuclear families ignored healthcare. In joint families the elders provided home made medicines or traditional treatments while the nuclear family provides the scope for seeking healthcare more quickly than joint families. The want of money and taking the complaint not seriously emerged as reasons equally responsible for not seeking any treatment.

8.2 Household Choice of Healthcare Provider

In the event of illness, a majority of the individuals try to take some kind of treatment. In the context of availability of different systems of medicine and agencies delivering the health services, the choice of provider of healthcare depends upon access to the service provider, economic status of the individual/household, among others.

It is common knowledge that government hospitals provide service free of cost and private hospitals charge fees. In some cases private hospitals charge exorbitant fees. Inspite of the above fact, data revealed that three out of every ten of the sample population took treatment from the private service provider and only three out of every ten of the population have sought government sources for treatment. It sends a message worth pursuing and reveals the reason for such preference.
Nearly four-fifth of Erode sample preferred private service provider over the Government services and self-treatment. However, marginally higher than one third of Coimbatore and Thanjavur households preferred Government services, while less than one-fifth of households only preferred Government hospitals services in Erode for treatment. In respect of self-treatment relatively higher Thanjavur respondents followed it than the people of the other two districts. In the choice of government and private hospitals there was no wide variation between Coimbatore and Thanjavur district respondents. Very small variation can be observed among them. So there was a marked difference in the choice of hospital between Erode and the other two districts.

There was no gender difference in seeking either government or private hospital services. Around two thirds have preferred private services and about three out of every ten preferred government hospital services. About three per cent of both males and females preferred self-treatment. However, there was a small difference in the choice between the ages. Among the different age groups, persons above 60 years chose Government hospitals followed by 6 to 14 years and 31 to 60 years. Nearly three-fourth of the children were given treatment at private hospitals. As age increased preference for private hospital declined to nearly sixty per cent. Around three per cent preferred self-treatment.

There is no uniform pattern of relationship between education and choice of hospital, a larger proportion of illiterates and persons with higher education chose private hospitals. Among the different occupational groups about forty per cent of agricultural labourers, rural artisans and non-agricultural labourers preferred government hospitals while the rest in those occupational groups have preferred private hospitals. A wide difference in percentage of households choosing government hospitals and private hospitals was seen among agriculturists, self employed and salaried households.
The study by Reddy and Sekhar, (1995) revealed that relatively higher number of illiterates used government medical care facilities compared to educated households. Thus, higher levels of education and the usage of private medical care facilities are positively related.

None of the higher-income groups chose government hospitals. Among the middle and low income groups marginally higher than 60 per cent of households chose private hospitals, even though the cost of treatment was high. Around one-third of low-income group and three-fifth of middle-income group also chose government hospitals for their treatment.

The studies by Duraisamy (2000) and Nanda and Baru (1993) had revealed that high-income group depends mostly on private hospital and income influences the choice of hospital. Contrary to this, a study by Gupta and Dasgupta revealed that income has not influenced the choice of hospital.

Studies often found that poorer patients depend mostly on public health services on account of higher charges levied by private healthcare providers. Also, the patients with higher levels of income use more of private care, which is believed to be superior when compared to government-managed hospitals in terms of quality (Selvaraj, 2001). The result of this study also corroborates the existing studies that as the level of income rises, the dependency on public facilities declines and there is a shift towards private facilities.

Three fourth of the minority community households and around three-fifth of the majority community households preferred the private hospital services. The socially deprived (SC/STs) have not discriminated between government and private hospitals. They have preferred government hospital equally with private hospital. Seven out of every ten BC and Other Community people preferred private to government hospitals. There was also absence of much difference between the types of family, (nuclear or joint) in their choice for the government or private hospitals.
The studies by Deppti and Gupta (1997), Duraisamy (2001) and Nanda and Baru (1993) had argued that caste was an important factor in determining the choice of treatment. Shenoy (1999) had pointed out that the socially deprived communal groups were significantly less inclined to use private hospitals than higher social groups.

Multinominal results of the study by Duraisamy (2001) revealed that the SC/STs and Hindus were more prone to choose treatment from private hospital. Education and caste also positively influenced the choice of hospital.

The majority who preferred government hospitals considered that they provided services either free of cost or at less cost while the choice for private hospital was due to its specialised treatment and quality and its nearness to the residence.

A majority of households belonging to the self-employed category and salaried/wage earners utilised private medical facilities, whereas most of the causal labourers used government medical facilities.

