CHAPTER VI

Utilization of Health Care and the Economics of the Household

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6.1. Introduction

In India, government spends an insignificant amount on health care services. Automatically, out-of-pocket health expenditure for health care becomes high even in case of out-patient care. Therefore, formal health care utilization, in the absence of any insurance coverage has serious impoverishing effect on the economic conditions as well as consumption possibilities of the household to which the patient belongs to in developing countries like India. Again, in all states of the country except Kerala, rural patients pay more for health care and bear a higher burden of treatment. For the poor section of people, not only the burden is higher, but a single hospitalization episode can increase the intensity of poverty for those households. Again, each year, a number of families who are marginally above the poverty line are pushed below the poverty line on account of single hospitalization episode of its family member (Krishnan, 1999). In case of in-patient health care, not only in case of private sector health care services, 40 per cent of those seeking in-patient treatment in the public sector services in rural areas also fall in debt-trap due to out-of-pocket expenditure which further leads to high level of morbidity as well as low rate of health care utilization (Dilip, 2005). Actually, health care utilization has duel burden on the in the form of direct cost of health care and indirect burden in terms of income forgone due to inability to attend the work.

Present chapter is an attempt to give an idea about the burden of health care in the study area. The outline of the chapter is as follows. Section 6.2 elaborates on the methodology used, section 6.3 of the chapter discusses about the direct burden of

health care for in-patient treatment for the study area. Section 6.4 discusses about the direct burden of health care for out-patient treatment for the study area. Finally, section 6.5 is the conclusion of the chapter.

6.2 Data Source and Methodology

This chapter is based on primary data collected from field study. Data has been collected regarding the direct burden of health care in the study area. In case out-patient treatment, direct burden of health care utilization for each of the patient has been calculated in terms of ratio between health care expenditure incurred in that particular ailment episode in last 30 days reference period and monthly per capita consumption expenditure of the household to which the patient belongs to during the same period. Then, average direct burden for out-patient treatment for each of the MPCE group has been calculated. On the other hand, in case of in-patient treatment, direct burden of health care utilization for each of the patient has been calculated in terms of ratio between health care expenditure incurred in a particular hospitalized ailment episode in last 365 days and Monthly per Capita Consumption Expenditure of the household during the last year to which the patient belongs to. Then, average direct burden for in-patient treatment for each of the MPCE group has been calculated.

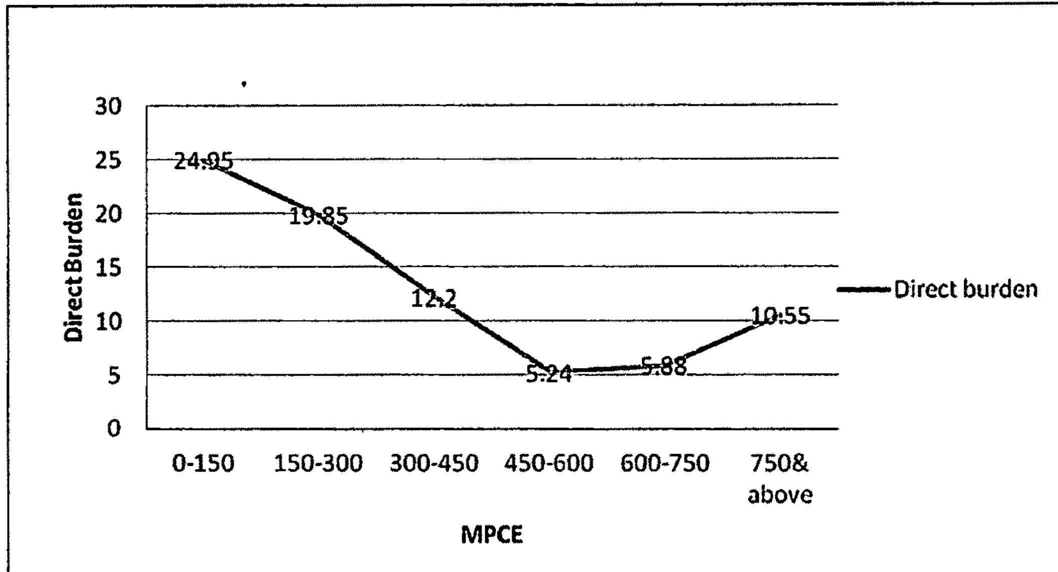
Indirect burden of health care can be expressed in terms of opportunity cost of health care. But, our study comprises of patients from both dependent and independent age group. So, it is really difficult to measure the opportunity cost of health care. In Indian context, Gupta and Dasgupta (2002) considered number work days affected by illness for measuring opportunity cost of health care. Still, measuring indirect burden in terms of number of work days lost is subject to serious limitation as already mentioned in chapter V. The number of work days lost by the patient depends upon the economic condition of the household to which the patient belongs. So, the idea of calculating indirect burden of health care has been dropped from the study.

