

**INCIDENCE OF NON-FATAL HEALTH OUTCOMES AND DEBT IN
URBAN INDIA**

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Abstract

Poor coverage of any health insurance programme and inadequacy of public health care system has made India a country where out of pocket expenditure for seeking health care contributed to 75 % of total expenditure on health care. Such a high level of spending on health care affects drastically the economic security of the ailing persons household. This paper tries to study the above phenomenon by analyzing the household level financing of hospitalization care services in urban India using the 52nd Round National Sample Survey Data Sets. Data on source of financing for 12,437 persons who were hospitalized during last one year prior to the survey date has been analyzed for this. Results showed that about 25 percent of households were meeting expenditure on inpatient care of a member through sale of animals/ sale of ornaments/ sale of physical assets/ borrowings. The percentage of households falling into debt trap because of incidence of hospitalization was 30 percent if treatment was sought from private health care sector and 20 percent if treatment was from public health care sector. Class differentials showed that the proportion of the ailing person's households falling into debt increased between richest and poorest subgroups from 17 percent to 26 percent if treatment was sought from public sector and from 23 percent to 41 percent if treatment was sought from private sector. Though the overall coverage of health security schemes are very low, the paper shows how the households covered under such schemes are benefited from it.

INCIDENCE OF NON-FATAL HEALTH OUTCOMES AND DEBT IN URBAN INDIA

The burden of health care in India is inversely related to economic status of the household and the poorer households are found to be victims of inefficient health care system (Visaria and Gumber, 1994; Gumber, 1997). It affects their already thin household budget in terms of payments made for treatment as well as through inability to earn during the period of illness. Though health expenditure in India is approximately 6 percent of GDP, the health care spending (excluding water supply) by the government is only 1 percent of GDP and the remaining 4.6 percent is spent privately i.e. by individuals or households (Gill and Kavadi, 1999). Another analysis on health expenditure by household (Shariff, *et al.* 1999) showed that about 6 percent of household income is being spent on curative care which amounts to rupees 250 per capita per annum. Estimates show health expenditure as a percentage of annual income was found to be varying from 3 percent in the richest 20 percent of the households to 12 percent in the bottom 20 percent of the households (Gumber 2002). This type impact of expenditure on health care is likely to affect economic condition of the household, and more drastically on the poorer households making them even poorer.

Health care sector has changed during last two decades with increasing role of private sector that has become the major provider of both inpatient and outpatient care treatment. Decline in utilisation of public health care services is mainly a function of decline in public health investment (Duggal 1997; GOI 2001) during the same period. Researchers have noted that the privatisation of health care could result in decline in access to health care among poorer section, poorer regions and poorer states in India (Krishnan, 1999). It has been pointed out that the private sector has not been restricted to upper and middle classes alone but is used by even poorer classes. Studies have shown non availability of public health care services is forcing poor to seek care from private sector, even if they are interested in seeking care from public sector (Dilip and Duggal 2002).

Information on health care expenditure has been gathered in a number of studies in India. Average expenditure on medical care was found to rise with monthly per capita consumer expenditure or household or per capita income of household (NSSO, 1992; Visaria and Gumber 1994; Rajarathnam, *et al.* 1996; Visaria, *et al.* 1996; Satya Sekar, 1997; NSSO, 1998). At the same time the medical care expenditure made by a poor household in comparison to its expenditure/earning potential is much higher than that of rich household (Kannan, *et al.* 1991; Visaria and Gumber, 1994; Visaria, *et al.* 1996; Kunhikannan and Aravindan, 1999; and Krishnan, 1999). Therefore health care market in the country is functioning in such a way that expenditure on medical care being dependent on ailing persons economic background and not on the ailment.

