# Public and Private Healthcare Institutions: Preference and Expenditure Pattern

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# Public and Private Healthcare Institutions: Preference and Expenditure Pattern

Kerala is recognised universally for its good health indicators. Long before India became an independent country, the Maharajas of the erstwhile kingdoms of Travancore and Cochin had made remarkable contributions in the domain of healthcare through specific policies and targeted efforts. Post independence, the unswerving governmental support for the welfare sectors until the middle of the 1980s served as a catalyst for the development of healthcare services in Kerala. This has reflected in the expansion of healthcare infrastructure in the state. Kerala is one of the few regions in the developing world that has achieved substantial progress in the realm of health. The state has substantial demographic morbidity, mortality, epidemiological and health transitions, which follow a pattern that is similar to many advanced countries. Kerala has become a model Indian state viewed in terms of low birth and death rates, low infant and maternal mortality rates, high life expectancy at birth and favourable sex ratio among other achievements. These have been made possible through a robust public healthcare system coupled with charitable medical institutions in the private sector. Surprisingly, the state realised these achievements, when it recorded low levels of per capita income and state domestic product.

In this context, the study aims to look into the factors influencing preference for private and public healthcare institutions and the difference in expenditure patterns in the public and private sectors. The paper is organised into four sections. Section I deals with literature survey, problems and objectives. Section II includes the methodology of the study. Section III deals with data analysis and Section IV takes up the policy implication and conclusion of the study.

# I

## Literature Survey

'Healthcare: Reaching out to the masses', a KPMG white paper, shows that over the last few decades, there has been tremendous improvement in the quality of healthcare services in India. This is illustrated by the significant improvement in healthcare indicators such as life expectancy at birth, infant mortality rate, maternal mortality rate etc over this period, which is a direct result of the improved penetration of healthcare services in terms of the increase in the number of government and private hospitals in India. Various studies have been conducted to assess the determinant of user choice of medical provider. A few selected studies are as follows.

National Sample Survey Organisation's (NSSO, 71st Round) 2015 report on key indicators of social consumption related to health in India pointed out that in 2014, 65.3 per cent of households depended on private hospitals for treatment, while only 34.7 per cent depended on public hospitals for treatment in rural Kerala. In urban Kerala, while 66.7 per cent of households depended on private hospitals for treatment, only 33.3 per cent depended on public hospitals. Private institutions thus dominate the field in treating inpatients in rural and urban areas. A steady decline in the use of government resources and a corresponding increase in the use of private resources over the previous three NSS rounds are evident in India, including Kerala.

Thilo Klein (2011) examines the preference for private healthcare services compared to public healthcare services. Past research has attributed this preference to a lack of accountability among public healthcare service providers, which can be observed in the lackadaisical attitude of the service providers, and the unavailability of even basic drugs in public healthcare facilities. It is stated that availability of medicines is the predominant factor that determines hospital choice for the poor. This paper disentangles user preference for the certain and uncertain components of expenses for medicines.

Dalal K and Dawas S (2009) examined women's opinions and reasons for the non-utilisation of public healthcare facilities, according to the categories of healthcare seeking in India. The respondents were asked why they did not utilise public healthcare facilities when members of

their households were ill, identifying their reasons with a yes/no choice. The following five reasons were of primary interest.

1. There is no nearby facility.
2. Facility timing is not convenient.
3. Health personnel are often absent.
4. Waiting time is too long.
5. The quality of care is poor.

This study concludes that improving public healthcare facilities with user-friendly opening time, regular presence of staff, reduced waiting time and improved quality of care are necessary steps to reducing maternal mortality rate and escaping the poverty trap due to sudden increase in healthcare expenditure.

A study by Koji NABAE (2003) showed that the state's fiscal crisis has affected the quality of healthcare provided in the public sector. A number of people the author interviewed mentioned that they preferred to utilise the healthcare services in the private sector because the care provided at the public sector did not satisfy them. They cited reasons such as shortage of medicines, inadequate/incompetent technology and the curt attitudes of doctors, even though services were provided free or at a minimum charge. Koji analysed the principal factors that have helped attain the high level of health status in Kerala. From the formation of the state, healthcare provision was one of the top priorities of the government, and the system was developed in a way that it incorporated both western and traditional medicines that were accessible to the people. A study titled 'Developments and Emerging Issues in Public and Private Healthcare Systems of Kerala' argued that most of the patients preferred to utilise private healthcare service because the care provided at the public sector did not fulfil them. Thus, the inefficiency of public facilities paved the way for the expansion of the private medical care setup in the state, which has resulted in the commercialisation and commoditisation of healthcare.

A state-specific study conducted by Kunhikannan and K P Aravindan (2000) stated proximity to private hospitals, lack of access to adequate care, drugs and doctors etc as the major reasons for the non-utilisation of government healthcare services. These reasons along with the

mushrooming of private hospitals created a biased perception of government hospitals. A study by Dileep T R (2009) revealed that the annual hospitalisation rate increased from 69 per 1000 population in 1986–87 to 126 per 1000 population in 2004. The proportion of individuals seeking care from private rather than government hospitals increased from 55 per cent in 1986–87 to 65 per cent in 2004.

Radha Thevannoor (2007) argued that with easy access and willingness to pay, the public preferred private healthcare services. Many borrowed from various private banking services for treatment in private hospitals, even when similar treatments were available in government hospitals. The perception that quality medical treatment is synonymous with private hospitals has deeply set in the public psyche. The answer to whether quality is assured in private healthcare centres calls for an assessment of these centres. Other findings on the preference for public versus private healthcare substantiate that in the traditional Kerala society, cultural and institutional factors determine the utilisation and non-utilisation of (public) healthcare services.

Fewer studies have looked into the impact of private hospitals on health expenditure. Some studies have worked out the total cost incurred by the patients during a specified period and others have touched upon the various sources of expenditure. NSSO (2015) report shows that the state reimbursed partly or fully 2 per cent of the expenditure on hospitalised treatment in rural areas. In urban areas, only 6 per cent of the expenditure on hospitalised treatments were reimbursed partly or fully by the state.

