AN ECONOMIC STUDY UTILISATION OF HEALTHCARE SERVICES AMONG RURAL HOUSEHOLDS IN VELLORE DISTRICT, TAMIL NADU

Dr.A.WILLIAM., Ph.D
ASSOCIATE PROFESSOR
PG & RESEARCH DEPT OF ECONOMICS
ARIGNAR ANNA GOVT ARTS COLLEGE
VILLUPURAM , TAMILNADU, 605 602

INTRODUCTION

Health is one of the basic capabilities that give value to human life and its importance in its own right cannot be overstated. The strong link between poverty and ill health needs to be recognized. The onset of a long and expensive illness can drive the non-poor into poverty. Ill health creates immense stress even among those who are financially secure. High health care costs can lead to entry into or exacerbation of poverty. The importance of public provisioning of quality health care to enable access to affordable and reliable health services cannot be underestimated (Sen, 1999).[1] This is specially so, in the context of preventing the non-poor from entering into poverty or in terms of reducing the suffering of those who are already below the poverty line. Health brings the capacity for personal development and economic security in the future for individuals and families. In economic terms, health and education are the two cornerstones of human capital and they form the basis of an individual's economic productivity (World Bank, 2006).[2]

HEALTH CARE IN INDIA

Western system of medicine was introduced in India in the latter half of the 18th century mainly to serve the needs of the colonial settlers and their armed forces that came to rule India. These facilities were extended to a small segment of people, mostly elite masses, living in urban areas. Those people could get better western medical facilities including health-related services such as sanitation and water supply. The Bhore Committee which was set up to study the health status in India, submitted its report in

1946, in which it had observed that the high morbidity and mortality rates were largely preventable and were mainly due to the absence of safe drinking water, sanitation, waste disposal, poor nutrition, lack of preventive and curative health services among the people (Government of India, 2005).[4] Moreover, the severe shortage of medical personnel that the country had inherited and a limited infrastructure of modern health services from the British were also cited by the committee.

In the plan period, the total plan outlay by the Centre and the State Governments on the health sector has increased in absolute terms, though it has declined in percentage term, which was in contrast to the recommendations made by the Bhore Committee. Total plan outlay by the Centre and the State Governments on the health sector has increased from Rs. 65 crores in the First Plan to Rs. 1252 crore during the Fifth Plan, further up to Rs. 14102 crore during the Eighth Plan, then to Rs. 140135 crore during the 11th Plan period and further upto Rs. 384223 crore during the 12th Plan. In percentage terms, it has decreased from 3.4 per cent of total Plan outlay in the First Plan to 3.1 in the Fifth Plan. Since then, it has started to go up, as it has gone up to 3.2 per cent during the Eighth Plan, 3.97 per cent during the 10th Plan and as much as 6.5 per cent during the 12th Plan (National Health Profile 2013, Government of India).[5]

However, public expenditure on health services, however, constitutes 1.2 per cent of the GDP. This implies that more than 75 per cent of the health expenditure is borne by the private sector and that too by the households in the absence of any significant contribution by public health insurance. As compared to this, in most developed countries, public sector accounts for the major share of health expenditure. For instance, the United Kingdom more than 85 per cent of the total health expenditure is borne by the public sector, which is 70 per cent in Australia, 86 per cent in Norway, 48 per cent in the United States, 62 per cent in Russia, 53 per cent in china and 44 per cent in South Africa. Thus, India's public health expenditure as a percentage of GDP (1.2 per cent) is one of the lowest among all countries (Government of India, 2014).[6]

PROBLEMS IN THE PUBLIC HEALTHCARE SYSTEM

The public health system in India has various drawbacks. The available health infrastructure however, shows lot of spatial variations not only among states but also within states. The number of people served per government hospital bed during 2011 in Kerala was 1045, 1391 in Tamil Nadu, 2490 in Madhya Pradesh and 5606 in Bihar against the national average of 1512. This is reflected in the basic indicators like death rate, birth rate, infant mortality rate and also life expectancy. For instance, in 2011, IMR in Kerala was 12, 22 in Tamil Nadu and 59 in Madhya Pradesh. In the same states, the rural – urban figures were 13 and 9 respectively in Kerala, 24 and 19 in Tamil Nadu and 63 and 39 in Madhya Pradesh (SRS Bulletin 2012, Government of India).[10]

There has been a steady increase in health care infrastructure available over the plan period, though in 2011 there was a shortage of 20903 Sub-Centres, 4803 PHCs and 2653 Community Health Centres as per 2011 population norm. Further, almost 50 per cent of the existing health infrastructure is in rented buildings. Poor upkeep and maintenance and high absenteeism of manpower in rural areas have also eroded the credibility of the health delivery system in the public sector. The primary reason for the absenteeism appears to be the quality of infrastructure at the facility.

