Out of Pocket Expenditure and Health Seeking Behaviour in Uttar Pradesh

A Study by SIFPSA

The objective of universal health coverage (UHC) is to ensure that all people obtain the health services they need, without suffering financial hardships when paying for them. Availability of valid, reliable and comparable information on out of pocket expenses on health is critical for developing health policies, managing programme implementation and evaluating efficiency and performance. The study commissioned by SIFPSA, brings to light several health care financing gaps needing urgent attention and program intervention towards providing accessible, affordable and quality health care to the population.
The World Bank defines out-of-pocket expenditures as any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, transport costs for accessing healthcare and over-the-counter medicines, goods and services, the primary intent of which is to contribute to the restoration or enhancement of health status (World Bank, 2011). Healthcare finance in developing nations is mainly attributed by out-of-pocket expenditure for health and indicative of inadequate health insurance coverage for community. In many cases, borrowing money is a common source of funds to meet healthcare cost. The impact of borrowing on households can be very severe, often leading to huge indebtedness. The private sector plays a vital role in the provision of health care services in India and due to lack of affordable and adequate health insurance protection, it is primarily funded through out of pocket payments. A WHO 2012 study reveals that India was at third rank in the south-east Asia region with highest out of pocket expenditure on health. Nearly 60 percent of the total health expenditure in India was estimated to be out-of-pocket as compared to 65 percent in Bangladesh and 82 percent each in Myanmar and Afghanistan. Developed nations on the other hand incur much less out-of-pocket expenditure on health with Netherlands, France and the United Kingdom spending 6, 7 and 10 percent respectively.

Evidence shows that the out-of-pocket cost burden falls most heavily on patients who are least able to bear it, both in terms of their health and their income. A household’s health expenditure is considered catastrophic if the ratio between the household’s out-of-pocket health expenditure and its disposable income reaches a certain critical point; commonly used thresholds include 40% of capacity to pay, or 10% of total expenditures (World Bank, 2011). Catastrophic health expenditure (CHE) is where the burden of out-of-pocket health expenditure has reached a certain level that a household must forgo expenditure on the needs of basic living in order to meet the medical expenses for one or more of the household members, thereby pushing the family into poverty or into the debt trap. On average, health expenditure accounts for six percent of the household consumption expenditure in India. This ratio is slightly higher i.e. seven percent in case of Uttar Pradesh.

The problem of catastrophic and impoverishing health payments has captured policy attention and has led to major legislation and system reforms. The National Health Mission (NHM) launched by GOI is one such attempt towards providing accessible, affordable and quality health care to the population, especially the most vulnerable, thereby reducing out-of-pocket expenditure and moving towards universal health coverage.

Availability of valid, reliable and comparable information on health seeking behaviour in light of privately incurred health expenditure (out of pocket expenses on health) is critical for developing health policies, managing programme implementation and evaluating efficiency and performance. SIFPSA commissioned a study to understand the dynamics of out of pocket expenses and health seeking behaviour in Uttar Pradesh. The objective of the study was three pronged - to understand the health seeking behaviour of the community, to determine the quantum of health expenditure and to understand the source of financing for out of pocket expenses in the state. The study was conducted by the Population Research Centre (PRC) of Lucknow University in FY 2015-16. A multistage stratified sample design was applied to randomly select 10 districts from five agro-climatic (economic) regions of Uttar Pradesh to address the geographical and socio-economic differentials of the state. The districts selected were Banda, Fatehpur, Jhansi, Kannauj, Kanpur Dehat, Meerut, Pilibhit, Shamli, Siddharthnagar and Sultanpur. The sampling villages and urban blocks were selected using population proportional to size technique. Door to door household listing was performed to generate a frame of households and to perform third stage stratification based on characteristics such as households having an incidence of critical non communicable disease (NCD), those experienced hospitalization in past 365 days, those who had a child birth in past 365 days and households with incidence of mortality in the past 24 months. The primary data was collected from 7205 sampled households, using structured schedule, between August-October 2015.

The study has been successful in obtaining wide variation in results across all key attributes. The essential background characteristics of the sample population studied revealed that there were 14
percent households having at least a member with regular wages and salaries. Nearly half the households were found to be living in pucca houses; three quarters had ration cards and two thirds were found to be having access to electricity. Out of ten, nine households reported having bank accounts. Only one out of six households reported having Kisan Credit Card. Nearly one-third households had access to safe drinking water, 45 percent used toilets, and a quarter had covered drains around their houses. Mean per capita expenditure for the state was estimated to be Rs 2072. Around 64 percent of the households fell into low SLI category. About 20 percent households had life insurance coverage but health insurance was as low as 6 percent in the state.

In terms of fertility trend and health seeking behaviour the results revealed that on average 2.71 children were ever born to the respondents, of which 2.54 survived. Among the children ever born, mean number of males was 1.46 and females 1.27 per woman indicating skewed sex ratio at birth in favour of male child. About 44 percent respondents believed the number of children a couple should have must not exceed two while 25 percent believed a couple should have three children, followed by over one fourth recommending four or more children, one of the reasons for recommending high number being preference for a son. On an average, desire for sons was found to be 1.7 sons per household as compared to 1.3 daughters per household. Various combinations may be tried to understand this phenomenon but the additional desire for 0.4 sons describes the extent of son preference. In other words, 35 percent households indicated their desire for more sons.