A case study by Varma (2009) on asthma patients in the Kochi Corporation offers a glimpse of the cost borne by such patients. Following the diagnosis, an asthma patient goes through various stages of treatment. Each stage involves different magnitude of direct and indirect costs. The direct costs comprise cost of medicines, doctors' fees, hospitalisation expenses, cost of clinical tests, transportation charges, injection cost, nebuliser cost and oxygen cylinder expenses. The researcher estimated the annual average direct cost to be around Rs 12,600 per year for a patient. The indirect costs include the number of working days lost to the disease, the loss of personal as well as family income, and other opportunity costs arising out of hospitalisation and treatment. Among the total number of patients interviewed for the case study, 36 per cent changed their jobs due to asthma, with 16 per cent of them reporting heavy work and frequent illness and 8 per cent citing their inability to travel as the reasons for changing jobs. Nearly 46 per cent of the working patients said that their personal income

declined up to 30 per cent due to their medical condition. Nearly 56 per cent believed that their personal income fell by 30–60 per cent. A whopping 96 per cent opined that asthma cut short their personal earnings up to 60 per cent. This study has not captured the aspect of indirect costs but an attempt is made to divide the total cost into out-of-pocket expenditure, insurance coverage etc.

## Research Problem

Kerala has a long history of organised healthcare system. When the state was founded in 1956, the foundation for a sound healthcare system had already been laid. Contemporary Kerala prides itself on an advanced healthcare infrastructure encompassing allopathic, ayurvedic and homoeopathic systems of medicine. The role of the allopathic system in Kerala's health infrastructure is considerable, as the maximum number of hospitals in the private and public sectors is devoted to it (Shiny, 2015).

Hospitals have come to play a significant role in the development of the health sector in Kerala. The growth of private hospitals in Kerala cannot be perceived as an independent phenomenon. The public health sector paved the way for the development of private healthcare services by sensitising the population to the need for sophisticated healthcare and thus creating a market for private hospitals. Factors such as growing incomes, high educational qualifications and increase in the number of aged population have contributed to this trend. The government continues to be in the lead in the training of all strata of health professionals that are largely absorbed by the private sector.

With rapidly expanding population and inadequate healthcare facilities in government hospitals, private hospitals have gained the upper hand in the healthcare scenario of Kerala. Even though there are many government hospitals catering to the local populace, the services rendered are inadequate in terms of quantity and quality.

The emergence of a robust market for private healthcare is in response to either arising demand for healthcare, which is not fulfilled by the government, or a strong preference for private institutions. Whether the mushrooming of private hospitals has had any impact on health expenditure is to be explored in the context of a serious dearth of studies on the subject matter. This paper intends to identify user priority in selecting a particular hospital for treatment. The paper also aims to analyse the proportion of patients willing to approach a

private or public hospital for treatment. It explores the factors affecting the users' preference and the expenditure pattern in private and public hospitals.

## Objectives

The objectives of the study are as follows.

1. To examine the extent of preference for private and public healthcare services
2. To analyse the factors influencing the choice of healthcare services
3. To understand the extent and pattern of health expenditure across types of healthcare institutions and regions

# II

## Methodology

Primary data were collected through interviews conducted in Panangad and Kaloor in October and November 2016. The number of respondents interviewed was 30 from Panangad and 55 from Kaloor. They were selected through random sampling using the list of households as the sampling survey. The methodology required gathering relevant data from the specified interviews and documents, and compiling databases in order to analyse the material and arrive at a complete understanding and historical reconstruction of the people's preference, when it came to healthcare choices. These interviews were administered through structured interview schedule.

Characteristics like age, gender, occupation, educational qualification and monthly income of the family were considered to form the profiles of the respondents. The respondents were categorised into three groups in terms of occupation: public service, private employee and business/self-employed. They were further categorised into five groups based on their level of education and income.

A focused group discussion was held with experts in the field of healthcare to understand the expenditure pattern and the reasons for the increase in healthcare expenditure in respect of different regions and hospitals.

# III

## Analysis

### Background Information

Gender, age, marital status, education, family income etc were considered under this category.

**Table 1: Distribution of Respondents by Gender**

| Areas | Male | Female |
|---|---|---|
| Panangad | 29 | 71 |
| Kaloor | 30 | 70 |

*Source*: Primary Survey

More than 70 per cent of the respondents were females because the study surveyed the head of households.

**Table 2: Distribution of Respondents by Age**

| Areas | Mean (years) | Median (years) | Standard Deviation |
|---|---|---|---|
| Panangad | 51 | 54 | 17 |
| Kaloor | 51.85 | 48 | 17.03 |

*Source*: Primary Survey

The average age of the respondents surveyed is 51 years in Panangad and 52 years in Kaloor. Hence, there is little difference between the average ages of the two samples selected for the study.

**Table 3: Distribution of Respondents by Education**

| Areas | Illiterate | High School Educated | Undergraduates | Postgraduates | PhD Holders |
|---|---|---|---|---|---|
| Panangad | - | 93 | 7 | - | - |
| Kaloor | 11 | 51 | 23 | 13 | 2 |

*Source*: Primary Survey

There are variations in the level of education of respondents across the study areas. Only few respondents received education beyond high school in Panangad, where the respondents mostly belonged to two categories, high school educated and undergraduates. The respondents in Kaloor, which is an urban centre, are distributed across the five categories identified in the survey. Though majority of the respondents come under high school educated, Kaloor has its share of postgraduates and PhD holders.

**Table 4: Distribution of Respondents by Marital Status**

| Areas | Single | Married | Divorced | Widowed |
|---|---|---|---|---|
| Panangad | 13 | 87 | - | - |
| Kaloor | 11 | 76 | 4 | 9 |

*Source*: Primary Survey

'Married' category constitutes the highest percentage of respondents in the study areas. This is followed by single, widowed and divorced categories. However, widowed and divorced categories were excluded from the rural study area.

**Table 5: Distribution of Respondents by Occupation**

| Areas | Public Service | Private Employee | Self-employed/ Business |
|---|---|---|---|
| Panangad | 10 | 53 | 37 |
| Kaloor | 29 | 47 | 24 |

*Source*: Primary Survey

In Panangad, 53 per cent of the respondents are employed in the private sector, while 37 per cent are self-employed. In Kaloor, 47 per cent of the respondents work in the private sector, while 29 per cent serve the public sector and the remaining 24 per cent are self-employed.

**Table 6: Distribution of Respondents by Income per Annum (in Rupees)**

| Areas | Less than 1 lakh | 1-2 lakh | 2-3 lakh | 3-5 lakh | Above 5 lakh |
|---|---|---|---|---|---|
| Panangad | 93 | 7 | | | |
| Kaloor | 55 | 10 | 8 | 15 | 12 |

*Source*: Primary Survey

The average annual income of about 93 per cent of households surveyed in Panangad is below Rs 1 lakh. The respondents in Kaloor are distributed across the listed categories with a skewed concentration towards less than Rs 1 lakh. The average annual income of the respondents is Rs 1,03,500 in Panangad and Rs 1,80,000 in Kaloor. The combined average income is Rs 1,41,500 per annum.