The burden of health care will be more among sections that do not come under any health insurance scheme. Only 10 per cent of India labor force is in organised sector and a large part of these 27 million employees and their families have access to insurance/medical benefits to cover the treatment costs (Gill and Kavadi, 1999). Even many of the employees in private sector are insured comes under the above schemes. The NSS data (Visaria, *et al.* 1996) showed a the insurance scheme enrolment rate for to be negligible in all the five states in India. There are researchers who consider that about 10 percent of households in India are support from different agencies for medical treatment (Peters D. H. *et al* 2002), which seems to be an over estimate. Not only is the enrolment in insurance schemes low, the willingness as

well as ability to participate in such schemes is low. For eg, a study in Delhi showed that most low and many middle income households considered the premium beyond their reach and even the middle income groups thought that there is no need to for such schemes as they had no major illness (Gupta, 2000). But there are studies from other regions pointing out the willingness of the population to participate in health insurance schemes (Mathiyazhagam, 1998; Gumber and Kulkarni, 2000). But these schemes are yet to become popular. The major factor towards lack of interest of insurance companies to voluntary medical insurance is because of low profitability, high risk and lack of demand (Gumber 2002). Therefore the present absence of collective payment mechanisms seems to inflate the burden of medical care in the country.

Health and health conditions in urban areas are different from the average Indian scenario. Statistics clearly show that the bed population ratio is higher in urban areas than in rural areas and that there has not been any significant decline in these disparities over time (Duggal *et al* 1995). This regional imbalance is there in government owned public sector and in the non government owned private sector. Further the public spending on health care is also disproportionately higher in urban areas. However, while critiquing the regional bias it is examined whether the urban areas in India where 22 percent of the population is residing in slums has the required number of public health care facilities? High rate of growth of urban population and consequent increase in population residing in slums has lead to over straining of infrastructure and deterioration in public health (Gupta and Mitra 2002). This makes this community more vulnerable to diseases of poor. Though urban areas are comparatively much better than rural areas in terms of health indicators, survey based information shows wide inequalities in accessing services within the urban context (IIPS and ORC Macro 2001; Sundar and Sharma 2002).

The present study examines how expenditure on health care affects economic condition of the ailing person's household, by analysing source of financing of health care services. Here we have included only inpatient care treatment because the expenditure on inpatient care is so high enough to push ailing persons family into poverty (Peters *et. al.* 2002). Another limitation is that we are considering only direct medical expenditure. The effect of indirect expenditure like travel, wages lost etc is even higher, but collection of this data is virtually impossible using one year recall period.

Data

The present analysis is based on the enquiry on morbidity and health care conducted in the 52nd round (July 1995-June 1996) survey of the National Sample Survey Organization. A total number of 49,658 households were surveyed in urban areas (NSSO 1998a). Details of utilization and expenditure pattern for each episode of hospitalization during one-year reference period were collected from these households during the survey. The data sets provides information on 'medical expenses' incurred on treatment for each episode of illness, which includes expenditure on items like medicines, bandages, fees paid for medical or paramedical services, fees for diagnostic tests and charges for operation therapies. Non-medical expenses are also covered in the survey. Information on source of financing like current income, past saving, sale of assets (ornaments/ornaments/land), borrowing, employer, other agencies and other sources were recorded in the survey. Data on source of financing of inpatient care treatment is used to understand the prevalence of hospitalization associated debt in the population.

Table1: Details of sample 52nd Round of National Sample Survey, Urban India 1995-96

	Size
Urban blocks surveyed	4991
Households surveyed	49,658
Population covered	249,003
Non hospitalized ailments covered	13937
Hospitalization cases covered	12497

Methods

Information on average monthly consumer expenditure (MPCE) of household, based on data collected for broad heads of consumption expenditure was used to classify the households/population into different economic class groups. Here consumption expenditure includes food, clothing, footwear, medical, education, transport and amusements. Based on this average monthly consumer expenditure the households were classified into MPCE quartile groups (i.e. 0-25, 25-50, 50-75 and 75-100), with 0-25 representing poorest quartile and 75-100 the richest quartile respectively.

The main variable which determines the out of pocket expenditure on health care ‘Source of treatment’ was classified into public and private sector based on their ownership. Here public sector includes public hospital, Primary Health Center/ Community Health Center (PHC/CHC), public dispensaries and Employees state Insurance (ESI) doctor and private sector comprises of ‘private hospitals, private nursing homes and charitable institutions. Another important variable influencing expenditure is duration of hospitalization. This variable has been classified into three categories: 1-4 days, 5-9 days and 10 + days, to capture the variations in burden of debt by duration of hospitalization.

Data on total expenditure incurred on treatment of each episode of ailment is used for studying class differentials in expenditure on medical care. It includes both medical expenses and other non-medical expenses incurred by the household in connection with each episode of inpatient care treatment during the reference period. For assessing health expenditure induced debt in the study population, the sale of physical assets and borrowing is treated as debt. The rationale behind including sale of assets in debt category is that ‘it is a desperate act out of inability to pay for health care through other alternative sources.