6.3. Direct Burden of Health Care for In-patient Treatment

In-patient health care utilization creates direct burden for all sections of people in the study area because not a single case was found, in which, there is insurance coverage. The overall average direct burden for in-patient treatment in the study area is 15.78. In 80% of the ailment cases in the study area where in-patient treatment was utilized, households to which those patients belongs to had been indebted and some of them sold their assets and cattle for meeting up the cost. Still, in-patient health care creates more burdens for low MPCE group where as lesser burden to high MPCE group. As in this study, MPCE of the household to which a particular patient belongs to is one of the proxy of household's economic condition, in fig.6.1, average direct burden arises from a single episode of hospitalization during the reference period has been portrayed against each of the MPCE group.

From fig.6.1, it has been observed that direct burden arises for in-patient treatment for the lowest MPCE group i.e., 0-150 MPCE group is highest. Actually, for them, in-patient health care is quite expensive in comparison to their MPCE. For this income group average direct burden arises from a single episode of in-patient treatment during the reference period is 24.95 in the study area. Impoverishing affect of health care utilization is highest for this MPCE group. They, generally, incur such expenditure by borrowing money from money lenders and relatives, liquidation of their movable and immovable properties etc. For the next MPCE group, average direct burden of in-patient treatment in the study area during the reference period declines to 19.85. Still, it is quite higher. Thereafter, the direct burden for in-patient treatment for each of the MPCE group comes below the overall average direct burden of in-patient treatment. And ultimately, it reaches the lowest one that is 5.24 for 450-600 MPCE group. Again, it starts rising from the MPCE group 600-750 and finally, reached to 10.55 for the MPCE group 750 and above.

Fig.6.1: Direct Burden of Health Care for In-patient Treatment



Source: Based on primary data

In the study area, 67.42% patients go to RPHC institution for in-patient treatment whereas 32.57% patients go to USHC institution. In the study area, most of the patients from the higher MPCE group like 600-750 and 750 and above prefer USHC institutions for in-patient health care. Utilizing USHC institution is more expensive because assuming other costs to be constant it requires more transportation cost. So, the among those MPCE group, direct burden of in-patient health care, again, starts rising.

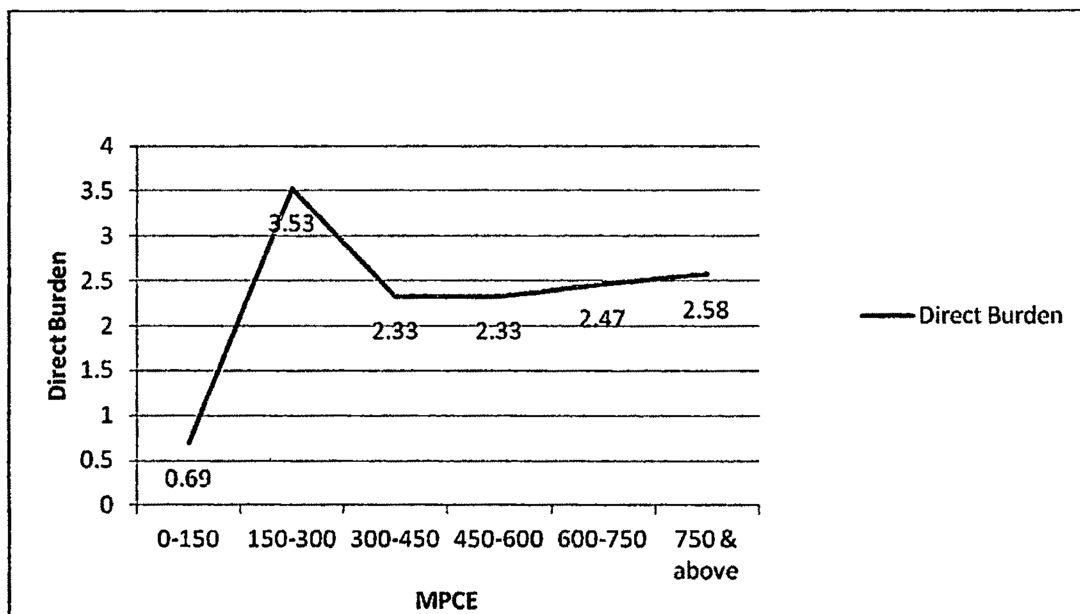
6.4. Direct Burden of Health Care for Out-patient Treatment