The data presented here illustrate that the respondents are predominantly middle-aged, married females with average education. They are mostly employed in the private sector with an average income of Rs 1,41,500 per annum. Having formed an understanding of the character profiles of the respondents in the two study areas, the study explored the respondents' preference for healthcare.

## Healthcare Preference

The study finds that majority of the respondents surveyed prefer private healthcare to public healthcare institutes.

**Table 7: Distribution of Respondents by Preference for Healthcare**

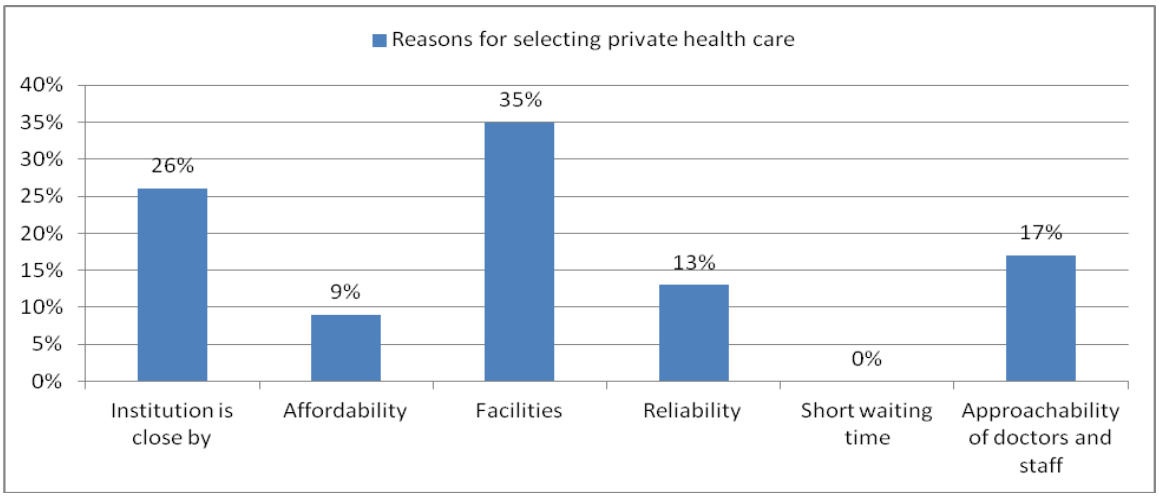
| Areas | Private Healthcare | Public Healthcare | Both |
|---|---|---|---|
| Panangad | 70 | 30 | - |
| Kaloor | 73 | 16 | 11 |

*Source*: Primary Survey

Nearly 70 per cent of the respondents prefer private healthcare system in Panangad, whereas 73 per cent prefer private healthcare in Kaloor. The percentage of households that prefers public healthcare services is 30 per cent in Panangad and only 16 per cent in Kaloor. About 11 per cent prefer both private and public healthcare services in Kaloor.

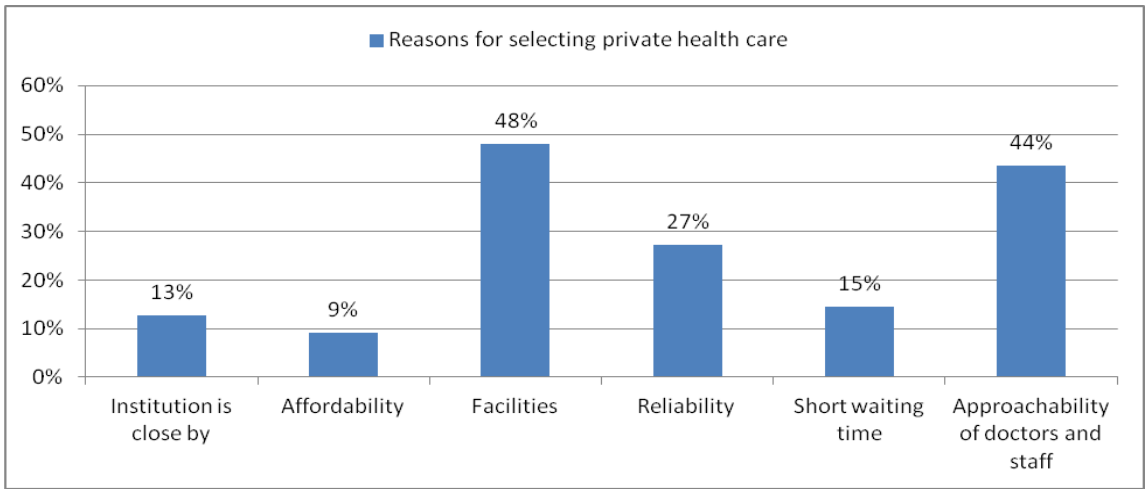
An expert discussion on the topic revealed that the general trend in the utilisation of private and public hospitals is that majority depended on private healthcare services. A study (Poornima, 2005) about the preference pattern of the public in obstetric care revealed that more than 58 per cent of the obstetric care took place in private institutions, while 39 per cent of the deliveries occurred in public healthcare facilities. The study also explored the reasons for selecting the healthcare system. Ernakulam has recorded 11.3 per cent growth in per capita income, which is the highest in the state. The district stands first in Kerala in terms of its contributions to the secondary and tertiary sectors. This income-occupational structure could perhaps explain the high affinity for private healthcare in the district.

**Graph 1: Distribution of Respondents by Reason for Selecting Private Healthcare in Panangad**




The respondents have picked more than one reason for selecting private healthcare services. The key reason as ranked by the respondents in Panangad is the facilities available in private hospitals. They argue that these entities offer facilities such as varied tests and medicines under one roof. This is followed by proximity to private healthcare institutions and friendly personnel. The approachability/friendly conduct of doctors and staff comes under 'friendly personnel'. Many respondents also cite the availability of specialist doctors in private hospitals as persuasive. When the responses are analysed in the context of an urban centre, the reasons vary slightly.