Despite a steady increase in public health care infrastructure, its utilization by the population for outpatient and inpatient care has not improved. In rural areas, the proportion of utilisation of public health facilities has declined from 59.7 per cent in 1986-87 to 43.8 per cent in 1995-96 and further down to 39.2 per cent in 2011-12, while in the case of urban areas, the corresponding figures have been 60.3 per cent, 43.1 per cent and 38.2 per cent respectively. Despite higher costs in the private sector, this shift shows the people's growing lack of trust in the public health care system (National Sample Survey Organisation, Government of India, 2013).[11]

RURAL HEALTHCARE

Rural health care services suffer from a shortage in public sector infrastructure. The failure of the public delivery system today is an outcome of systemic breakdown of accountability relationships within the institutional framework. There is a shortfall not only in terms of physical infrastructure but also human resource, measured even against the minimal norms prescribed by the government. Even if a

healthcare provider is present in a village, he/she can be reached easily, provided some basic access issues are taken care of. However, there exist many limitations especially in the context of road connectivity and adequate transport services. Many of the healthcare facilities, public or private, are not accessible throughout the year in many villages (Banerjee *et al*, 2004).[12]

PROBLEM OF THE STUDY

Good health plays the crucial role in enabling the individual to employ himself productively, increase the domestic product and generate income. Ill health of a human being, thus not only wastes human resources but also reduces his income level. The extent of fall in his income depends directly not only on the severity of illness, but also and more importantly on the availability and accessibility of public health services. Data indicate that the growth in health infrastructure is not commensurate with that of population growth and thus it has pushed down the relative availability of the health services. The onset of economic reforms has restricted the public role in the health sector, while the introduction of globalisation has led to the arrival of multi-speciality, super-speciality and corporate hospitals. Thus, in India, public health infrastructure has not improved on the one hand, while the private health infrastructure has grown at a rapid rate. This implies that whatever increase that has taken place in the stock of health infrastructure, has occurred mainly in the urban areas through the private sector. This is evident from the differing health infrastructure between the urban and rural areas. The indicators like IMR, MMR, death rate and birth rate are quite higher in the rural areas than that of urban areas, though the latter itself is higher than that of other developing countries.

Many steps and measures have been taken to increase the relative availability of manpower in the rural health sector, particularly in Tamil Nadu, in order to improve the extent of its accessibility. Lack of sufficient infrastructure, absenteeism of personnel, lack of availability of necessary drugs all put enormous pressure on the meagre resources possessed by the rural households, which potentially reduces their earning capability and also exacerbates the quantum of rural poverty. In this backdrop, it becomes pertinent to analyse the degree of availability, extent of accessibility, the rate of utilisation of the rural health infrastructure and healthcare expenditure among the households.

SIGNIFICANCE OF THE STUDY

Provision of health services is the prime responsibility of the State, which is especially true in the developing countries where the income level of the masses and that too, the rural masses are remarkably low. Poor income level however, cannot pre-empt them from spending on their health. The necessity of maintaining good health is more relevant among the poor both due to their precarious level of income and vulnerable health status. Among the rural masses, many factors push down their relative income level which includes rising general price level on the one hand and on the other hand, rising expenditure which is inevitable. Health care expenditure is one such expenditure which ought to be incurred to make themselves employable again. In this pre-text, this study attempts to bring out the availability of health infrastructure, the extent of its accessibility, the rate of utilisation and also the cost incurred by the rural household on their healthcare. This is warranted given the fact not only that no attempt has been made so far in Tamil Nadu to carry out such a holistic study, but importantly it is not attempted in the recent past, where there is a proliferation of private healthcare services in the State.

AREA OF THE STUDY

This study examines the choice and utilisation of healthcare services and expenditure among the rural households. For this purpose, Vellore district is identified as the sample district, since it provides a right mixture of varied healthcare services in all the taluks. From this district, two taluks, viz., Arcot and Vellore have been chosen as the sample areas, since they portray the availability of healthcare services in a better manner. From these two taluks, two villages each, viz., Agaram and Kavanur villages located in Arcot taluk and Anaikattu and Sekkanur villages located in Vellore taluk are chosen as the sample villages and these four villages form the area of the present study.