Along with this the relative burden of debt is examined by taking the ratio of average amount raised through sale of assets/borrowings as a ratio of average medical expenditure on treatment of ailment.

Debt-Medical Expenditure Ratio =

$$\frac{(\text{Total amount raise through borrowing or sale of assets}) * 100}{\text{Total Medical Exp on Hospitalisation}}$$

Ratio varies from 0 to 100 and represents amount raised as debt in comparison with total medical expenditure. This will be useful in understanding the class differentials in debt levels by source of treatment, duration of hospitalization and other subgroups of population.

Results

Since the study is on expenditure on health care induced debt, a preliminary analysis of economic inequalities in utilization of and expenditure on health care is necessary. Results of the analysis along with that of inpatient care induced debt is presented below.

Morbidity and hospitalization

Table 1 shows that ailments were reported during this 15-day reference period at a rate of 54 per thousand population. Class differentials were marked, as there was a consistent increase in reported ailments with every increase in MPCE quartile group. Reported morbidity rates increased between lowest and highest MPCE quartile groups from 44 per thousand population to 67 per thousand population in urban India.

Table 2: Morbidity rate and annual hospitalization rate (rate per 1000 population) by MPCE groups, Urban India 1995-96

MPCE quartile	Morbidity ¹	Hospitalisation
0-25	44	13
25-50	52	17
50-75	56	19
75-100	67	30
Total	53	19

¹15 day recall period

This type of negative relationship between economic background and reported health status is usually observed in morbidity data based on cross sectional surveys. But class differentials was observed in the case of hospitalization, an event which is relatively free from underreporting of ailments associated with reporting of morbidity. Annual hospitalization rate increased from 13 per thousand population to 30 per thousand population in urban areas, between lowest and highest MPCE quartile groups. This is mainly because of under utilization of health care services, as earlier it was seen a certain amount of under reporting of morbidity among poor. Under reporting of ailments could be justified by linking it to low level of willingness to perceive illness and seek care arising out of their poor economic background. In urban areas where the physical accessibility is not such a big issue, the under utilization of hospitalization observed above is mainly due to their lack of resources to meet health care expenses. The top quartile in India is the class which is above subsistence and has significant purchasing power and hence this sudden jump in hospitalization rates. Other quartiles are subsistence or poverty levels.

Untreated ailments

About 9 percent of ailments remained untreated in urban India. Untreated ailments were reported to be higher in lowest MPCE quartile groups, when compared to highest MPCE quartile groups (Table 3). Share of untreated ailments was a low of 6 percent in highest MPCE group and a high of 13 percent in lowest MPCE groups.

Table 3: Percent of ailments which were not treated by MPCE fractile groups, India 1995-96

MPCE quartile	%
0-25	13.2
25-50	7.9
50-75	6.4
75-100	5.8
Total	8.5

This reiterates the earlier observation that decision to seek treatment is widely influenced by the ailing persons financial capacity to seek medical care.

Source of inpatient care treatment

The percentage utilizing health care services in public sector and private sector for inpatient care treatment was 43 percent and 57 percent respectively (Table 4). The economic background of the ailing person is a crucial factor that determines source for utilization of inpatient care services. Proportion utilizing inpatient care services from public sector increased from 28 percent in the highest MPCE quartile group to 61 percent in the highest MPCE quartile group. In the private sector it was reversed.

Table 4: Percentage distribution of preferred source for inpatient care treatment by MPCE quartile group and duration of hospitalization, Urban India 1995-96

MPCE quartile Group	Duration hospitalization						Total	
	1-4 days		5-9 days		10+ days		Public sector	Private sector
	Public sector	Private sector	Public sector	Private sector	Public sector	Private sector		
0-25	57.5	42.5	57.5	42.5	70.0	30.0	60.8	39.2
25-50	42.0	58.0	43.2	56.8	63.0	37.0	48.3	51.7
50-75	34.7	65.3	38.6	61.4	49.8	50.2	40.3	59.7
75-100	24.2	75.8	25.5	74.5	34.2	65.8	28.3	71.7
Total	38.9	61.1	40.5	59.5	50.9	49.1	43.1	56.9

Analysis by duration of hospitalization gives a full picture about the preference for utilization of health care services. It is observed that services in public sector are preferred for long duration ailments that are costly. The proportion who utilized services in private sector declined from 61 percent for ailments requiring a stay of 1-4 days to 49 percent for those requiring stay of 10 or more days. Even a sizeable proportion among the rich were found to be shifting to public health care services for long duration ailments.