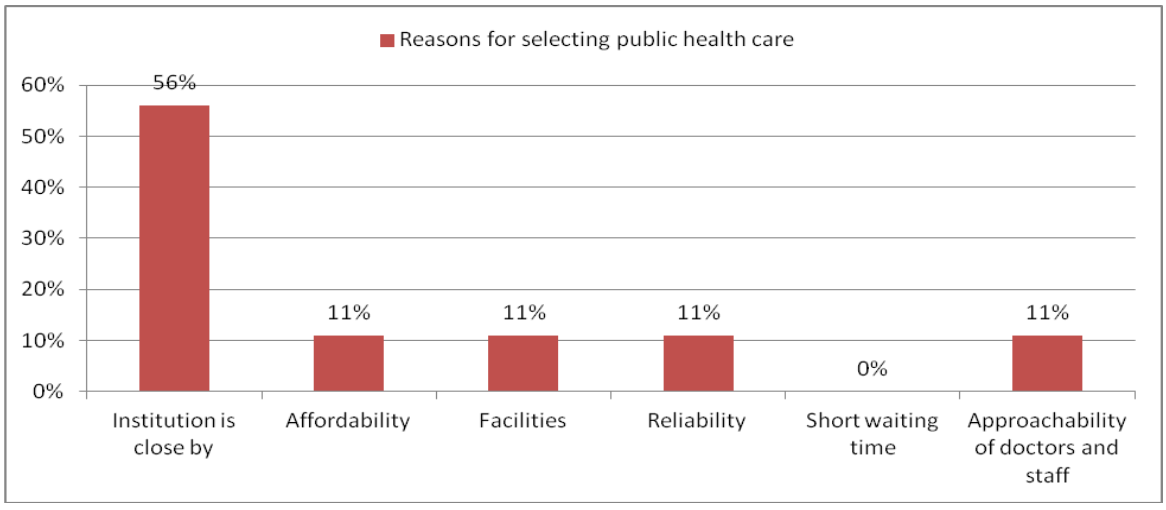
**Graph 2: Distribution of Respondents by Reason for Selecting Private Healthcare in Kaloor**



The respondents cite facilities offered in private healthcare institutions as the major reason for their preference for private services. While 35 per cent prefer private healthcare in the rural centre, 48 per cent prefer private healthcare in the urban centre. The urban respondents counted cleanliness as part of the facilities offered at hospitals. Almost 12 per cent of them pointed out that they consider cleanliness while selecting a hospital. Friendly personnel or approachability/friendly conduct of doctors and staff is the second major reason, followed by reliability. While 44 per cent of the respondents expressed their preference for private hospitals due to friendly personnel, 27.27 per cent said they preferred private healthcare institutions since they were reliable. Only 13 per cent and 9 per cent of the respondents preferred private healthcare institutions because of proximity and affordability respectively.

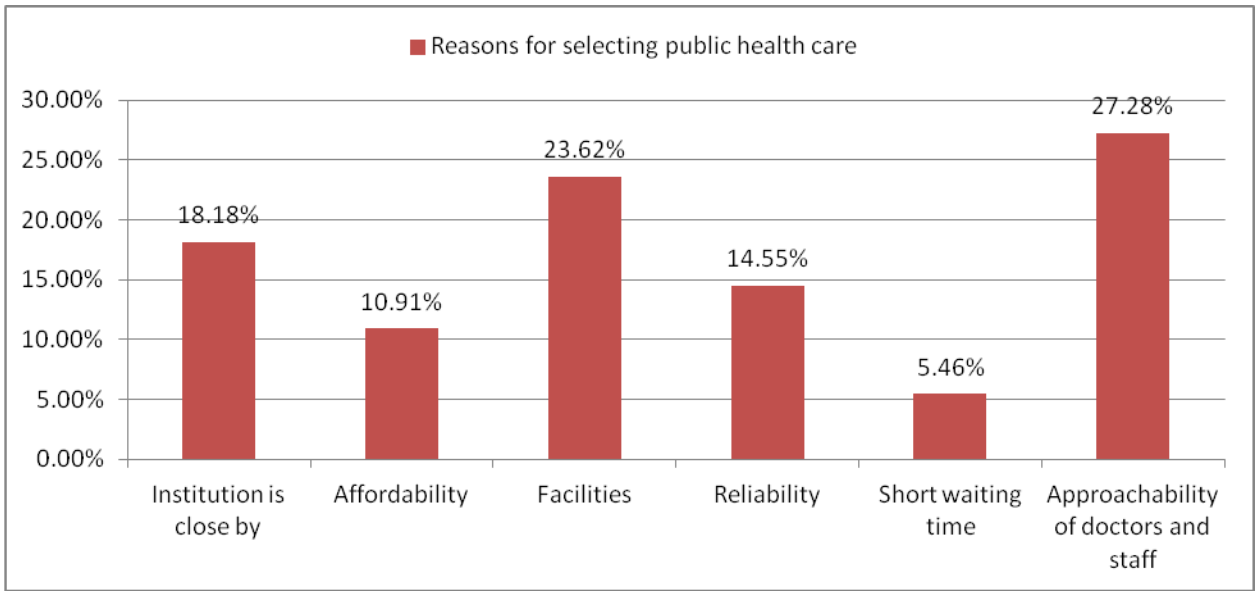
Access to advanced medical facilities under a single roof is the main reason for selecting private hospitals in both rural and urban areas. This is followed by proximity in rural Panangad, and approachability/friendly conduct of doctors and staff in urban Kaloor. Reliability is the third major reason in Kaloor, whereas friendly conduct of doctors and staff is the third major reason in Panangad. In short, advanced facilities, reliability and approachability/friendly conduct of doctors and staff are the major reasons identified for the preference for private healthcare institutions. However, proximity is an equally important reason for the preference for private hospitals in rural area.

**Graph 3: Distribution of Respondents by Reason for Selecting Public Healthcare in Panangad**



As against the reasons for the selection of private healthcare, the key reason for preference for public healthcare is the proximity aspect, which received 56 per cent votes in Panangad. At 11 per cent each, affordability, reliability and availability of facilities under one roof constitute the other reasons for preference for private hospitals.

**Graph 4: Distribution of Respondents by Reason for Selecting Public Healthcare in Kaloor**




The major reason cited for selecting public hospitals is approachability/friendly conduct of doctors and staff, including experienced doctors. Nearly 27.28 per cent of the respondents expressed this view. About 12.73 per cent of the respondents, who preferred public healthcare institutions because they were clean, fall into this category. This is followed by the availability of advanced facilities under a single roof at 23.62 per cent. Proximity of public hospitals is another determining factor, which is supported by 18.18 per cent of the respondents. Nearly 14.5 per cent of the respondents stated that they preferred public healthcare institutions, as they were reliable. A mere 11 per cent of the respondents cited affordability as a factor determining their choice of public hospitals.

