CHAPTER – I

INTRODUCTION

Good health is an essential prerequisite for economic well-being of the people and a substantial factor for the economic growth of the country. Every human being must possess a state of good health in-order to engage in the production process which will benefit to ameliorate the standard of living and it also helps in contributing to the productivity of the country which leads to economic growth and development. According to the Bhore committee report (1946)\(^1\), the term ‘health’ implies more than an absence of sickness in the individual and indicates a state of harmonious functioning of body and mind in relation to his physical and social environment, so as to enable him to enjoy life to the fullest possible extent and to reach his maximum level of productive capacity. The World Health Organization (WHO)\(^2\) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” These definitions broaden the scope of health beyond the conventional thinking and explain comprehensive preventive, curative and promotive dimensions. It also highlights that health is a state of well-being of an individual. It is understood that the state of health is not the same throughout the entire span of life therefore improvements in health can be obtained by accessing the health facilities or medical care. It is indeed the prime target for individuals to obtain good health. Since individuals demand for health care, health is considered as an economic good, which has utility, choices and thus has a production function followed by demand and supply.

“Health and Health Care should be understood separately but not to be treated as two different entities. In economic terms, health is a fundamental commodity and the goal of health care is to improve health. Therefore health care should not be studied as the supply of treatment that the hospitals provide but the impact that this has on the health of patients and on the economic activities that the individual performs and can be

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\(^1\) Report of the Health Survey and Development Committee (1946), Government of India Press, Calcutta.

extended to the population as a whole. Having understood that health is important not only for the well-being of the individual but also for economic growth and development, it is important to evaluate the benefits that the society can achieve when good health is delivered to them. Since health has a social and economic value and a common good for everyone, the allocation of health or health care gains importance.

The constitution of World Health Organization states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” In the actual scenario, health care is not distributed equally to everyone in the society even though it is a public good. This imbalance is the root cause for serious poverty considerations throughout the world. However the main aim of the international welfare organizations has been continually upon the world countries is to ensure the masses with quality and equal access to health care.

In India the health care system is operated by the public and the private sector. The sectoral report by Indian Brand Equity Foundation (IBEF), 2017, states that the public (government) health care system includes limited secondary and tertiary care institutions in key cities and focuses on providing basic health care facilities in the rural areas such as the Primary Health Centres (PHCs). While the private sector provides majority of secondary, tertiary and quaternary care institutions, concentrating mainly in Metros, Tier I and Tier II cities. This makes evident that the Indian health care system faces serious shortcomings in its working and intense disparity in offering health care service. Apart from the differences in the range of health services the public and private sector provides, there also prevails shortfall of health infrastructure, human resources in health sector, health care financing and regional imbalances in the health sector. These shortfalls are more likely to threaten the health outcomes in the country and the sector needs significant reforms.

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3 Morris, Stephen, Nancy Devlin and David Parkin (2009), “Economic Analysis in Health Care” John Wiley & Sons Ltd.


According to the World Health Organization (WHO)⁶, “good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies”.

In the India Health Report (2010)⁷, the authors highlight the importance of making significant improvements in the public health system and to enhance protection against the financial risk bore by the unhealthy population. The reasons the authors quote for this is as follows: (i) Health is a major factor influencing aggregate economic outcomes (ii) Instances of ill health can expose entire household to financial risk and leads to impoverishment (iii) Health status itself is an indicator of human well-being and (iv) Improvements in health carry an added importance in the country undergoing great economic and social transition.

As mentioned earlier, the importance of health and health care delivery systems is well realised globally, nationally and locally (at state level). The constitution guarantees two important fundamental rights in relation to health care, which is presented as follows:

Article 14. Equality before Law: The State shall not deny any person before the law or equal protection of the laws within the territory of India.

Article 21. Protection of Life and Personal Liberty: No person shall be deprived of his personal life or personal liberty except according to procedure established by law.

The constitutional framework was established to ensure all its citizens social and economic justice. This can be better understood by overseeing few of the policy frameworks that are adopted by world organizations and the policy recommendations and the entitled constitutional framework framed in our country.

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### Box 1.1

**Health Inequality and Financial Access**

<table>
<thead>
<tr>
<th>Health Survey and Development (Bhore) Committee, 1946</th>
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</thead>
<tbody>
<tr>
<td>• No individual should fail to secure adequate medical care, curative or preventive, because of an inability to pay for it.</td>
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</table>

**Constitution of India, 1950**

| Preamble: | To secure….equality of status and opportunity. |
| ARTICLE 38(2): | The state shall…endeavor to eliminate inequalities in status…not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations. |
| ARTICLE 41: | The state shall, within the limits of its economic capacity…make effective provision for….public assistance in cases of …old age, sickness and disablement, and in other cases of undeserved want. |

**Alma-Ata Declaration, 1978**

| | The existing gross inequality in the health status of the people… ‘within countries is politically, socially and economically unacceptable …’ (p.1). |

Box 1.2

Improving Health and Nutritional Status

<table>
<thead>
<tr>
<th>Health Survey and Development (Bhore) Committee, 1946</th>
</tr>
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<tbody>
<tr>
<td>• The creation and maintenance of as healthy an environment as is possible in workplaces, home….</td>
</tr>
<tr>
<td>• Preservation and maintenance of the health of the population should be the responsibility of the state.</td>
</tr>
</tbody>
</table>

Constitution of India, 1950

• Article 47: The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.