Expenditure on Inpatient Care Treatment

Average of total expenditure incurred (including non-medical expenditure) on treatment of an ailment is presented in table 5. The average expenditure was rupees 3990 per episode of hospitalization. Expenditure was found to be 2.4 times higher in public sector than in private

sector. Average expenditure was found to increase with every increase in MPCE quartile group and that too very sharply in 75-100 MPCE quartile group. Average expenditure varied between lowest and highest MPCE quartile groups from rupees 1087 rupees to rupees 8789 in urban areas.

Table 5: Average expenditure (in rupees) on each episode of inpatient care treatment by source of treatment, MPCE quartile groups and duration of hospitalisation, Urban India 1995-96

Duration of hospitalisation	Source of Treatment	MPCE Quartile group				
		0-25	25-50	50-75	75-100	Total
1-4 days	Public sector	389	509	990	1342	712
	Private sector	868	1492	1602	3337	2020
	Total	593	1079	1389	2853	1511
5-9 days	Public sector	666	953	1619	3445	1452
	Private sector	1643	2650	3305	6733	4071
	Total	1081	1916	2655	5893	1520
10+ days	Public sector	1140	2205	2889	11236	4265
	Private sector	3475	5097	6696	19526	12212
	Total	1842	3275	4800	16687	8165
Total	Public sector	704	1235	1860	6259	2198
	Private sector	1681	2574	3396	9789	5347
	Total	1087	1928	2778	8789	3990

1 US \$ = Rupees 42 in 1996

Table above shows that the rich are spending more on medical care, which was found to be true even for public health care sector. This further adds to the earlier observation that that the rich are preferring public sources of treatment for treatments that are relatively expensive. Earlier it was observed that the level of utilization of health care services from public sector was relatively lower among high MPCE groups. Poor will be spending lesser if they are going to public/private sector while rich are spending more even if they are going to public sector. Also accessing services in public sector are not without costs and patients were spending substantial amount out of pocket if they are treated in public sector.

Source of financing for Inpatient care treatment

Reported sources through which the health care services has been financed is presented in table 6. It can be seen that 37 percent had utilized their past saving for treatment while 2.5 percent sold physical asset and 23 percent had to borrow money from different sources to meet their inpatient care treatment expenses. A look at class differentials indicates that the potential to meet medical expenditure through past saving increases with increase in economic back ground, while the chances of borrowing/sale of physical assets increases with lower economic backgrounds.

Table 6: Source of financing of inpatient care treatment by MPCE group, Urban India 1995-96

	Current Income	Past Saving	Sale of physical assets	Borrowings	Others
0-25	38.6	24.4	2.5	27.1	7.6
25-50	40.3	31.7	2.6	25.4	6.9
50-75	42.1	37.1	2.4	21.9	8.3
75-100	39.5	51.0	2.4	18.7	11.1
Total	40.2	37.2	2.5	22.9	8.6

The above table only gives a general idea about sources through which health care expenses had been financed. To have a better understanding about the amount raised through different sources, contribution of each source of financing has been calculated on the basis of reported amount raised through various sources (Table 7).

Table 7: Percentage distribution of contribution of each source towards medical expenditure incurred during hospitalization by MPCE quartile group, Urban India 1995-96

Source of financing	MPCE Quartile group				
	0-25	25-50	50-75	75-100	Total
current income	19.3	19.8	18.7	10.4	13.3
past savings	26.1	30.7	37	39.2	37.2
Sale assets	4.4	4.8	3.3	4.8	4.5
Borrowings	34.9	36.1	30.6	21.9	25.6
Other sources	12.5	6.2	7.3	11.1	10
Employer	0.8	2	2.6	11.9	8.7
Other agencies	2	0.5	0.4	0.7	0.7
Total	100	100	100	100	100

Note : Table is based on reported expenditure in rupees from different sources

The above table shows that though current income has been used by 40 percent (see Table 6), it contributed only 13 percent of the amount raised for treating an ailment. Past savings contributed to 37 percent of the expenditure. About 26 percent and 5 percent had to depend on borrowing and selling of physical assets respectively. It is evident that the major share of amount spent by the poor comes from borrowings/ sale of assets, while major share of expenditure made by rich comes from past savings. Share of 'employers/other agencies' together was 3 percent for lowest quartile and 13 percent for the highest quartile group.