To sum up, the major reason for preference for public healthcare institutions is proximity in rural area and approachability/friendly conduct of doctors and staff in urban area. Most of the other reasons for preferring public hospitals to private in rural area received almost equal number of votes. Access to advanced facilities is the second key reason in urban area, followed by proximity and reliability. In short, proximity, advanced facilities under a single roof and approachability/friendly conduct of doctors and staff are the major identified

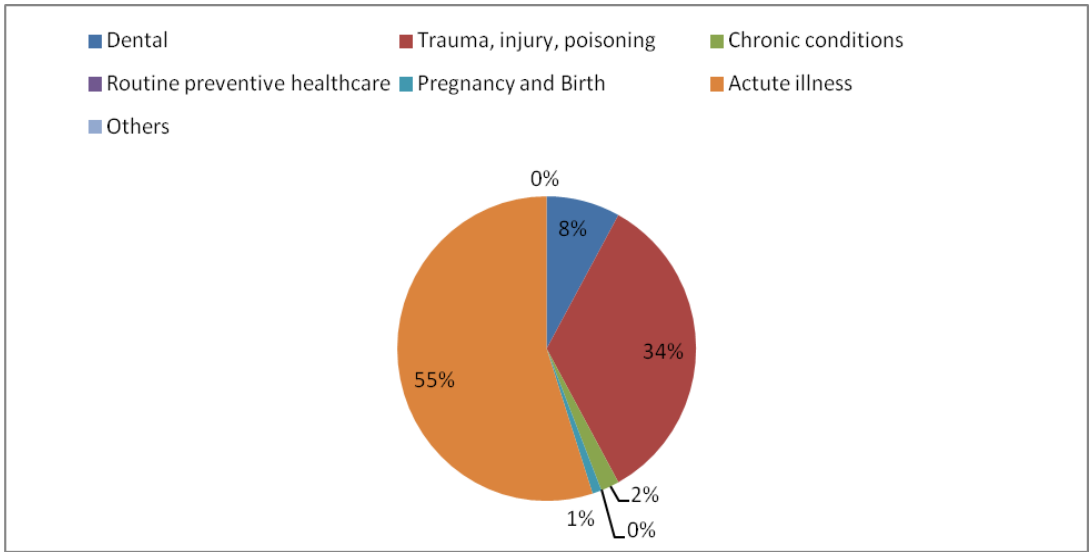
reasons for the preference for public healthcare institutions. An expert discussion revealed the increasing role of the private sector in healthcare. The experts also indicated the increasing dependence on specialist doctors as another major trend in the sector.

The study failed to identify any significant relationship between healthcare preference and factors such as education, occupation, income etc in rural and urban centres. (Pearson chi2 (105) = 107.4137Pr = 0.416 in Panangad and Pearson chi2 (70) = 70.6925Pr = 0.454 in Kaloor)

The null hypothesis of no relationship between healthcare preference and the qualitative factors is accepted here, as shown by the probability values in both the cases. It means that healthcare preference does not vary significantly, according to the level of education, occupation and income in urban and rural areas. An evaluation of the types of illnesses among the respondents is necessary to take the study forward.

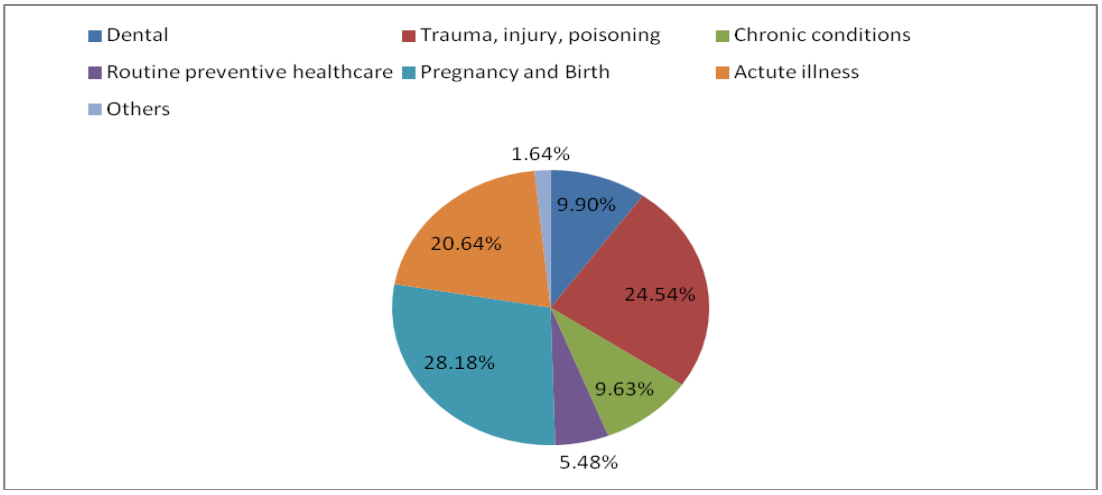
## Types of Illnesses

**Graph 5: Distribution of Respondents by Illness in Panangad**




In Panangad, acute illnesses took up a major part of healthcare spending with 55 per cent votes. Trauma, injuries and poisoning came next with 34 per cent votes .It is interesting to note that none of the respondents utilised public healthcare institutes for these illness types. They relied on public healthcare institutes for routine preventive healthcare only.

**Graph 6: Distribution of Respondents by Illness in Kaloor**




In Kaloor, 28 per cent of the respondents stated that their highest healthcare spending was on pregnancy and delivery. Trauma, injury and poisoning received 24 per cent votes, while 21 per cent chose acute illnesses. The urban respondents used public healthcare institutes mainly for routine preventive healthcare. A few reports on healthcare claim that surgical and labour cases reported in government hospitals dipped in the recent years, due to the growth of private hospitals and users' preference for private hospitals. Another study (HDRC, 2009) on the declining number of labour cases reported in government hospitals highlights a similar trend.