Alma-Ata Declaration, 1978

• The conference strongly reaffirms that health…is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social whose realization requires the action of many other social and economic sectors in addition to the health sector… Primary health care is the key to attaining this target as [a] part of development in the spirit of social justice…

• Primary healthcare:…includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunization against the infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs…

1.1 RESEARCH ISSUES

In order to have a better understanding of the health care systems, health services, health expenditure and universal coverage, the study identifies the following research issues.

1.1.1 Health Infrastructure

Offering health services is the key function of the health systems. According to WHO, health services includes all services dealing with the diagnosis and treatment of disease or the promotion, maintenance and restoration of health including personal and non-personal health services. Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions. Improving access, coverage and quality of services depends on these key resources being available; on the ways services are organized and managed, and on incentives influencing providers and users.

The health infrastructure that presently exists in India is not sufficient and even falls short of the minimum requirements. The National Health Profile Report (2013) indicates that the total number of registered allopathic doctors were 26878 as of 2013 which has reduced from 30017 in the year 2012. The registered AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy) doctors were 6,86,319 in India and 31,473 in Tamil Nadu in the year 2013. The number of population served by per doctor (allopathy and AYUSH) was 1,217. The number of Sub Centres (SCs) in the country is 1,55,069, Primary Health Centres (PHCs) were 25,354, Community Health Centres (CHCs) were 5,510 and Sub-divisional Hospitals (SDHs). According to the National Health Mission (NHM) there is a shortfall of 35,110 SCs (20%), 65,72 PHCs (22%) and 2,220 CHCs (30%) in the country. This accounts to serious implication where a larger percentage of population is not able access the facilities as and when they require.

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1.1.2 Cost of Treatment

Cost of treatment is a major factor responsible for increased health care burden among the lower income groups and in the rural area. The primary healthcare is the main source of health services in the rural area. But as mentioned above, with these serious shortfalls and wide disparity of services, the cost of treatment raises and it becomes a constraint for the people to utilize the health services. According to the cross-national survey on health by National Sample Survey Organisation (NSSO) 2014\textsuperscript{10}, the cost of treatment rose at a double digit pace of growth, outpacing average inflation in both rural and urban India over the last decade. It is injudicious to know that India’s health care cost is rising and is unaffordable to its own population. At the same time, India is becoming a destination of choice for medical tourism, with super-specialty hospitals offering medical care at rates lower than the developed countries. Among the other factors, the health care costs are more impoverishing due to hospitalization including the case of public hospitals, leads to catastrophic health care expenditure and 63 million people are facing poverty due to health care cost alone. Health care in India is affected by the 70:70 paradox where 70 per cent of health care expenses are incurred by people from their pockets, of which 70 per cent is on medicines leading to impoverishment\textsuperscript{11}.

According to NSS 71\textsuperscript{st} round\textsuperscript{12}, in India only 14.1\% of the rural population and 18.1\% of urban population are covered of health expenditure through government funded insurances, employment support health protection and also private health insurance agencies. In Tamil Nadu the average medical expense and non-medical expense per person on account of hospitalization is Rs.23,757 and Rs.2336 respectively. In rural Tamil Nadu only 8 persons per 1000 number of hospitalization cases could get reimbursement of their expenditure fully or partly whereas in urban areas it is 49 persons in Tamil Nadu. Such whooping hospital and medical expenses with minimal support from the government increases the financial burden of the people.


\textsuperscript{12} Health in India (2014), NSS 71\textsuperscript{st} Round, Government of India, Ministry of Statistics and Programme Implementation.
1.1.3 Financing Health Care

Health financing is concerned with how financial resources are generated, allocated and used in health systems. In most of the developed countries, health care is financed by the government through a tax-financed mechanism or with a multi-layered health system where the health sector is predominantly financed by the government. The total health expenditure in India as a percentage of GDP is 4.6 out of which 1.4 percent is contributed by public\textsuperscript{13}. Countries under the Organisation for Economic Co-operation and Development (OECD) spend between 5% and 8% and the US government spends nearly 9% of its GDP on health. Achieving universal access to health care is the main aim of many countries including India. In spite of spending a significant share of GDP to health care, the OECD countries still could not achieve their target due to the way health care is financed\textsuperscript{14}. The Indian government however encourages the FDI inflows and private players in this sector and has also reduced the customs duty and taxes on life-saving equipment as a way of fostering investment in the health sector. In spite of these financing health care is still a major problem the country faces. The government is yet to identify and ensure financing health care not only in the urban areas but also in the rural pockets of the country.