Hence there is strong evidence to believe that expenditure on inpatient care treatment is pushing many households into debt. Now we look into details of health expenditure induced debt in the study population. Here sale of physical assets and borrowing is treated as debt.

Average Debt Incurred

The table below gives class differentials in amount raised through sale of physical assets/ borrowings. The average debt incurred per episode of hospitalization was rupees1140.

Table 8: Average amount raised through sale of physical assets and borrowings for inpatient care treatment, Urban India 1995-96

MPCE Class	Source of treatment		
	Public sector	Private sector	Combined
0-25	256	558	374
25-50	360	996	689
50-75	515	1055	837
75-100	1846	2501	2315
Total	654	1509	1140

The average amount was found to be higher if treatment was from private sector than if treatment was from public sector. Also the average debt is found to increase with every increase in MPCE class, in both these sources of treatment. In short the average amount raised through borrowings/sale of physical assets shows similar relationship with as the average expenditure on medical care.

Relative Amount Taken as Debt

Since there has been a positive relationship between both medical expenditure and debt incurred with economic background of hospitalized person, it was felt necessary to find out the relative amount raised through debt. Since the radix was 100, the ratio value ranges from 0 to 100, though it does not represent percentage in real sense.

Table 9: Ratio average debt amount to total medical expenditure on inpatient care treatment, Urban India 1995-96

MPCE Group	Source of treatment		
	Public sector	Private sector	Combined
0-25	45.5	33.3	40.7
25-50	24.1	31.0	27.7
50-75	19.4	23.9	22.1
75-100	14.0	20.9	18.9
Total	27.5	25.8	26.5

Ratio shows that the amount raised through sale of assets/borrowings in comparison to total medical expenditure is much higher among lower class groups than upper class groups. The ratio varies from 41 in lowest MPCE class while it was only 19 in highest MPCE quartile. Ratio value was found to decline with every increase in MPCE class in both public and private sector. The fact that only very small proportion are preferring public sources of treatment might have lead to a relative amount was higher in public sector than private sector for 0-25 quartile group.

Burden of Debt

Since there has been severe class differentials in expenditure on medical care and relative debt amount, it was necessary to find out the ability of different classes to recover from debt. This depends on their income level, whose information is not available. Here we have used MPCE of the household as a proxy for income level. Hence MPCE-debt amount ratio can be

used to study this. But throughout the study we have seen that medical expenditure to be increasingly dependent on income/levels and hence the debt amount. Therefore the ratio has been standardized by multiplying it with medical expenditure. This debt recovering potential index is measured as

Debt recovering potential index

$$= \left[\frac{\text{Monthly per capita consumer exp of the household}}{\text{Total amount raised through borrowings/sale of assets}} \right] \times \text{Total medical expenditure}$$

It is to be noted the index values have been computed for inpatient cases where borrowings/sale of assets have taken place. Though the values does not have any meaning as such it helps in accessing the amount raised as debt in comparison to their income levels. Here higher the value higher will be the potential to recover from debt incurred and vice versa.

Table 10: Potential to recover from debt by source of treatment and MPCE class, Urban India 1995-96

MPCE Class	Debt recovering potential index		
	Public sector	Private sector	Total
0-25	305	419	360
25-50	547	549	548
50-75	718	1541	1285
75-100	2576	2100	2214
Total	826	1228	1083

Index value shows potential to recover from debt incurred during hospitalization more than 6 times higher in richest quartile (2214 points) than in the poorest quartile (360 points). This clearly indicates that though the debt amount is lower among poor, the time taken by them to recover from it is very much higher than that for richer groups. The burden of debt seems to be relatively lesser for those treated in private sector than in public sector. Perhaps the low debt recovering potential itself might have made them choose public sector instead of private sector. It seems that except in 75-100 MPCE groups debt recovering potential was higher in persons treated in private sector than in private. Low value for public sector in 75-100 mpce quartile group is due to preference for public sector for long duration ailments. This table also gives reason why people are preferring different sources of treatment.