OBJECTIVES OF THE STUDY

The present study is based on the following objectives:

1. To analyse the extent of availability of health infrastructure at the all-India level and in Tamil Nadu;
2. To study the extent of utilisation public healthcare and the out-of-pocket expenditure made by the households at the all-India level and in Tamil Nadu;

3. To examine the nature of healthcare choice and the extent of utilisation of healthcare services made by the sample respondents in the study area;
4. To probe the nature, extent and reasons for the preference for PHCs by the sample respondents in the study area;

HYPOTHESES OF THE STUDY

The following are the hypotheses of the study:

1. There is no significant association between choice of healthcare provider and the income level of the sample respondents in the study area;
2. There is no significant variation in the extent of utilisation of public healthcare services among the sample respondents in the study area;

METHODOLOGY OF THE STUDY

This study examines the choice and utilisation of healthcare services and expenditure among the rural households, both at the macro and micro levels. At the macro level, the secondary data pertaining to the growth in the availability of public health infrastructure, health indicators, utilisation of health services, out-of-pocket expenditure incurred by the households in India and in Tamil Nadu have been collected from various Government publications which include Statistical Abstract of India and Tamil Nadu, Annual Health Reports of Government of India, Economic Survey, Rural Health Statistics, Bulletins of Sample Registration System, Economic Appraisal of Tamil Nadu, Statistical Handbook of Tamil Nadu, reports of Centre for Monitoring Indian Economy and reports of National Sample Survey Organisation, etc., for various years. These annual reports and publications have been accessed from various libraries like Madras Institute of Development Studies, Connemera Public Library, Madras School of Economics, University of Madras, etc.

At the micro level, data from the sample households have been gathered through field survey with the help of questionnaire. A standard questionnaire was developed for this purpose and a pilot survey was conducted. Based on this survey, necessary modifications were carried out in the questionnaire, which was used in the field survey. From the sample households, information regarding their identification, household members, household income, expenditure, health awareness particulars,

nature and extent of morbidity, choice and utilisation of health care services, healthcare expenditure and also the availability of health infrastructure at the PHC level have also been gathered from the sample PHCs in the study area. This information has been analysed on the basis of levels of education of the respondents, their community, age levels and income levels.

SAMPLING DESIGN

In this study, multi-stage random sampling method is used. In the first stage, Vellore as the sample district is chosen, since it provides a right mixture of varied healthcare services in all taluks. In the second stage, from this district, two taluks, viz., Arcot and Vellore have been selected as the sample taluks, since there is sufficient availability of all types of healthcare services. In the third stage, from these two taluks, two villages each, viz., Agaram and Kavanur villages located in Arcot taluk and Anaikattu and Sekkanur villages located in Vellore taluk have been selected. In the fourth and final stage, the sample households have been identified. The number of total households in each of the village and the sample households are shown below:

Taluk	Village	No. of Total Households	No. of Sample Households
Arcot	Agaram	539	108
	Kavanur	611	122
Vellore	Anaikattu	595	119
	Sekkanur	556	111
Total		**2301**	**460**

Source: Primary Census Abstract, Census of India, 2011, New Delhi.

Thus, as shown in the table, from a total of 2301 households, which form the population of this study, 460 households have been selected. This accounts for 20 per cent of the available population. The sample households have been selected randomly in order to make the sample as much representative as possible. Moreover, apart from the sample households, two PHCs from each of the sample village and one CHC have also been considered in order to find out the extent of availability of healthcare facilities in them.

CONCLUSION

The analysis in this study is based on the secondary data pertaining to the nature and pattern of morbidity, out-of-pocket expenditure of the households among others. However, these data which have

been collected from the NSSO and Rural Health Statistics reports do not available on an annual basis. Thus, only a few observations are available at the all-India and Tamil Nadu levels. In the case of primary data which had been collected through field survey, data regarding the health awareness, nature of morbidity and mortality and the health expenditure of the households have been gathered with much difficulty as the households were not quite forthcoming in revealing such information. Moreover, the data about the stock of available health infrastructure in the sample PHCs have been gathered from the staff of those PHCs, which again may not be totally revealing for obvious reasons.

REFERENCES

1. Sen, A., (1999), "Development as Freedom", Alfred A. Knopf, New York, pp. 14-23.

2. World Bank, (2006), "India: Inclusive Growth and Service Delivery: Building on India's Success", World Bank, Washington D.C., p. 14.

3. Challey, A.M., (1986), "A Text Book on Health Economics", Deep and Deep Publishers, New Delhi, Vol. I., p. 8.

4. Government of India, (2005), "Rural Health Care System in India", Ministry of Health and Family Welfare, New Delhi, p. 28.

5. Government of India, (2013), National Health Profile 2012, Department of Health and Health Research, Planning Commission, New Delhi, p. 144.

6. Government of India, (2014), "Economic Survey 2012-13", Ministry of Finance, New Delhi, p. 277.