e-ISSN : 2347 - 9671 p- ISSN : 2349 - 0187

Impact Factor : 0.998

EPRA INTERNATIONAL JOURNAL OF ECONOMIC AND BUSINESS REVIEW

www . epratrust.com

December 2014 Vol - 2 Issue- 12

A STUDY ON HOUSEHOLD HEALTH CARE EXPENDITURE IN KAKIRIGUMA VILLAGE OF KORAPUT DISTRICT, ODISHA

Mr. Prasant Kumar Behera[1] & Amrita Dhal[2]

[1]Assistant Professor & Head In-charge, Centre for Economics, Central University of Orissa, Koraput, Odisha, India.

[2]MA Economics Student, Centre for Economics, Central University of Orissa, Koraput, Odisha, India.

ABSTRACT

Kakiriguma is a backward village of Koraput district with a low level of urbanization and educational development, the level of health consciousness among the villagers are poor in comparison to people of other areas. The study examines the accessibility of basic household health care services in the Kakiriguma village during 2014 using the field survey data. The specific objectives of the study were to analyse the household health care expenditure in Kakiriguma village and to study the public health care expenditure in Kakiriguma village. This study is based on primary data and collected through a specific questionnaire. Multi-stage random sampling method is adopted to select households (HHs). The first stage units are the wards and second stage units are the HHs. In total a hundred households have been covered for the study. Besides for the detail analysis secondary data from District Health Statistics and Economic Survey of Odisha have also been collected. The finding shows that the health status of Kakiriguma villagers is very poor and the staple reasons for this are: illiteracy, low income and lack of health care facilities from the government. Households with less education and low level of income are spending less on health care expenditure and vice versa. The study suggested that there should be emphasis on the Public Private Partnership (PPP) approach so that the large gap in the field could be filled up. Health care expenditure through PHC and NRHM should be increases in Kakiriguma village.

KEY WORDS: *Health Care Expenditure, Household Income, Education.*

INTRODUCTION

Health is necessary for the realization of basic human needs and to attain the status of a better quality of life. The issue of health is of great importance both from the point of view of individuals and nation as well. Health is universally regarded as an important index of human development. Improvements in health would translate into higher incomes, higher economic growth, and accelerated declines of poverty. According to the National Health Accounts, the out of pocket expenditure stands as a significant contribution to health expenditure in low-income states and in developed states and but these expenditure affect individuals and force them to pay terrible proportions of their available income and push many households into poverty. In this context the role of the government in providing satisfactory health services which are accessible and reasonable to all sections of its population is of critical importance. Most of the health problems exist among the poorer sections of the population which needs some kind of an involvement from the government. Central government efforts at influencing public health have focused on the five year plans, on coordinated planning with the states, and on sponsoring major health programmes like PHC and NRHM. Odisha has one of the worst set of health indicators in the country as per the WHO reports. Public expenditure on health is not so impressive, while the number of national programmes is large, the financing is not; neither does the state spend anywhere close to the required amounts for its health services. As a state of welfare India, Odisha is under obligation to provide economical and efficient health services to its citizen. Although the health care system in the state has improved remarkably over the years, communicable and nutrition related diseases continue to be a major problem mostly in the tribal and backward regions as well as in the remote rural areas.

REVIEW OF LITERATURE

Sa Nanda Sachita and Sridevi G. (2009) found that in the Balangir region especially SC and ST were in a worst condition due to poor health services. They suggest possible option for doing better health services for the SC & ST people of Balangir region. Similarly, Sen Bhabesh and Rout Sekhar Himanshu (2008) identified that there is a significant difference between the average male and female HHE in rural, urban and combined areas but not in tribal areas. He suggested that to reduce gender disparities in household health care expenditure long term and sustained improvement required in men and women health. Chakraborty Sonali (2011) study shows that almost all the households in urban slums of Cuttack suffered from catastrophic health expenditure. She suggested that the multi skilling of pharmacists through training as laboratory technician for TB and malaria programme should be mandatory. Ghuman B. S., Mehta Akshat (2009) argued that the social sectors in India particularly health and education have been accorded a very low priority in terms of the allocation of resources. He suggested that to improve access and quality of health services, government should enhance public spending on health sector.