8.3 Household Choice of Systems of Medicine

Healthcare systems can be broadly divided into allopathic and non-allopathic Indian systems of medicine. Non-allopathic Indian systems of medicine being practised in India are Ayurveda, Homeopathy, Siddha and Unani.

There are five systems of medicine available for treatment of diseases in the sample area viz. Allopathy, Ayurveda, Homeopathy, Siddha and Traditional home medicines. A substantial proportion of the people in each district has opted for Allopathic system. Very few people (6 per cent) chose homeopathy and traditional home treatment (maximum of 4.9 per cent in Thanjavur). Less than one per cent of the people were following Siddha or any other systems of medicine.
Similar findings were reported by studies conducted by NCAER (1992), Reddy and Sekhar (1995), Nanda and Baru (1993), Pepin (1986) Rajaratnam Abel, Duraisamy and John (1996).

It was observed from the study that there was an inverse relation between the age and option for allopathic system of medicine. As the age increases the percentage of people opting for allopathic system of medicine decreases. In respect of children, it was the parents who decided the choice and one finds that all children are given allopathic treatment. Educational status of the individual and income of the household have not contributed to any difference in the choice of medicine. There was no significant difference among social groups and type of family on the choice of systems of medicine.

The Multi nominal Logit result of Choice of System of medicine indicates that the aged people were more likely to opt for non-allopathic systems such as Ayurveda, Homeopathy, Siddha and Unani than Allopathy. Normally aged people have more health problems and they try different systems for cure. From the results it is clear that non-agricultural labourers and Hindu patients preferred allopathic to non-allopathic system of medicine. The Backward Class community were likely to seek treatment from non-allopathic systems of medicine rather than from allopathic system.

8.4 Household Healthcare Expenditure

Expenditure on healthcare is defined as the expenditure incurred by the household on various direct and indirect items to get relief from illness. In the present study, data on expenses incurred by households for both hospitalised (inpatient) and non-hospitalised (outpatient) treatment was collected and analysed. However, hospitalisation of female members for childbirth was not considered to be hospitalisation for the purposes of the study.
8.4.1 Household Healthcare Expenditure for Non-Hospitalised Treatment

There was no vast difference in healthcare expenditure among the three sample districts. Most of household preferred private hospitals for healthcare treatment and similar findings were reported in other studies which estimated healthcare expenditures at household level (IIM 1987, FRCH 1987, Duggal 1986, Ravishangar 1989, Subbarao 1989, NSSO 1989, NCAER 1991, Bhat. Ramesh 1993, Sanyal 1996, Vijaya 1997, Nandraj et al. 1998, Shenoy 1999, Duraisamy 2001, Selvaraj 2001, Duggal 2003). For private hospitals, the proportion of direct expenditure was around 60 per cent in all districts and for government hospitals it was found to be around 25 to 30 per cent only. People opt for self-treatment when the nature of complaint is ordinary and in their perception it is simple and can be cured by using home-prepared medicine. When the patient happens to be poor, aged or a woman, they learn to live with complaints due to lack of awareness of the need for securing opinion of a doctor or fear of cost of travel and treatment. It was observed that in case of self-treatment nearly three-fourth of total expenses was the indirect expenditure, because the direct expenditure is only the cost of medicine.

The average household healthcare expenditure for treatment per illness varied based on gender in both private and government hospitals. The difference was small in private hospitals while it was higher in government hospitals. Both in government and private hospitals, the direct expenditure for female patients was higher than that for male patients. The indirect expenditure for male was more because the loss of earning was higher in the case of male patients than females.

Similar to the findings of our study, the studies by Nataraj et al. (1998) and Ramamani Suraar, (1992) revealed that there was a gender difference in the cost and household healthcare expenditure.
As the age increased, direct expenditure for treatment at government and private hospitals also increased. The difference in expenditure per illness at each age group in private hospitals was higher by 70 to 80 per cent than in government hospitals. The percentage share of direct expenditure to total expenditure for those who took treatment in government hospital was smaller than that for those who took treatment at private hospital. Further, within the direct expenditure category, cost of medicine constituted the single highest item of expenditure which pushed the direct expenditure in both type of hospitals and relatively much higher in private hospitals.

There was no significant variation in the direct and indirect expenditure incurred by patients with different levels of education who took treatment at government and private hospitals. There was a vast difference in the direct mean healthcare expenditure of salaried group who took treatment at the government (Rs.58) and private hospitals (Rs.554). The average household healthcare total expenditure per episode of the self-employed group was very high both in government and private hospitals when compared to other occupational groups. In private hospitals the proportion of direct expenditure ranged between 55 and 70 per cent out of the total among the different occupational groups. The indirect expenditure for these groups was between 29 and 44 per cent.