National Family Health Survey 4 (2015-16) reports that Kerala has relatively high caesarean section rate at 35.8 per cent as against 30.1 per cent in 2005-06 (The caesarean rate was 17.2 per cent in 2015-16 as against 8.5 per cent in 2005-06 at the national level.). The expert panel discussion revealed that Ernakulam has the highest incidence of caesarean cases, reported mostly in private hospitals, in Kerala. Majority of the experts on the Focus Group discussion panel considered profit as a major factor that led to the increase of caesarean rates in private hospitals. They cited the quality of services provided by private hospitals as a major reason for people depending on them, thereby leading to high incidence of caesarean rates.

## Health Expenditure: Extent & Pattern

Table 8 presents data on average expenditure incurred by the respondents for treating illness across the two healthcare systems.

**Table 8: Distribution of Respondents by Descriptive Statistics**

| Items | Areas | Mean | Standard Deviation |
|---|---|---|---|
| Expenditure in private healthcare | Panangad | Rs 12,336 | Rs 25,290 |
| | Kaloor | Rs 20,314.09 | Rs 39,660.45 |
| Expenditure in public healthcare | Panangad | Rs 76 | Rs 95 |
| | Kaloor | Rs 335.63 | Rs 1551.98 |
| Combined expenditure | Panangad | Rs 8658 | |
| | Kaloor | Rs 14,784 | |

*Source*: Computed from Survey Data

The respondents from Panangad spent an average of Rs 12,336 on private healthcare in a period of three months, while their average expenditure on public healthcare in the same period is Rs 76. The average expenditure of a household on private healthcare is Rs 4112 per month, whereas the combined average expenditure on private and public healthcare is Rs 2886 per month.

In Kaloor, the average expenditure is Rs 20,314.09 on private healthcare and Rs 335.63 on public healthcare in a period of three months. The average expenditure on private healthcare is Rs 6771 per month and the combined average expenditure is Rs 4928 per month. The overall average medical expenditure of a household in Kaloor and Panangad is estimated at Rs 4207 per month. The overall average expenditure on private healthcare is Rs 5833 per month, whereas it is Rs 244 on public healthcare. Hence, the medical expenditure on private healthcare in the urban centre is almost 65 per cent higher than that of the rural centre. The

medical expenditure of households on private healthcare services is almost 24 times higher than their expenditure on public healthcare services. The healthcare expenditure in the urban area is almost 71 per cent higher than that in the rural area.

The point to be noted is that the difference in expenditure incurred is not for treating the same type of diseases. It simply shows the expenditure borne by the households under different healthcare systems. The patients in the study depended on private hospitals for treating serious illnesses and public hospitals for routine preventive healthcare. Naturally, the money spent on healthcare institutes will be higher than that of public healthcare institutes.

This finding can be compared with the findings from two studies – Zachariah and Irudaya Rajan (2007) and Varma (2009). They calculated the average cost of medical services per month incurred by a household in Ernakulam as Rs 3880, as against the state average of Rs 2992. Hence, the healthcare cost in the district is almost 30 per cent higher than the state average. The present finding that analysed latest data indicates that the medical cost incurred has increased to Rs 4112.

**Table 9: Distribution of Respondents by Source of Medical Funds**

| Source of Medical Funds | Panangad | Kaloor |
|---|---|---|
| Out-of-pocket expenses | 80 | 86 |
| Insurance | 3 | 3 |
| Governmental support | 7 | 10 |
| Charity | 3 | - |
| Others | 7 | 1 |

*Source*: Primary Data

Nearly 80 per cent of the respondents in Panangad and 86 per cent in Kaloor met their healthcare expenses with out-of-pocket expenses. About 3 per cent of the respondents in each study area had their medical expenses covered by insurance. The combined average of out-of-pocket expenses on healthcare is 84 per cent. The combined average of governmental support on healthcare expenditure is 9 per cent, followed by insurance at 3 per cent, charity

at 1 per cent and other sources at 3 per cent. The study by Varma (2009) on asthma patients in Kochi Corporation estimated the annual average direct expenditure to be Rs 12,600 per year for an individual. Of this, the cost of medicines constituted 49 per cent of the expense. While doctors' fee is only 7 per cent, other non-medical costs constitute the rest of the expenditure. The direct cost is expected to rise sharply over the years.

## Health Insurance

The study reveals that health insurance coverage is negligible at just 3 per cent of the total medical expenditure. Yet, the penetration rate of health insurance is slightly better, as is verified by the data presented in Table 10.

**Table 10: Distribution of Respondents by Insurance Cover**

| Insurance Cover | Panangad | Kaloor |
|---|---|---|
| Yes | 23 | 47 |
| No | 77 | 53 |

*Source*: Primary Data

About 23 per cent of the respondents in Panangad and 47 per cent of them in Kaloor have healthcare insurance coverage.

**Table 11: Distribution of Respondents by Insurance Type**

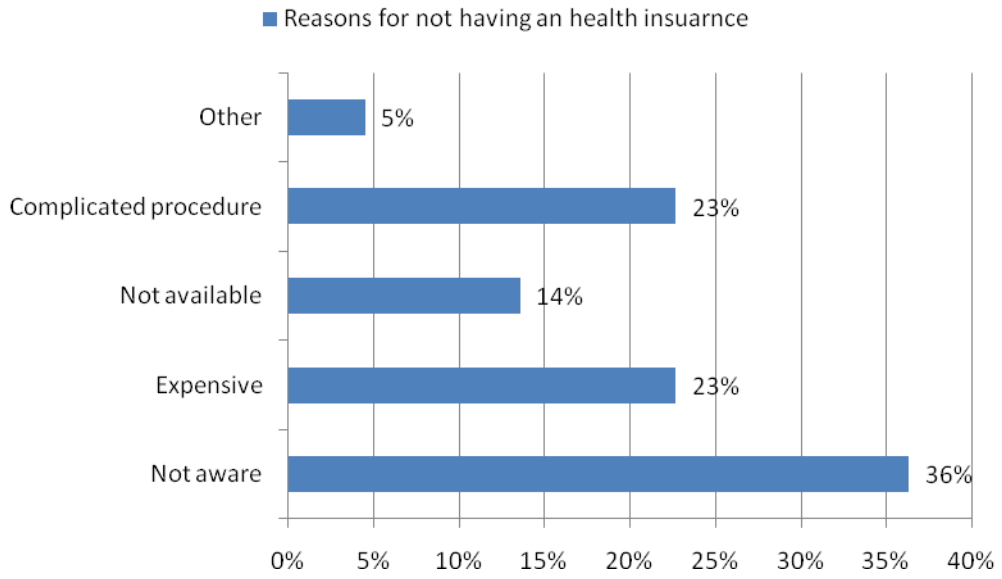
| Insurance Type | Panangad | Kaloor |
|---|---|---|
| Individual healthcare insurance | 14 | 22.5 |
| Family health insurance | 86 | 64.5 |
| Senior citizen health insurance | 0 | 3.23 |
| Personal accident insurance | 0 | 9.68 |