Acharya Akash, and Ranson Kent M. (2005) found that health indicators in India may have seen substantial improvements in recent decade but quality and affordable health care continue to elude the poor. They suggested that community based health insurance schemes could be attached to other decentralised agencies of governance such as Panchayatiraj institution. Sen Dave Priti (1997) focused on community control of health financing in India.

She found that community controlled financing is fairly wide spread in India. George Thomas (2005) in his study showed that high percentage of the population of India spends a substantial amount of its monthly income on health care. He suggested that the good health will be at the cost of impoverishment of the existing poor.

OBJECTIVES

- To analyse the household health care expenditure in Kakiriguma village.
- To study the public health care expenditure in Kakiriguma Village.

DATA SOURCES AND METHODOLOGY

This study is based on primary data and collected through a specific questionnaire. Multi-stage random sampling method is adopted to select households (HHs). The first stage units are the wards and second stage units are the HHs. In total a hundred households have been covered for the study. Besides for the detail analysis secondary data from District Health Statistics and Economic Survey of Odisha have also been collected. General statistical tables and diagrams have been used for the analysis of the study.

ANALYSIS OF HOUSEHOLD HEALTH CARE EXPENDITURE

In this section, household-level analysis of the various issues, namely demographic features, education, occupation, income, categories of health care expenditure, source of health care expenditure, public health care expenditure etc are presented. This analysis is useful to understand the effects of the health care expenditure on the people. Further it will be clearer to know whether or not the education and income have made significant contribution to the health care expenditure of the people or not.

Table-1 Occupation and Monthly Income of the People

Occupation	Income Group (in Rs)/ Households In Percentage					
	Up to 1000	1000-5000	5000-10000	10000-20,000	Above 20000	Total
Government Job	…	…	4	9	7	20
Private Job	…	1	…	1	2	4
Business	2	12	7	8	2	31
Agricultural and Farm Sector	6	26	7	2	…	41
Domestic Servant	3	1	…	…	…	4
Total	11	40	18	20	11	100

Source: Own Survey

Table-1 explains the various job types and the monthly income of the households. The different occupations are government job, private job, agricultural works, and domestic servant. It is found that only 11% of the total population have more than Rs 20000 as monthly income and 40% population have less than Rs 5000 as monthly income. It is observed that around 31% people are business man and around 41% people depend on agriculture.

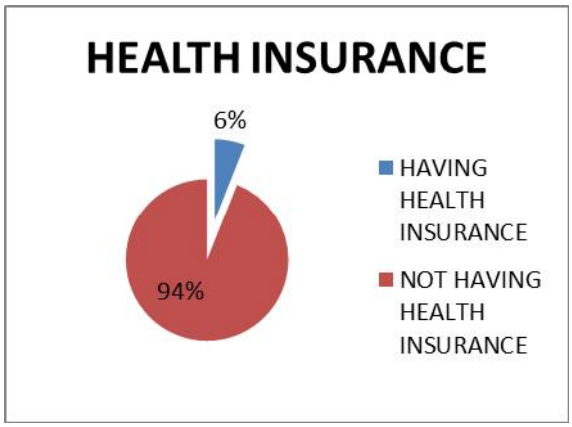
Table-2 Distribution of Population Based On Income and Education

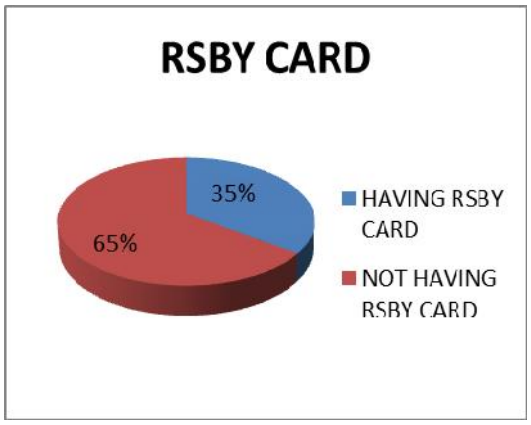
Educational Status	Monthly Income (In Rs.)/ Households In Percentage			Total
	Up to 5000	5001-15000	Above 15000	
Primary Education	17	14	2	33
Secondary Education	3	3	8	14
Higher Secondary Education	2	6	4	12
Graduation And Above	1	4	9	14
Illiterate	26	2	....	27
Total	**54**	**24.5**	**21.5**	**100**

Source: Own Survey

Table 2 explains the distribution of population according to income and literacy level. It is found that only 2% of population with literacy up to primary education have income above Rs. 15,000, 26% of illiterates have income up to Rs 5000 and only 2% of them have income up to Rs 15000. So it is clear from the table that educated persons are more income earners than less educated people.