In the case of government hospitals the average direct expenditure on healthcare decreases as the income increases, whereas at private hospitals the expenditure increases with increasing income except for the high-income group. There was no much difference in the direct and indirect healthcare expenditures among different income groups at private hospitals. But in the case of government hospitals there is inverse relationship between the proportion of direct and indirect expenditure and income.

Most of the rural studies in India revealed that the income of the household influences and determines the healthcare expenditure (Nitcher 1980, NCAER, 1992, Shenoy 1999).
Considering the average household healthcare expenditure per illness, Other Community (OC) households spent more in both government and private hospitals when compared to Backward Class (BC) and Scheduled Caste and Scheduled Tribe (SC/ST) patients. In the case of indirect expenditure in private hospitals SC/ST patients incurred more expenditure than the other two communities.

The result of OLS regression on healthcare expenditure indicates that Coimbatore and Erode district patients incurred higher household healthcare expenditure when compared to Thanjavur district patients. The Hindu patients incurred higher household healthcare expenditure as compared to the Muslims. The households incurred lesser expenses when they sought treatment in government hospitals. This is because of subsidised medicine cost and free treatment. Distance of hospital also influences positively the total household healthcare expenditure.

8.4.2 Household Healthcare Expenditure for Hospitalised Treatment

It is common knowledge that persons seeking healthcare services receive treatment as an outpatient or an inpatient depending upon the nature of health problem of the individual and the nature of treatment. A person is regarded as having been hospitalised if he/she has availed of medical services as an inpatient in any medical institution. Normally such hospitalisation is considered more expensive than non-hospitalised treatment or treatment as outpatient.

In the government hospitals, the expenditure in general wards was higher when compared to special and emergency wards. But in the case of private hospitals, the general ward expenditure was relatively less than that incurred in special and emergency wards. The cost of treatment at private hospitals was two times higher when compared to government hospitals. In the analysis of average cost of treatment per episode at government hospitals it was costlier in Coimbatore district than in the other two districts.
i.e., more than two times as that of Thanjavur district and around 60 per cent higher than Erode district. When cost at private hospital was considered it was found that there again Thanjavur district households incurred about one third of what households in Coimbatore district faced, while there was not much difference in the private hospitals at Erode and Coimbatore districts.

There was a significant difference in household expenditure between both sexes for hospitalised treatment. The households incurred about fifty per cent more expenditure at government hospital and forty per cent more at private hospitals for men than women. At private hospitals expenses on surgery and loss of earning, was more for female than for male patients and all other heads of household spent more for male than for female patients.

There was an inverse relationship between the household healthcare expenditure in government hospital and literacy rate. The illiterates incurred higher average healthcare expenditure in government hospitals than those with higher education. But in the private hospital graduates incurred higher average expenditure for hospitalised treatment.

All the occupation groups took treatment in both private and government hospitals. But the amount spent by each occupational group in private hospital was higher than that in government hospital.

At government hospital it was the low-income group, which incurred higher expenditure than middle, while high-income group has not at all received treatment at government hospital. In private hospitals it was the middle income group which incurred two and a half times more expenditure than the low-income group. The high-income group spent only one sixth of what the middle-income group spent in private hospitals. Then again surgery and medicine played a major role in determining the cost of treatment in private hospitals. In government hospital it was the cost of medicine and loss of earning which constituted around half of the total cost for low-income group.
The total average household healthcare expenditure per episode incurred by SC/ST community was higher in both government and private hospitals than for BC and other Community patients. None of the other community patients took treatment at government hospitals and even for the treatment at private hospital they incurred relatively around 20 per cent lower than BCs.

The OLS regression result indicates that Erode and Coimbatore district patients incurred higher household healthcare expenditure as compared to Thanjavur district patients. The Muslim patients incurred lower household healthcare expenditure as compared to the Hindus. The household healthcare expenditure decreases with increasing income level. The households incurred lesser expenses when they sought treatment in government hospitals. This is because of subsidised medicine cost and free treatment and surgery.

There is a variation in the ratio of household healthcare expenditure to household annual income among the districts. The share of income devoted for healthcare by households varied widely between six per cent in Erode district and 1.63 per cent in Thanjavur district. Among the social groups also it varied between 4.49 per cent for BC and 2.38 per cent for other community groups. The share of income devoted to healthcare by households ranged between 5.20 per cent by low-income group and 0.63 per cent by high-income group.

