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Subir Gokarn: Health care - how, where & how much?

Low access and high costs raise risks of a vicious circle between morbidity and poverty

Subir Gokarn August 09, 2015 Last Updated at 21:50 IST

In my previous column, I wrote about some patterns emerging from the National Sample Survey Office's (NSSO's) household survey on expenditure on education. The same round also queried expenditure on health by households. This column explores some findings from the 71st Round survey of social expenditures by households, carried out between January and June 2014.

By way of context, there are two critical issues that are common to both education and health care. The first is that, in the Indian context, universal access to quality education and health care has simply not been achieved. This is not to suggest that there have been no gains at all on both fronts. In education, primary school enrolment is almost universal. In the health domain, focused missions like small pox and polio eradication have succeeded and there has been substantial progress on the Millennium Development Goals of infant and maternal mortality. However, the overall sense is that quality is highly varied, costs of reasonable quality services are high and the success on individual parameters does not add up to a sense of systemic achievement.

The second relates to the social and economic costs of low access and inefficient delivery. In both the education and health domains, the consequences of inadequacy are felt over decades, even generations, and cannot be reversed in any significant measure. Whatever the legacy might be, it must remain a priority at all levels of government to find solutions that will provide widespread access and reasonable quality at reasonable cost.

The health expenditure survey provides data on a number of indicators. It covers about 66,000 households, with about 33,000 members across all states. In this column, I focus on three indicators under the broad rubric of access and cost; quality is not really possible to gauge from the survey responses.

The first is the kind of care that patients receive. The health administration distinguishes between allopathy and the omnibus category AYUSH, which clubs Ayurveda, Yoga, Unani, Siddha and Homoeopathy. The survey indicates that, for the country as a whole, 90.6 per cent of "spells of ailment" among rural males were treated by allopathy, while 88.7 spells among females were so treated. Only 5.3 per cent of the spells among males and 7.3 among females were treated by AYUSH. The remainder went untreated. In urban areas, 90.4 per cent of male spells and 91 per cent of female spells were treated by allopathy. Use of AYUSH was actually slightly higher for both genders than in rural areas.

This huge skew could reflect a number of things, many of which may provide a rationale for policy intervention in pursuit of the access-quality-cost trinity. It could be just the number of practitioners. But, it could also be the result of a lack of trust in the AYUSH practitioners. Regulation, licensing, skill upgradation and continuous monitoring are as much required for all health practitioners as they are for teachers. Safe and cost-effective treatments for many ailments could well be provided by AYUSH practitioners, either on a stand-alone basis or in hybrid arrangements. But, this will only happen if patients trust these alternatives. Putting a regulatory

framework in place that builds and sustains trust should be an integral part of a policy thrust on AYUSH.

The second indicator I want to highlight is the institutional source of health care services. On the public side of the delivery mechanism, there are Health Sub-Centres, Primary Health Centres and Public Hospitals. In the private sector, there are Private Doctors and Private Hospitals. Going by spells of ailment across both rural and urban areas, 7.9 per cent of male patients were treated in HSCs and PHCs and 16.4 per cent in Public Hospitals. Among females, the percentages were nine and 17.4. This again reflects a significant skew, this time towards the private sector. 51.3 per cent of spells among males were treated by Private Doctors and 24.3 per cent by Private Hospitals. Among female patients, 49.7 were served by Private Doctors and 23.9 per cent by Private Hospitals.

Narrowing it down to patients that required hospital treatment, the skew actually reduces somewhat, expectedly more for rural than for urban areas. Among all rural patients hospitalised, 41.9 per cent were treated in public hospitals, with the remaining 58.1 per cent using private ones. Among all urban patients, 32 per cent of all patients used public hospitals, while 68 per cent went to private establishments. There is, of course, significant variation across states and income groups, which the survey enables analyses of, but at the aggregate level, it would be reasonable to say that "private" trumps "public" in health care delivery.

Finally, I want to examine what people spend on health care. The raw numbers suggest that the average expenditure per hospitalisation case in rural areas was Rs 14,935 on medical expenses and Rs 2,021 on other expenses. In urban areas, it was Rs 24,436 on medical expenses and Rs 2,019 on other expenses. These numbers are not interpretable without some benchmark. The survey itself provides sample estimates by quintile for Usual Monthly Per Capita Expenditure by quintile. The bottom three quintiles in the rural sample are in UMPCE ranges of Rs 0-800, Rs 800-1,000 and Rs 1,000-1,264. The ranges for the bottom three quintiles among the urban sample are Rs 0-1,182, Rs 1,192-1,600 and Rs 1,600-2,200.

Assuming an average household size of five in both rural and urban areas, a rural household at the 60th percentile of the expenditure distribution would spend almost three months' worth of household expenditure on one hospitalisation. In urban areas, this number would work out to almost two-and-a-half months' worth. In the absence of comprehensive insurance, this is obviously a huge setback for even households that are well above the conventional poverty line.

In relation to the aspiration of widely acceptable health services at reasonable cost, at a national level, the survey data suggest that we have considerable distance to go. More public facilities are obviously one requirement, particularly in the rural areas. But, the constraints run much deeper. Inadequate treatment and care before a person needs to get to a hospital is a burden to both households and the system as a whole. This part of the system urgently needs to be strengthened.

The consequence of inaction is a vicious circle between morbidity and poverty.

The author is director of research, Brookings India and former deputy governor, Reserve Bank of India. The views are his own.