Chart-1 Households Having Health Insurance and RSBY Card





Source: Own Survey

Availing health insurance is most essential for people to overcome heavy expenses and support poor people financially during emergencies. The people should also have RSBY CARD, which can avail them extra benefits. It is found that. 94% of the people don't have any health insurance and 65% people don't have RSBY card. Out of respondents, only 6% households are registered under any insurance and only 35% have RSBY card. Among the 35% of the active RSBY card holder only 7% have claimed the benefit and 93% have never claimed the benefits. Registration of households for RSBY card is the responsibility of the gram panchayat and should be open throughout the year (Chart-1).

Table-3 Alcohol Addicted People

Sl. No.	Types of Alcohol	(Yes) In percentage	(No) In Percentage
1	Smoking	24	76
2	Drinking	44	56
3	Tobacco	66	34

Source: Own Survey

Alcohol addiction indicates the quality of awareness among the people. Smoking, drinking, tobacco is quite injurious for people and it could bring them a lots of health problem .Alcohol addiction has a huge influence on health care expenditure. Here it is clearly identified that most of the people are alcohol addicted. Around 66% are tobacco addicted, 44% are drinking addicted, and 24% are smoking addicted (Table-3).

Table-4 Households Suffering from Various Diseases

Sl, No.	Diseases	Persons Suffering (In Percentage)
1	Malaria	10
2	Fever	37
3	Jaundice	5
4	Accident	7
5	Diabetics	5
6	Cold, cough	11
7	Typhoid	3
8	Heart problem	2
9	Any other	10
10	No diseases	10

Source: Own Survey

Table-4 indicates the population suffering from various diseases. Common health problems among the villagers were fever, malaria, cold, cough and jaundice. All of these health problems occur because of heavy work in a bad environment. About 37% of the people have suffered from fever and 10% people suffered from malaria .It is quite clear from the above data that most of the people are lacking proper sanitation condition and health care.. Majority of people (70%) prefers allopathic treatment and others prefer homeopathic and ayurvedic treatment. It is also found that still 17% people didn't avail any treatment. This shows the less awareness of people about the importance of health care.

Table-5 Categories of Health Care Expenditure of Households

Type of Expenditure	Expenditure in Rupees/Households in Percentage					
	(No Charge)	(0-500)	(500-1000)	(1000-5000)	(5000-10000)	Total
Doctor Fee	80	12	4	4	..	100
Medicine Expenditure	19	26	9	20	26	100
Bed Charges	91	6	2	1	..	100
Accommodation	71	13	9	5	2	100
Travel	49	35	10	8	..	100

Source: Own Survey

Table-5 explains the categories of expenditure on health by the households. It is found that most of the patients are getting free medical service in the local govt. hospital. From the total population 80% don't pay any doctor fee, 91% don't pay any bed charges and 71% don't pay for accommodation. It is also found that very less people going for big expenses andthey prefer private hospitals. It is also found that only 19% of medicine has been provided by government, So It is most essential that medicine should be provided to the people at free of cost. Answering a question about performance of local government hospital 61% of the respondents says that the service of govt. hospital is good but rest 39% don't agree to them. A huge unit of people disagrees due to the insufficient staff, unavailability of medicine and improper treatment.

Table-6 Monthly Income and Health Care Expenditure of Households

Monthly Income (in Rs)	Yearly Household Health Care Expenditure (in Rs)/ Households In Percentage					
	Up to 500	500-1000	1000-3000	3000-10,000	Above 10000	Total
Up to 1000	8	2	2	1	…	13
1000-5000	11	5	5	12	4	37
5000-10000	9	1	3	7	…	20
10000-20,000	2	4	7	7	…	20
Above 20000	4	…	1	3	2	10
Total	34	12	18	30	6	100