Four-fifths of women had registered for antenatal care (ANC) for their last delivery. Of these, 85 percent had registered in a government health facility. Proportion of three or more ANC visits was found to be 40 percent while four or more ANC visits dropped to 20 percent. Similarly, the incidence of institutional delivery was estimated to be 69.6 percent with 58.1 percent being in government health facilities and remaining (11.5%) in private health facilities. Overall, proportion of safe deliveries was computed to be 72.9 percent, with 79 percent of those who had delivered at a government institution reporting to have received JSY benefits. The presence of Accredited Social Health Activists (ASHAs) was acknowledged by 91 percent of the respondents, 84 percent of whom recognized them as being useful and supportive.

As per the responses, more than 50 percent of the household members go to government health facilities for treatment. Attempt was made to understand from the remaining 48.4 percent households, the underlying reasons for not visiting government health facilities. Three-fourth respondents reported that longer waiting times prevented them for going to government health facilities followed by unavailability of drugs (71%), absence of facilities (68%), poor quality of care (64%), no adequate infrastructure being available (60%) and non-availability of health personnel (54%). There is not much variation in availing government health facilities by social groups and religion signifying that preferences to go or not to go to government health facilities may be guided by reasons as specified above. Of those who availed treatment in the private sector, 80 percent went to a qualified private sector provider/hospital, while remaining 20 percent approached quacks, faith healers or drug stores/pharmacies for treatment.

Persons reported to be ailing from the past one month was estimated to be 4.8 percent. The incidence of ailment was 4.1 percent for males and 5.5 percent for females. Persons reported to be hospitalised in the past one year was estimated to be 13.1 per thousand (12.4 males and 13.9 females), which was 13 per 1000 in rural and 14 per 1000 in urban. As expected, the incidence of hospitalization increased with age.

The average per person out of pocket expenditure for households having an ailing member (non-hospitalization/OPD expenditure) was estimated to
be Rs 469 per month. Major proportion (53%) of OOPE was on medicines followed by 19 percent on doctor's fee, 14 percent on lab tests, 14 percent on X-ray and other miscellaneous expenditures. The expenditure was 53 percent higher in private facilities (Rs 597) compared to the government health facilities (Rs 272). More than half of the OPD care expenditure was on medicines with proportion of 57 percent in rural areas and 40 percent in urban areas.

The average person out of pocket expenditure for households having a hospitalised member was found to be Rs 18607. The expenditure was marginally higher in urban areas (Rs 19459) as compared to rural (Rs 18368) and as expected, this increased with households with higher SLI. Nearly half (48.4%) was spent on medicines, followed by 15 percent on hospital/nursing home charges, 14 percent on lab tests, 7 percent on doctor’s fee and 9 percent on others miscellaneous expenses. The expenditure significantly varied between government (9983) and private (21112) facilities with latter having more than twice as much expenditure.

The monthly per capita consumption expenditure (MPCEs) for Uttar Pradesh is estimated to be Rs 2072 which is marginally lesser in case of rural UP (Rs 1972) as compared to urban (Rs 2489). The monthly per capita expenditure on health care in UP is estimated at Rs 155 of which 125 was spent on OPD care and Rs 30 on in-patient care. This accounts for 7.5 percent of MPCE on health care, which is higher than the national average. The share of health care expenditure is 7.8 percent in rural areas and 6.6 percent in urban areas and tends to increase with capacity to pay.

Since the healthcare expenditures are often non-negotiable in nature and pose challenge to households, the expenditure on healthcare is termed ‘catastrophic expenditure’ if it exceeds 10 percent of per capita consumption expenditure (MPCE). The study estimated that about 15 percent households have had catastrophic health expenditures in last one year. The catastrophic expenditure was reported to be higher amongst SC/STs, Muslims, rural population and in western UP as compared to rest of the population. It is believed that critical illness (NCDs) is often a key contributor to catastrophic health expenditure. The survey revealed that about 6.3 percent households reported incidence of specified (critical) NCD within past five years. Costs of per person treatment of these NCDs were estimated to be Rs 1.35 lacs. Costs in private facilities were 43 percent higher than that of government facilities. In total 1.1 percent of surveyed households reported that they had to sell some asset for meeting health care needs. Of these, most did it for treatment of critical illness (NCDs). Likewise 2.1 percent of surveyed households reported that they had taken loan for meeting health care needs, mainly for treatment of critical illness (NCDs). A negligible proportion of 0.10 percent of surveyed households reported receiving any assistance for meeting health care needs.

Availability of valid, reliable and comparable information on out of pocket expenses on health is critical for developing health policies, managing programme implementation and evaluating efficiency and performance. The study serves exactly this purpose and brings forth many areas that need urgent attention and program intervention to reduce out-of-pocket expenditure on health.

The objective of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. This requires a strong, efficient, well-run health system; a system for financing health services with appropriate health insurance; access to essential medicines and technologies; and a sufficient capacity of well-trained, motivated health workers. The National Health Mission (NHM) is a genuine attempt towards reducing out-of-pocket expenditure and moving towards universal health coverage by way of extending accessible, affordable and quality health care to the population, especially the most vulnerable. Nevertheless, new strategies and approaches need to be adopted to counter the gaps that still exist, as revealed by the study.