*Source*: Primary Data

Among the respondents, 86 per cent in Panangad and 65 per cent in Kaloor opted for insurance coverage for the family. In both the areas, hardly 20 per cent of them had individual health insurance policies. Vidya V Menon (2004), in her study on healthcare financing in the Kadavanthra and Thopumpady wards of Ernakulam district, found that people belonging to the lower economic sections of the society did not have any health insurance policy. Nearly 68.33 per cent had relied on hospital care, of which 43.9 per cent were inpatients. Among them, only 11.11 per cent had their health insured. Nearly 40 per cent of the population did not have an insurance policy, due to financial difficulty, and about 23 per cent were unaware of health insurance policies.

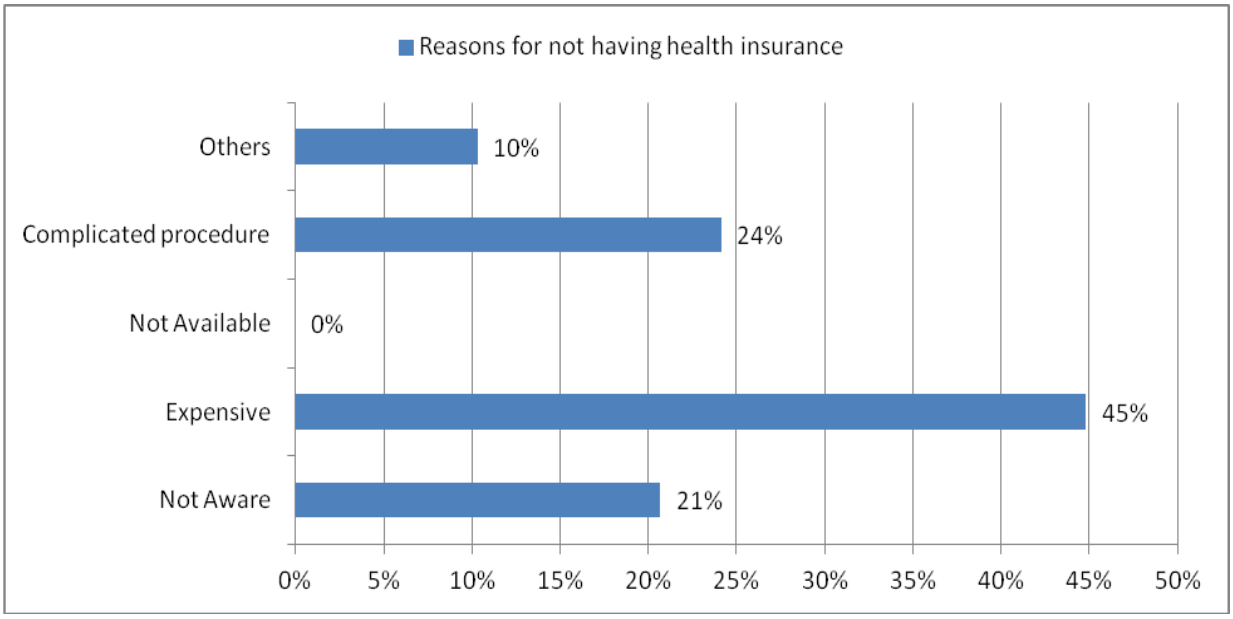
Graphs 7 and 8 explore the reasons for the low penetration and low share of individual healthcare insurance policies among the respondents.

**Graph 7: Reasons for Lack of Health Insurance Coverage in Panangad**




The key reason for the lack of any type of healthcare insurance among the respondents of Panangad is their ignorance of such schemes. Nearly 36 per cent expressed this view. This is followed by expensive schemes and complicated procedure, each gaining 23 per cent votes.

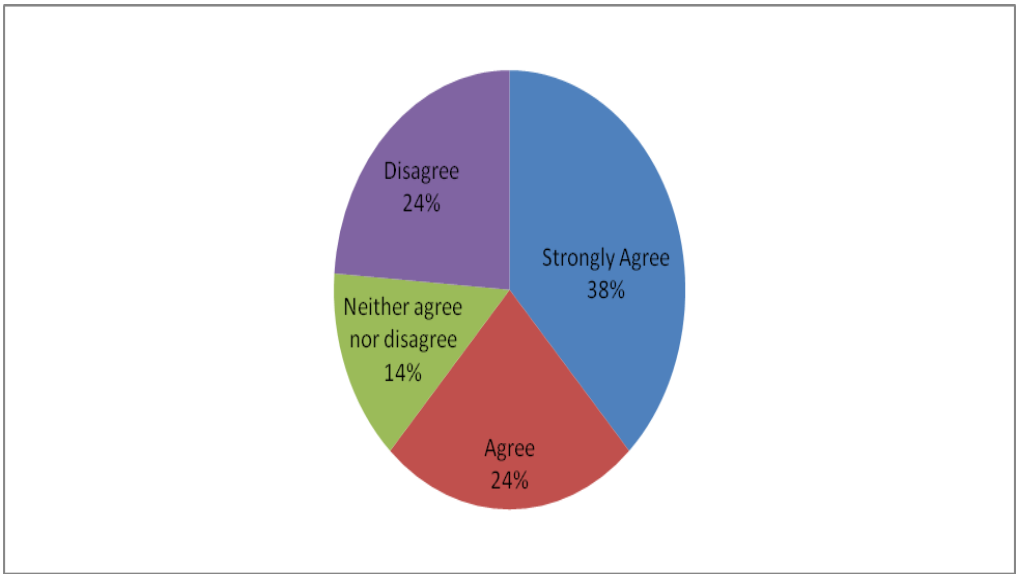
Graph 8: Reasons for Lack of Health Insurance Coverage in Kaloor



