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HEALTH CARE EXPENDITURE PATTERN OF THE LABOUR CLASS IN THE ORGANISED AND UNORGANISED SECTOR OF GUWAHATI - ROLE OF HEALTH INSURANCE AS A PROTECTIVE MECHANISM

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ABSTRACT

The health of the people is very important component of the growth process of any country; developed or developing but state has shown a very little concern in respect of monitoring and implementing various health care / insurance schemes to secure the health of the people. Available literature suggests that very few studies are conducted to see the pattern of utilization of health care facilities by the workers in both formal and informal sector and their attitude towards health care. The present study intends to study the health profile, health care expenditure pattern of the workers in both the organised and unorganized sector as well as viability of health insurance, public or private to safeguard the workers from any financial vulnerability arising from sudden medical emergency. The study also suggests some policy implications that can be utilized by the government to make health a universal right. We have done cross tabulation and percentage analysis to show the relationship between health care expenditure and utilization of health care facilities thereby evaluating the attitude of the workers towards health care. Findings suggest that availability of health care facilities is very important for the workers of both organised and unorganized sector health insurance can be one of the solution for strengthening the health care financing.

KEY WORDS: *health care expenditure, health insurance, organised and unorganized sector.*

SECTION I INTRODUCTION

A healthy population is crucial for speedy socio - economic development of the country and hence health care policy reform is an primary part of socio-economic policy reform. Some types of health care have a public good or externality characteristics implying private provision would be inadequate. Health

care is not a pure public good ; but it has some degree of public good characteristics. Simple market solutions, as are common in other sectors of the economy, do not work well in the health sector owing to a number of types of market failure. In the case of health services, the key sources of market failure are the monopoly power of providers, ignorance and uncertainty among consumers and an element of externality. Another fact about health care is that the consumer has difficulty in

evaluating the service received. Since health expenses are not regular and unpredictable, an element of uncertainty is always associated with it and so a scope for health insurance exists. But before we go for the policy prescriptions we must know the attitude of the people towards health care and availability of insurance schemes in Assam for protection against high medical cost of the workers in both the sector . The present study highlights the same.

1.1.1 REVIEW OF LITERATURE

Y. Machnes(2006) in his study explores the demand for private health care and supplemental health insurance in Israel, where universal national health insurance provides all inhabitants with a standard package of medical care. It was found that the self-employed in Israel demand more private health services and supplemental health insurance than wage-earners. Income, age, education, health status, marital status, origin, and profession were found to be the major determinant in explaining these demands.

A study conducted by **David M.Dror (2006)** in seven locations of Tamil Nadu, Karnataka, Maharashtra and Bihar finds that the health care needs of the poor are strongly context dependent and demand for health insurance, evidenced by willingness to pay for it, is also strongly location-dependent.

Peter Diamond, (1992) states that the concept of health care and health insurance cannot be separated . Some of the empirical studies also highlighted the attitude of the workers towards health insurance schemes provided by the employer or state. Impact of health insurance on performance of workers is also studied by a few studies.

The analyses of **Goodman and Musgrave (1988), Jensen and Gabel (1992), Marsteller et al (1998), and Jensen and Morrissey (1999)** found some evidence that mandated health insurance benefits reduce health insurance coverage. But the evidence was not uniform and was often in-consistent across studies. The existing literature on small-group reform has studied the topic from different perspectives, but most studies have focused on the prevalence of health insurance coverage as an outcome.

Jensen and Morrissey (1999), Hing and Jensen (1999), and Simon (2000) looked at whether or not these reforms affected decisions that employers make related to health insurance.

Simon (2000) controlled for state fixed effects and found that extensive small-group reform increased the price of health insurance for small firms and reduced the percentage of work.

In a discussion of the impact of a government mandate, **Mark Pauly (1997)** ruled out any real benefits to the employer. In a recent paper in which he reviewed existing empirical evidence.

Thomas Buchmuller (2000) also found that employers reap few or no “spillover benefits” from providing health insurance to workers.

Slade (1997) argued that individuals who change jobs frequently are less likely to be employed in jobs with Health Insurance. On job change, the result of the availability of and the demand for health insurance is sensitive to empirical specification.

1.1.2 OBJECTIVE

The present study is carried out to focus light on the following objectives:

- i. To investigate the health care expenditure pattern and utilization pattern of health care facilities by the workers in both organized and unorganized sectors.
- ii. To have an theoretical insight about various available health insurance schemes in the city of Guwahati as well as in Assam as a mechanism for protection against heavy medical expenditure.

SECTION II

1.2 RESEARCH METHODOLOGY

The present study is a descriptive study based on empirical data. Primary data is collected from the survey and secondary data is collected from journals, reports of state and central government.

1.2.1 Study Area:-

Guwahati is considered as the main sampling area because the city is observing rapid urbanization and consequent migration of people in search of job, organized or unorganized, during the last few years. Again, according to the National Health and Family Survey Report, the concept of health insurance is popular only in the urban part of the state of Assam. Guwahati being the state capital, the city is observing more and more growth of employment opportunities as a part of its increasing rate of urbanization. In this context, it is quite justified to select Guwahati as a sample area. Generally, population of the Guwahati engage themselves in formal (government and private) and informal sectors economic activities for earning their livelihood.