Source: Own Survey

The monthly income of the people plays a significant role in health care facility of family. Table-6 elaborates the various income level and health care expenditure of the households in Kakiriguma village. It explains the income category of people and shows effect of income on health care expenses. 37% of the people belongs to Rs 1000-5000 income category and they spent significantly on health care. 34% of the households have health care expenses up to Rs 500 and 30% of the households are bearing heavy health care expenses of Rs 3000-10000. It is found that very low income category people are unable to bear the high health care expenses and its effecting their daily life .They are struggling for basic needs and their economic condition is getting poorer

Table-7 Source of Health Care Expenditure

Sl. No.	Sources	Percentage
1	Health Insurance	2
2	By the Employer	2
3	Pocket Expenditure	64
4	By Selling Assets	12
5	Borrowing	20

Source: Own Survey

Table 7 shows that 64% of households spent from their own pocket on health care, 20% spent on borrowing and only 2% households get their health expenses from insurance. So it is most essential for them to have a health insurance and RSBY CARD.

PUBLIC HEALTH CARE EXPENDITURE IN KAKIRIGUMA VILLAGE

In Kakiriguma village the government is spending on health care faculties mainly through RCH programme, NRHM and Janani Surakhya Yojana. The details of these programmes and expenses are as follows.

REPRODUCTIVE AND CHILD HEALTH PROGRAM (RCH)

The RCH programme incorporated in the earlier existing programs i.e. National Family Welfare Program and Child Survival and Survival & Safe Motherhood Program (CSSM) and added two more components one relating to sexually transmitted disease and the other relating to reproductive tract infections. The program was formally launched on 15 October 1997. In Koraput district the amount of expenditure under RCH programme was Rs 1018.79 lacks and Rs 1097.98 lacks in the year 2012-13 and 2013-14 respectively, while the expenditure under this programme in Kakiriguma village is only Rs 98500.

NATIONAL RURAL HEALTH MISSION (NRHM)

The National Rural Health Mission (NRHM) is undertaken by the government of India to address the health needs of underserved rural areas. It was founded in April 2005. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. In Koraput district the amount of expenditure under NRHM was Rs 1364.45 lacks and Rs 1319.24 lacks in the year 2012-13 and 2013-14 respectively. But xpenditure of govt for NRHM Initiative project in Kakiriguma village is only Rs 96300.

JANANI SURAKSHA YOJANA (JSY)

Janani SurakshaYojana is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women. In Koraput district the amount of expenditure under this programme was Rs 142.21 lacks and Rs 90.15 lacks in the year 2012-13 and 2013-14 respectively. But the xpenditure of govt for this project in Kakiriguma village is only Rs 64300. It is found that most of the mothers are getting free medical service & JSY package in the govt. hospital. In Kakiriguma village the total expenditure in the year 2013-14 in JSY was Rs.76550 where mothers are getting Rs 48000 & the Asha workers are getting Rs 28550 annually. But the expenditure amount shows that Kakiriguma has been continuously neglected by the government and it is not getting its desire amount for the health care facilities as the amount is very less as compared to the other regions of the Koraput district.

FINDINGS AND DISCUSSIONS

In Kakiriguma village the percentage of literate is more than the illiterate but 33% are having primary education only. If we compare the Literacy level females are lagging behind the males. Regarding the occupation of the households, maximum people are domestic servants, daily workers and agricultural labourers, It is known that out of 100 households, around 56% family are in BPL category which indicate the poor condition of the villagers and it also reflect on the health care expenditure of the family. From total, 48% people have education only up to primary and secondary level. Comparing the higher Education, the ratio of male, female is 5:2 in Kakiriguma village. Low education is the root cause for low income. 56% families of the total population are in BPL category. Out of total 94% of the people don't have any health insurance and 65% percentage people don't have RSBY card. This is a good sign that 70% of the people go for Allopathic treatment but still 15% people don't received any treatment. It found that only 19% of medicine has been provided by government. Hence 81% households depend on others to cover their medicine expenses. Around 66% of the total population are tobacco addicted, 44% are drinking addicted, and 24% are smoking addicted, so the alcohol addiction creating heavy health care problem and increasing expenditure on heath care. The local health Centre needs more staff and new medical equipment and 21% of the villagers strongly complain that the treatment in local PHC is very poor, unavailability of ambulance, and also there is a shortage of medicines. The income of the households in the study area ranges