The share of household healthcare expenditure in income varies among various studies. The study by Selvaraj (2001) had revealed that there was a regional variation in the ratio of household healthcare expenditure to household income and it ranged between 1.38 per cent in Karnataka and 9.21 per cent in Himachal Pradesh. The ratio was 15 to 20 per cent in the study by Vijaya (1997), nine per cent in the studies by Rajaratnam, Abel, Duraisamy and John (1996), 7 per cent in the study by Nitcher (1980), 8.44 per cent in the study by Nandra (1993) and 7.64 per cent in the study by Duggal and Amin (1989).
8.5 Source of Financing for Healthcare Treatments

Unlike other areas of spending, health treatment is neither regular nor predictable. Moreover, in the Indian context with poor environmental and general standards of living, all household members are likely to require health treatment although women, children and the elderly are likely to suffer more due to poor health. Unlike other categories of expenditure, spending on health treatment is often unavoidable, since illness may lead to lack of active life and work. However, the amount spent may widely vary and may be determined by the nature of the illness, the type of treatment provided, the system of healthcare chosen and the healthcare service provider. Often people report sickness suddenly and there are incidences like accidents, which warrant emergency treatment. Hence, it becomes necessary to consider the sources through which the households financed.

Among the four sources of financing we have considered for our analysis, one can normally list the order of sources one would resort to. The first of the four, own funds or current income may be called out of pocket. The second, borrowing from relatives and friends, may vary depending upon the network one has. The third preference would be disposing of asset or property. The fourth one is getting assistance from NGOs, which is not common for all the complaints.

There was not much difference among the districts as far as the source of financing for treatment was concerned. Among the districts, Erode district households depended more on current income than other district samples.

Using out of pocket source the household spent slightly more for females (85.5 per cent) than for male patients (82.1 per cent). Expenditure by sale of assets and borrowing from relatives was slightly more for male than for female patients. Thus, against common belief, discrimination against women was not found with regard to the source of financing healthcare treatment through different sources.
As human capital theory claims that education confers many advantages to the individuals and it provides allocative efficiency, we tried to find the variation in the source of finance and source of payment and the level of education of health service seekers. Around four-fifth of illiterate and primary, secondary and higher secondary level educated persons managed to finance their health expenditure out of their own savings or their pockets. Perhaps the educational status itself is an index of their better economic status. The higher educated respondents met their entire cost of healthcare treatment out of pocket, while four-fifths of all other levels met the expenditure from out of pocket source and a few through selling of assets. Around 1.5 per cent of illiterates and primary, and three per cent of secondary level educated patients met their healthcare expenditure by disposing of their assets. Around one to four per cent of patients received support or assistance from NGOs.

In the attitude to life and behaviour of people the occupational group to which one belongs may have a role in determining the pattern of source of finance for healthcare expenditure. Nine out of every ten agriculturists or farmer families met their healthcare expenditure from out of pocket, while about four-fifth of agricultural labourers and self-employed category met through the same source. Three-fourth of the other occupational groups also relied on the current income or savings. So between five to ten per cent all the occupational groups met their expenditure out of pocket. The dependency on borrowing varied among the occupational groups between relatively small portion (5 per cent) by farmers and nearly one-fifth (22 per cent) by non-agricultural workers. Sale of asset to finance healthcare expenditure was resorted to by about three per cent of artisans and salaried class. In receiving assistance from NGOs and others it was the self-employed and artisans who ranked higher than other occupational groups.

The high-income group met their healthcare expenditure mostly from out of pocket (93 per cent) and a small portion (7 per cent) by borrowing. However the other
two income groups met four-fifth of the expenditure from out of pocket and about 13 per cent depended on borrowing. Further, a small portion (2.5 per cent) footed the bill for their healthcare treatment by disposing of their assets and with the support of NGOs.

Three-fourth of SC/ST group, marginally higher than four fifth of backward class people, nine out of every ten of other community met their healthcare expenditure out of own savings or income. Socially deprived (SC/ST) group depended double that much of the BC and other groups on borrowing. SC/ST and BC depended on other sources of financing more or less equally while the other social groups have not faced this situation. In other words relatively better economic condition enabled other social group households to meet medical expenditure from out of pocket than others.

Larger number of joint-families depended on own source than nuclear families, while large number of nuclear families resorted to borrowing than joint-families. If out of pocket expenditure is considered as preparedness, then joint families provided more security than nuclear families in meeting household expenditure.