1.1.4 Universal Health Coverage

Globally, all the UN member countries have agreed to try to achieve Universal Health Coverage (UHC) by 2030, as part of the Sustainable Development Goals\textsuperscript{15}. India’s initiative towards universal health coverage started after independence but it did not derive the expected results due to various factors including improper planning and resource constraints. India is embarking on achieving the target of Universal Health Coverage for all during the 12\textsuperscript{th} plan period, with a framework for providing easily accessible and affordable health care to all citizens. With financial protection as the principal objective, it was also realized that the delivery of UHC also requires the availability of adequate healthcare infrastructure, skilled health workforce and access


to affordable drugs and technologies\textsuperscript{16}. Hence, the question on the actual action plan about universal health coverage is at stake and tends to draw attention towards it.

1.1.5 Catastrophic Household Health Care Payment

Health care financing in most of the developing and low income nations are predominantly out-of-pocket payments. These out-of-pocket expenditures have the tendency to push the households/individuals to poverty. According to Raban et al. (2013)\textsuperscript{17} ‘the proportion of households that incur catastrophic health expenditure in a country is widely used as an indicator of the extent to which the health system protects households needing health care against financial hardship. Offering such protection is a major goal of health systems and is the purpose behind universal health coverage’. In the developed countries, tax funded mechanisms like insurance and extensive contribution by the government helps in relaxing the people from such catastrophic payments. In India, health insurance is just gaining pace among the people. In the year 2015 the gross direct premium income from health insurance was 25.4 per cent of overall gross direct premium income from non-life insurance and growing at 15.36 per cent CAGR\textsuperscript{18}. The government has established major schemes such as Rashtriya Swasthya Bima Yojana (RSBY), community health insurance schemes and other state funded insurance schemes which tends to cover the maximum population rather than the private insurance schemes which skims major section of the population. This has resulted in the reduction of OOPE 69.4% in 2004-05 to 64.2% in 2013-14 and an increase in household prepayments from 1.6% in 2004-05 to 3.4% in 2013-14\textsuperscript{19}.


\textsuperscript{17} Raban k. Magdalena, Rakhi Dandona and Lalit Dandona 2013. “Variations in Catastrophic health expenditure estimates from household surveys in India”, Bulletin of World Health Organization.

\textsuperscript{18} Healthcare - Sectoral Report (2017), Indian Brand Equity Foundation (IBEF).

\textsuperscript{19} Nation Health Mission 2016, Household Health Expenditures in India (2013-2014)
1.1.6 Health Education

In order to achieve the expected results in health care, one of the important requirement is ‘Health Education’. Health education in terms of both the preparedness of the health care work force and public health education are most important. Preventive measures are better than the curative measures. The WHO defines health education as a combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes. Hence the public health education has been a long expected solution to multitude of health care problems and better utilization of services provided. The focus on public health education came into consideration in the 1940s, along when the Bhore Committee was formed.

1.2 RESEARCH QUESTIONS

With these insights, the researcher has drawn the following research questions:

- Is health care expenditure a major part of the household consumption expenditure?
- Do households with major spending on health care expenditure are pushed to the verge of poverty?
- If the out-of-pocket spending on health care is catastrophic, what are the ways in which the households meet this expenditure?
- What are the factors that are responsible for catastrophic out-of-pocket health care payments?
- What are the measures the households adopt to overcome the catastrophic health care expenditure?
- How aware are the people about the health insurance schemes?

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1.2 GENERAL OBJECTIVES

The general objective of the present study is to analyse the factors that determine the demand and supply of health care. The pattern of household health care expenditure and also the components of health care with respect to the households are to be analysed; also to explore the awareness level of health insurance.

1.4 SCHEME OF STUDY

The study is organized into six chapters and a brief description of each chapter is given as follows.

The First Chapter introduces the research topic, highlighting the research issues, drawing the research questions of the study and enunciates the general objectives of the study. This chapter also presents the scheme of the study.

The Second chapter provides comprehensive details of the general profile of health and health care system at the global, national and state level. It also discusses the important and relevant economic – health, health care and health insurance theories that are fundamental to understand the present study and its significance.

The Third Chapter discusses the previous research works in the areas that are closely relevant to the present study. The chapter is sub-divided into the following themes as – (i) out of pocket health care payments and impoverishment, (ii) determinants of household health care expenditure, (iii) financing health care, (iv) health insurance, (v) disease burden, health care seeking behaviour and health care delivery (vi) studies relating to Tamil Nadu.

The Fourth Chapter draws out the research problem while describing the study area chosen and explaining its significance. The chapter also explains the research design drawn to study the objectives, the methodology adopted to conduct the study and describes the nature of the statistical tools applied in the study.

The Fifth Chapter is the analysis of the data that has been collected. This chapter is organized into four parts as to discuss and present the analysis of the four objectives of the present study.
The *Sixth Chapter* lists out the findings of the study based on the objectives formulated for the study. This chapter includes the suggestions, conclusion of the study and states the scope for future research.