Role of Insurance sector

The proportion of persons who received some support from employer/ other agencies for treatment is given in table below. The support that they received ranged from covering of partial expenses to full expenses.

Table 11: Percentage who received support from employer/other agencies for inpatient care treatment Urban India 1995-96

MPCE Class	Percentage
0-25	2.3
25-50	3.6
50-75	5.1
75-100	11.1
Total	5.9

Overall only about 6 percent of the inpatients have received some support from any agencies for treatment of ailments. Class differentials varied from about 2 percent in lowest quartile to 11 percent in highest quartile. It indirectly shows the over all coverage of these schemes to be higher in rich than poor and one reason for higher hospitalization rates (Table 2) observed above among rich may be due to this.

Table 12: Support from employer/ insurance agencies for treatment and debt-medical expenditure ratio, by MPCE Class, Urban India 1995-96

MPCE Class	Debt-Medical Expenditure ratio	
	Without support	With support
0-25	40	27
25-50	27	15
50-75	22	12
75-100	19	19
Total	26	18

Only direct expenditures are covered by these agencies and one can expect that chances of debt still remain to cover the indirect expenses associated with hospitalization. The above table suggests that the amount raised through sale of assets/ borrowings in comparison to total medical expenditure to be much lower among people who received support than those without support. Other notable factor is that class differentials in debt-medical expenditure ratio are less sharper among those with support than those without support.

Discussion

Initial analysis captured the rich-poor divide in urban India in terms of utilization of and expenditure on health care services. Unlike in rural areas it is not a question of unavailability of health care services in urban areas, but it is of differential access to health care services between communities living in the same neighborhood. Lack of mechanisms to regulate prices and inadequate support from health insurance sector has added to their woes. On one hand the public health care services are suffering from lack of infrastructure facilities and staff (IIPS 2001), resulting in a high expenditure on treatment in public sector. Health care system in recent years has developed in a direction which enables the rich to utilize the elite higher level services, while the poor access largely the basic services in the public sector. Results of expenditure and utilization pattern shows present health care system provides user

with options/choice (general ward, pay ward and paying special) for spending within both public and private health care system. This is a dangerous trend especially in the case of public health care system which essentially gets reflected in the expenditure incurred by each user.

Expenditure on medical care seems to have a negative impact on economic condition of the households. Borrowing/ sale of assets is widely prevalent in all classes of the study population. But the amount borrowed in comparison to amount spent on treatment was higher among poorer sections than the rich. Impact of such borrowing was also found to be remaining for a longer period on these poor sections where debt recovering potential is lower than their counterparts who are relatively rich. Risk of falling into debt might have been the barrier between poor and hospitalization care services, leading to a low over all level of hospitalization among them.

Lack of coverage from Insurance sector for support of treatment was another issue as only 6 percent of the patients received some sort of support from either employer/ insurance agencies. Though it was partial support in majority of the cases, the debt levels were relatively lesser among the persons with support than those without support. The paper addresses the urgent need to develop better collective payment mechanisms for covering medical expenditure.

Health care needs of the urban poor could only be met through the strengthening of public health care system. This is because, bringing the poor under the purview of insurance schemes is a distant reality. However, even if there is a felt need for health care services, one reason cited against public investment on health care is that it is the rich who benefit from public spending more than the poor. Such arguments have gained strength through a benefit incidence analysis, which showed that it is rich who benefit from tertiary level hospital services (Mahal *et al* 2001). Though the over all utilisation of resources is more among the rich than poor, the intensity of utilisation of public health care services by poor is much higher when compared to rich. As compared to the rich the poor are having low levels of hospitalisation rates, full- immunization and institutional delivery (NSSO 1998a&b). Benefit incidence analysis did not take into account class differentials in: hospitalisation levels for inpatient care, full immunisation of children and level of institutional deliveries. Results of the analysis would have been other way around if the benefit incidence model had been standardised for these three items. Therefore in the present situation a decline in investment in the public hospital sector or a hike in user fees in public health care facilities on the basis of the above argument is both dangerous and anti-poor. The poor report lower prevalence and have lower utilisation rates because of lack of purchasing power in a health care market that is largely dominated by private care. If public services are strengthened and access for the poor to these services improves prevalence and utilisation rates for the poor will also go up and the class differentials we now see will also diminish if not disappear.

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