8.6 Knowledge on Health Insurance

Health insurance in the Indian context is justified because of unregulated nature of private healthcare expenditure. Private out of pocket spending is the single dominant source of financing healthcare in the country. It is important to streamline the private resources for overall benefit of patients. In this context, health insurance can be seen as the latest avatar. The size and distribution of economy also suggest a large potential demand for health insurance and only less than one-tenth of it has been tapped so far.

In the present study none of the respondents in the sample area had been covered by health insurance schemes. Only 2.4 per cent of total sample rural households have known about health insurance and in Thanjavur district not even one per cent of the
respondents have knowledge about it. Some of the life insurance policyholders also were not aware of the availability of health insurance programmes. Most of the sample respondents were willing to pay for health insurance. It is recommended that measures to be taken to popularise the health insurance schemes their exists a need for taking up health insurance in the rural areas through campaigning movements.

8.7 Conclusions

In the event of illness, a majority of individuals seek some kind of treatment and very small portion of the people opt out. The household income influences the healthcare seeking behaviour. A higher number of socially deprived SC/ST population and a small number of BCs are not seeking treatment. Higher proportion of joint-family patients ignored healthcare than members of nuclear families. The want of money and taking the complaint not seriously emerged as reasons equally responsible for not seeking any treatment.

In the choice of government and private hospitals there was no wide variation between the districts. There was also no gender difference in seeking either government or private hospital services. However there was a small difference in their choice between the ages. Income has played an important role in the choice of hospitals. As the level of income rises, the dependency on public facilities declines and there is a shift towards private facilities. There was also absence of much difference between the type of families and social groups in their choice of hospitals.

The aged were more likely to opt for non-allopathic than allopathic system. The Backward Class community members were inclined to seek treatment from non-allopathic systems. All children were given allopathic treatment.

Coimbatore and Erode district patients incurred more household healthcare expenditure as compared to Thanjavur district patients both in hospitalised and non-hospitalised treatment. The Hindu patients incurred relatively higher household
healthcare expenditure for non-hospitalised treatment and the Muslim patients incurred relatively lower household healthcare expenditure for hospitalisation. The households incurred lesser expenses when they sought treatment in government hospitals. Distance of hospital also influenced positively the total household healthcare expenditure. The households incurred lesser expenses when they sought treatment in government hospitals both in hospitalised and non-hospitalised treatment. This is because of subsidised medicine cost and free treatment and surgery. The share of income devoted to healthcare by households was much higher for low income groups (5.20 per cent) and a low of 0.63 per cent for higher income group.

There was no much difference among the districts as far as the source of financing treatment is concerned. In the present study none of the respondents in the sample area had been covered by health insurance schemes and only 2.4 per cent of them have known about health insurance. Some of the life insurance policyholders also were not aware of the availability of health insurance programmes.

8.8 Policy Recommendations

In India government hospitals provide service free of cost without discriminating between the poor and the rich. Even with sophisticated technologies, instruments and highly qualified super speciality medical and para-medical staff, the quality of treatment and efficiency in the government hospitals is not satisfactory. User fees in the government hospitals have strong potential for improving the efficiency of healthcare systems in India. It is better to introduce user charges with differential fees to protect the rural poor. The high-income group can also use government hospital facilities with nominal cost.

The introduction of fees would reduce the inequity by obliging better-off persons to pay. The funds made available could be targeted towards services for the poor, who
could be charged lower fees or be fully exempted from payment. It can also be expected that the quality of services in governmental hospital will improve, if the healthcare seekers pay a nominal fee instead of claiming free treatment.

The government was unable to provide high quality and efficient public services to the people particularly in the rural areas, while private healthcare providers rendered quality services but it is inaccessible to the rural poor. Private insurance can improve the availability and quality of healthcare. The role of health insurance is very limited or negligible in the rural areas of Tamil Nadu and only two per cent of rural people have knowledge about it. Economic reform is likely to increase the demand for private health insurance and at the same time, the rural poor cannot pay the premium towards these health insurance policies. People are willing to pay some minimum amount if such a scheme is available to them in rural areas. Hence, Government of India will do well to introduce social health insurance at subsidised or free of cost, which may reduce the public share in the delivery of health services.

It was observed from the study that people believe in a particular system of medicine for treatment of a certain type of illness irrespective of the economic status and they do not have clear-cut knowledge about each system. So the government could streamline the various alternative systems of medicine for treatment of different diseases and provide it through a single window. This will be of a great help for the whole community particularly in the rural areas.