annually from Rs 1000 to Rs 10000. The household of Kakiriguma village are spending more on food and other items as compare to health in the study area. This is because the income level, high level of illiteracy and blind beliefs of Kakiriguma villagers. Regarding the expenditure on health, educated families of Kakiriguma village are spending more on health as compare to the uneducated families of Kakiriguma village. In case of health care expenditure as a percentage to total expenditure, OBCs are in a good position as compared to SCs and STs in the study area. From the analysis it is known that households from Kakiriguma village are spending more on assets and other items in comparison to the health. In Kakiriguma village still 17% of people are not getting any type of medical treatment. It is also found that for meeting their immediate health expenditure either they borrow money from money lenders with high interest charge or sold their asset at very cheap price. It is also seen that most of the people are not happy with the basic facility as electricity, drinking water and transport facility. The households are getting some facility as local PHC, direct transport facility in NH4 but still the villagers facing lots problem in different aspects. Basically the local health Centre needs more staff and medicine. 21% of the villagers strongly complain that the treatment in local PHC is very poor and there is a shortage of medicine. They also complain about the unavailability of ambulance and presence of insufficient staff. 26% villagers think that government processes are not implemented and people don't get the chance to avail the benefits. They claim that government should take more steps to solve the sanitation problem and organize awareness program to prevent people drinking alcohol. So the local health care centre should have all the facility to avail good and quick cure to the people. As the Kakiriguma comes under a backward region of Koraput district, some special processes needs to be introduced for the fulfilment basic needs and development of people.

SUGGESTIONS AND CONCLUSION

Kakiriguma is primarily an agricultural and backward village with a low level of urbanization and educational development, the level of health consciousness among the villagers are poor. Most of the respondents expressed their ignorance about different diseases. Only higher educated people have knowledge about these diseases. Although some attempts have been made by the govt. in the past to improve the rural public health infrastructure but they are still unsatisfactory and much behind desirable needs. The finding shows that the health status of Kakiriguma villagers is very poor and the staple reasons for this are: illiteracy, low income and lack of health care facilities from the government. Households with less education and low level of income are spending less on health care expenditure and vice versa. The study suggested that there should be emphasis on the Public Private Partnership (PPP) approach so that the large gap in the field could be filled up. Health care expenditure through PHC and NRHM should be increases in Kakiriguma and registration of households for RSBY card by the gram panchayat should be open throughout the year.

REFERENCES

1. *Acharya Akash, and Ranson Kent M. (2005), 'Health Care Financing for the Poor: Community-Based Health Insurance Schemes in Gujarat', Economic and Political Weekly, Vol. 40, No.38, pp. 4141-4150.*
2. *Bhabesh Sen. & Himanshu, Sekhar Rout, (2007), 'Determinants of Household Health Expenditure: Case of Urban Orissa', MPRA Paper 6492, University Library of Munich, Germany.*

3. *Chkraborty Sonali (2011), 'Catastrophic Household Expenditure on Health Care in Urban Slums of Cuttack: Focus on Health Sector Reform in Odisha', Journal of Arts, Science & Commerce, Vol. 2, No. 2, pp. 161-170.*
4. *District Health Statistics, Koraput, Government of Odisha.*
5. *Economic Survey of Odisha, Government of Odisha.*
6. *George Thomas (2005), 'Good Health at Low Cost: How good and how low?', Economic and Political Weekly, Vol. 40, No. 25, pp. 2488-2491.*
7. *Ghuman, B.S. and Mehta, Akshat. (2006), 'Health Care for the Poor in India with Special Reference to Punjab State'. In Raza Ahmad (ed.), The Role of Public Administration in Building a Harmonious Society. Network of Asia-Pacific Schools and Institutes of Public Administration and Governance (NAPSIPAG), Asian Development Bank.*
8. *Sa Nanda Sachita Sridevi G. (2009), 'Access to basic Health Care Services by rural SC's: A case study of two village of Balangir of Odisha', viewed on 25th July, 2014, http://www.mse.ac.in/ Frontier/ppt/27%20sachita.pdf.*
9. *Sen Dave Priti (1997), 'Community Control of Health Financing in India: A Review of Local Experiences' viewed on 27th July, 2014, http:// www.researchgate.net/.../ 237446684_Community_Control_of_Health.*