Although direct burden of out-patient health care is quite lesser than in case in-patient health care utilization, still, there is some amount of direct burden especially for lower MPCE group. The overall average direct burden of out-patient treatment, in the study area is 2.43. But, it creates lesser burden for higher MPCE group. This result again contradicts the result of Berman et al (2010) according to which burden of out-

patient health care is more burdensome. As in this study, MPCE of the household to which a particular patient belongs to is one of the proxies of household's economic condition, in fig.6.2; average direct burden arises from a single out-patient during the last 30 days reference period has been portrayed against each of the MPCE group.

From fig.6.2, it has been observed that in contrast to in-patient treatment, average direct burden arises for out-patient treatment for the lowest ((i.e., 0.69) for the lowest MPCE group i.e., 0-150 MPCE group. Actually, it is quite below the overall average direct burden arises from out-patient treatment in the study area. This is because; the patients from this group, generally, prefer the Informal Health Care (IHC) service for out-patient treatment, which is generally, least costly.

Fig.6.2: Direct Burden of Health Care for Out-patient Treatment



Source: Based on primary data

For the next MPCE group (150-300), there is sudden jump in the average direct burden and becomes the highest among the entire MPCE group in the study area. This is because of the fact that from these MPCE group, patients, in the study area, start utilizing formal health care services which suddenly leads to increase the health care expenditure at a much higher rate than the increase in the MPCE. So, this result

shows some consistency with Berman et al (2010) according to which the impoverishing effect of health care expenditure as highest among the middle income quintile in rural areas rather than the lowest quintile in India.

Again, the average direct burden for the next MPCE group (i.e., 300-450 group), comes down to 2.33 and remains at the same figure for the next MPCE group also. Thereafter, direct burden of out-patient treatment starts increasing and becomes greater than the overall average direct burden for the next MPCE groups. For the MPCE group 600-750, it increases to 2.47 which is slightly higher than the overall average direct burden of out-patient treatment in the study area. For the highest MPCE group i.e., 750 and above, the average direct burden for out-patient treatment is 2.58. This is because, although, patients from higher MPCE group generally prefer USHC service for out-patient treatment; there is not so much difference in the cost of health care between USHC and RPHC services for out-patient health care. So, direct burden of health care for outpatient health care which is a ratio between outpatient health care expenditure in a particular ailment episode and MPCE remains almost same. Because, the higher health care expenditure is outweighed by the higher MPCE for those groups.

6.5. Conclusion

While making a comparative analysis about the impact of both in-patient and out-patient health care utilization in rural Goalpara, three important points has been observed. Firstly, no one is free from direct burden of health care whether it is a case of in-patient treatment or out-patient treatment and whether the patient belongs to higher MPCE group or lower MPCE group as in the study area health care insurance is virtually non-existent. Secondly, in-patient treatment is much more burdensome as the overall direct burden from single episode of in-patient treatment is more than six times larger than the overall direct burden from single episode of out-patient treatment in the study area. Lastly, there is no similarity between in-patient treatment

and out-patient treatment regarding its direct burden on different MPCE groups. Average direct burden of in-patient health care is highest for the lowest MPCE group, whereas, average direct burden of out-patient health care is lowest for the same MPCE group. This is because in case of out-patient treatment, lower MPCE group often choose informal health care which quite inexpensive than the formal kind of health care. But, those ailment cases where in-patient treatment is required, there is no alternative to formal health care. So, the impoverishing impact on this group is very high in case of in-patient treatment. From the next MPCE group average direct burden for in-patient treatment comes down whereas for out-patient treatment it shows a sharp increase. Thereafter, average direct burden for both in-patient treatment and out-patient treatment decreases for middle MPCE group and ultimately, rise for the upper MPCE group in the study area. So, in the absence of any insurance coverage, people of rural Goalpara suffer very much particularly in case of in-patient treatment.

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