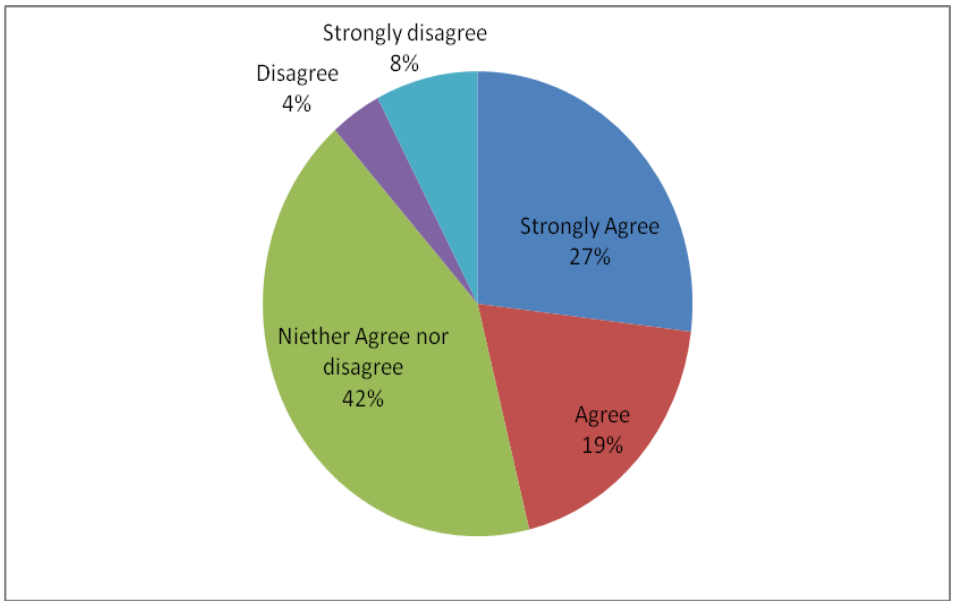

The key reason for the lack of any type of healthcare insurance among the respondents in Kaloor is that most of them found insurance policies expensive. This is followed by complicated procedures (24 per cent) and lack of awareness (21 per cent). In short, the main reasons for the low penetration of healthcare insurance in these areas are expensive insurance schemes, lack of awareness and complicated procedures. Many NGOs run health insurance outreach programmes for the poor but their level of penetration is paltry.

On the other hand, while half the respondents with insurance coverage stated that they were satisfied with their schemes, the other half expressed their dissatisfaction over the schemes.

Graph 9: Level of Satisfaction over Healthcare Insurance Policies in Panangad




Graph 10: Level of Satisfaction over Healthcare Insurance Policies in Kaloor




In Kaloor, 46 per cent of the respondents with insurance coverage were satisfied with the schemes as against 12 per cent, who were dissatisfied. Panangad had 62 per cent of its respondents with insurance coverage stating that they were satisfied and 24 per cent of them

expressing their dissatisfaction over the schemes. The rest did not have an opinion on the performance of their insurance policy.

To sum up, respondents generally depended on public healthcare services for routine preventive healthcare and private healthcare institutions for acute illnesses, trauma, injury, poisoning etc. The average expenditure incurred for treatment in private healthcare institutes is higher than that of public healthcare institutes because of the high dependence on the former for treating serious illnesses. However, the average expenditure borne by the respondents on private healthcare in the urban area is 65 per cent higher than that of the rural area. This is 24 times higher when compared to the expenses in public healthcare institutions. This proves that respondents largely depended on private hospitals for treatment. The main source of health expenditure is out-of-pocket expenses. Insurance does not play a major role in meeting medical expenditure. Though 23 per cent of the respondents were insured, only 3 per cent of the total healthcare expenditure was met by way of insurance claims. The main obstacles for the high penetration of health insurance are expensive policies, lack of awareness about the policies and complicated procedures.

# IV

# Policy Implication and Conclusion

## Policy Implication

People's need for advanced healthcare services is fulfilled by private or public (government) sectors. The study concludes that majority of the population avail the services of private healthcare institutes. Even the respondents from low-income groups relied on private healthcare services. The study did not find any significant relationship between the age group, income of the household, the mode of expenditure, education etc of the respondents and their preference for private healthcare services. It can be concluded that majority of the households surveyed prefer private hospitals to public because of the facilities offered in private institutes. Most of them were sceptical about the facilities provided in public hospitals. The moderate medical expenditure in public hospitals could not attract the respondents to the public healthcare system. The main reason to choose public hospitals happens to be proximity. This highlights the fact that the policy makers should take necessary steps to improve the facilities and offer quality services in public hospitals.

The role of the private sector in providing healthcare services is growing rapidly. A major trend of increasing dependence on specialist doctors can be discerned. Experts in the field of health and medicine explain that despite high costs, this service is called for, usually through private medical institutions. Such services could have been effectively managed through Primary and Block Health Centres, the roles of which need to be redefined in the present-day context and environment. The scope of improving the system through efficient intervention of the Local Self Government institutions is tremendous. This can improve the efficiency and effectiveness and revive the long lost glory of the State-sponsored healthcare system.

Undergoing medical treatment in the private sector is a costly affair. It is not always comfortable for a family in the low-income group to pay the steep fees at private hospitals. Insurance can be a pragmatic way to reduce the financial burden of a household, in case of a medical emergency. However, almost 80 per cent of the households did not have health insurance coverage. The insurance penetration and density is much lower in the study areas, even when most of the respondents were not privileged enough to handle private healthcare expenses comfortably. The present investigation shows that there exists a huge protection

gap – the difference between losses covered by insurance and losses not covered by insurance. The main challenge leading to under-insurance is the practice of price fixing in insurance, which is not based on specific risks of the policyholder. Moreover, the adherent problems of health insurance such as adverse selection and moral hazards are noticed in this scheme also. Removing these constraints will create room for the health insurance market to expand and thus cover more areas. It will be risk minimisation for the households to insure themselves to prevent financial crisis at the time of need. No doubt, health insurance is a viable solution to minimise financial burden while availing medical services.

## Conclusion

A wide network of health infrastructure, general health consciousness and clean health habits of the people, combined with virtually total literacy among not only men but also women of Kerala have helped to achieve high success in the healthcare outcome of the state. The current rate of mortality and life expectancy in the state is also impressive and is more akin to countries with higher per capita income. The Government of Kerala aims to move towards universal health coverage with an aim to provide accessible, equitable and affordable healthcare for all. The healthcare expenses in Kerala are disproportionately high compared to other Indian states. The implication of the study is that the government can build a viable market for the people by improving the facilities in the public hospitals and facilitating private players to improve and provide their services at reasonable costs. In this way, a symbiotic relationship can been created, wherein both the systems can complement each other.

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