

Commentary

Socio-economic inequity in health care utilization & expenditures in richer States in India

Equity in health is an important and long-standing goal for society. The poor, by virtue of lower incomes, unsanitary living conditions, poor access to health care not only tend to have higher levels of morbidity and mortality but despite needing it more, have lower levels of health care use compared to those who are better off. They also spend higher proportions of incomes on the little health care that they access. Uncertainty related to health and catastrophic nature of health expenditures often render even non-poor households into cycles of poverty. Health equity is most often measured as inequalities in health outcomes, health services utilization, out-of-pocket expenditures and use of public sector subsidies between the poor and the non-poor. In case of out-of-pocket expenditures, the focus is on achieving progressivity of health care expenditures. If health expenses incurred are proportionately higher for higher incomes and lower for lower incomes, health expenditures are progressive¹. Further goal is to achieve vertical equity (households of unequal ability should make appropriate dissimilar payments) and horizontal equity (households of the same ability should make the same contribution) which are then examined to see whether these have improved or worsened over time and why.

In this issue, Prinja *et al*² examine inequities in self reported health status, health service utilization and out-of-pocket health expenditures in Punjab, Haryana and Chandigarh using data from the 60th round of National Sample Survey. They chose the relatively richer States of India to assess the extent of inequity in health utilization among the rich and poor. Their focus was on utilization of public health facilities to ascertain the inequities in usage of public distribution systems. Bivariate analyses using concentration curves and concentration indices were used to describe health inequalities. Monthly per capita consumption expenditure was used as a proxy for income and five

quintiles were used to represent the continuum from rich to poor. They found that a higher proportion of rich reported morbidities compared to those in lower income quintiles. Hospitalization rates as well as out-of-pocket health expenditures, particularly outpatient expenditures showed a progressive distribution. However, catastrophic health expenditures were higher among the poor in Punjab and Haryana. Use of public hospitals and free wards were higher amongst the poor in two of the three States. Medicines accounted for a very high proportion of hospital and outpatient expenditures in the public sector in all three States.

Overall, the study finds inequities in self-reported morbidity, health service utilization, health care out-of-pocket expenditures and public subsidy utilization. Although the poor use public sector hospitals and health services more than the rich, persistently high out-of-pocket expenditures seem to be a deterrent for the poor from using these services. Part of the reason for high expenditures is high cost of medicines. A prior study by the same researchers³ found that using generic drugs and thereby reducing the cost of medicines led to an increase in utilization of public sector services. In order to improve inequities in health service use, the authors suggest incentivizing the use of public sector facilities among the poor, by keeping drug prices low and thus health expenditures low.

In a country like India where a large proportion of the population lies below the official poverty line, achieving health equity is an important goal to ensure the wellbeing and survival of the economically disadvantaged. However, this is far from realization especially with rapid privatization that has taken health care farther from the reaches of the poor. Prior to economic liberalization in 1991, inpatient care was mostly available at public hospitals. Even though these services were fraught with access and quality issues, the

poor could still access public inpatient and outpatient care. However, in the 1990s, user fee was introduced in the public health facilities. Outpatient facilities cropped up mostly in the private sector. This resulted in large socio-economic inequalities in access and affordability of health care and even public sector hospitals were used more by the better off. The poor were squeezed out of the public hospitals partly because there was not too much difference in costs between the public and private health facilities⁴. The finding in this study that the use of public sector health services was higher among the poor than the rich based on data from 2004 National Sample Survey is thus encouraging.

Despite an increased use by the poor, this paper reports that hospitalization and outpatient services at public health facilities are still very low in Haryana (30%) and Punjab (20%). The reasons stated are high cost of care including high cost of medicines. Deregulation of the pharmaceutical sector led to a flood of highly priced imported and branded drugs which further contributed to disproportionately high out-of-pocket health expenditures. This study suggests improving the use of public health facilities in order to reduce socio-economic inequities. The way to do this is to reduce out-of-pocket spending by the poor and make the health care system more progressive. However, progressivity in payments will still provide an incomplete picture as the poor may not seek care due to inadequate financial protection and lack of accessibility. Better risk pooling and prepayment mechanisms as well as increasing public expenditures to improve accessibility and quality of public health facilities are necessary⁵. A similar experience of deregulation and privatization of the health system in Vietnam showed regressive nature of health payments with disproportionate burden on the poor initially. However, with the subsequent introduction of free health insurance and health fund membership for the poor, the health system became less regressive⁶.

In the State of Punjab, the Punjab Health Systems Corporation encompasses public hospitals and community clinics through which the poor can access services. In 2008, two schemes were introduced

to reduce out-of-pocket expenditures for families below the poverty line. These two schemes were '*Jan Aushadhi*' where cheaper generic medications were made available through public health care centers and '*Rashtriya Swasthya Bima Yojna*' through which a family of five below poverty line would receive cashless treatment upto ₹ 30,000 per annum⁷. Further study to determine whether these schemes, similar to ones suggested in the study by Prinja *et al*², help in reducing health spending and increasing public sector utilization by the poor, is warranted. Further research on the extent of horizontal equity, with respect to age, gender, social class and health status, in these three States would add a valuable dimension.

Anoshua Chaudhuri

Department of Economics, College of Business
San Francisco State University
1600 Holloway Avenue
San Francisco, CA 94132, USA
anoshua@sfsu.edu

References

1. O'Donnell O, Van Doorslaer E, Wagstaff A, Lindelow M. *Analyzing health equity using household survey data: a guide to techniques and their implementation*. Washington D.C.: World Bank; 2008.
2. Prinja S, Kanavos P, Kumar R. Health care inequalities in north India: Role of public sector in universalizing health care. *Indian J Med Res* 2012; 136 : 421-31.
3. Prinja S, Aggarwal A, Kumar R. *Impact of decentralization and user charges on health systems and health services utilization in North India*. Chandigarh: PGIMER School of Public Health; 2008.
4. Sen G, Iyer A, George A. Structural reforms and health equity: A comparison of NSS surveys, 1986-87 and 1995-96. *Econ Political Wkly* 2002; 37 : 1342-52.
5. Roy K, Howard DH. Equity in out-of-pocket payments for hospital care: Evidence from India. *Health Policy* 2007; 80 : 297-307.
6. Chaudhuri A, Roy K. Changes in out-of-pocket payments for healthcare in Vietnam and its impact on equity in payments, 1992-2002. *Health Policy* 2008; 88 : 38-48.
7. Punjab Health Systems Corporation, Department of Health & Family Welfare, Govt. of Punjab. Available from: http://punjabhealth.co.in/RSBY_overview.aspx?ID=qpSQcDp5Dhw=, accessed on July 17, 2012.