1.2.2 Sample Coverage:-

Being a comparative analysis of labour households occupied in the organized and unorganized sectors the selection of the households will be made in such a way that they are comparable to certain extent and share at least some common characteristics. The respondents may be insured and non -insured. The sampling procedure used for the household survey was based on purposive cum stratified sampling technique. At first, purposive sample of five areas of the Guwahati city is selected to represent the south, north, east, west and core part of the city where workers of both organized and

unorganized sector resides (based on an exploratory research). Then, a sample of 360 households was taken from the sample areas by the technique of stratified random sampling with proportional allocation. Literature on employment scenario of Assam and Guwahati shows that more number of workers belongs to unorganized sector. Out of 360, 234 are from unorganized sector and 126 from the organised sector depending on the work participation rate of Guwahati city sector wise¹.

1.2.3 Methods:-

We have done simple tabulation and cross tabulation. A few statistical tools like percentage and frequency are calculated. Data are represented with suitable graphs and diagrams.

SECTION III

1.3. RESULTS AND DISCUSSION

1.3.1. Morbidity Prevalence:-

The data on morbidity prevalence during the reference in the month is collected from the sample population and an observation is done about the out of pocket expenditure on each illness episode. Prevalence in this context referred to all illness episodes that exist during the reference month even if they started before the reference period.

Table 1.1 reveals an increase in the morbidity prevalence and showed that 40% households from the total sample reported sickness during the reference month and if we consider the rate separately for the organized and unorganized sector, and then it will be 46.8% and 36.3% respectively. Overall 60% of household do not reported any sickness.

1.3.2 Pattern of illness:-

When pattern of illness is investigated, infections including fever (78.9%) like malaria, measles, influenza etc is reported by majority followed by respiratory disease (6.85%) including cold, cough, asthma, sore throat etc and digestive problems (6.0%) during the reference month as reported in table 1.2.

When pattern of illness or presence of any chronic illness among the total sample households during the reference period is investigated, blood pressure (11.3%) is reported by majority followed by diabetes (9.4%) and gastroenteritis problems (8.4%) as reported in table 1.3. Neurological problem and eye problem constitutes 2.7% and 2.4% respectively.

1.3.3 Health care cost/expenditure:-

The data collected on health care cost is subdivided into some segment for analytical purpose. In this phase we have encountered a problem because the respondents are not capable of saying the exact figure and all the cases are not reported to any health care facility. For example laboratory fee, hospital fee and surgery cost is not common to all. Again in case of illness episode lasting more than six months period, respondents are unable to give proper information regarding certain heads of expenditure as visible in the following table. From the table it is evident that cost of medicine is quite high along with the laboratory charges. Since all the cases are not subject to surgery and hospitalization, costs under this head have shown a moderate value.

It is clear from the table 1.4 and 1.5 that respondents those went for private health care facilities, the cost of treatment is really very high under each every expenditure head.

For the illness lasting for longer time period, i.e. for chronic illness, the distribution of cost of treatment according to health care facilities used is given in table 1.5. From the table 1.4 and 1.5 it is clear that cost of health care is very high for those using private health care facilities. But laboratory charges and surgery cost do not differ so much in both the cases. However cost of medicine is very high even in case of public health care facilities. We can conclude that cost of treatment is very high irrespective of the facility used.

In table 1.6 expenditure in the surgery head is maximum (Rs 271750) followed by transportation cost (Rs106150), doctor fee (Rs131780) and hospital charges (Rs62285). It is obvious that expenditure incurred by the organized sector is more than the expenditure incurred by the unorganized households as reflected in both the tables because of the fact that organized sector can afford better quality care and may go outside of the state for further improved treatment in case of severe cases. In most of the cases their expenditure is also reimbursed to a certain extent as reported by the households in the organized sector and due to the problem of moral hazard also they may report high medical cost.

In the unorganized sector, expenditure on surgery is very high (Rs187650) followed by laboratory inspections (Rs 94100), hospital charges (Rs 45805) and doctor fee as Rs 44735. Cost of medicine accounts for Rs 32,825. However, transportation cost is less as compared to the organized sector and it may be due to the fact that they have utilized nearby health care facilities.

It is further investigated in the table 1.6 and chart 1, where proportion of money spent under each head is analyzed for both the sectors. Proportion of money spent by the organized sector is more under doctor fee, transportation and special food category as revealed in the table 1.5 and chart 1 but otherwise

¹ For this part of work we are extremely dependent on the works of Mahadevia, Desai, Mishra, Profile of Guwahati, Centre for Urban Equity, Working Paper 24, 2014

proportion of money spent by the unorganized sector is more in all other heads.

1.3.4 Source of treatment:-

For short duration of illness, 48.9 of total respondents prefer public facilities and mostly organized sector is utilizing (22.6%) this provision as they may go to railway hospitals, oil dispensaries and other hospitals which they can use as a part of their remuneration profile. But 27.1% of unorganized sector is utilizing private hospitals followed by 26.3% utilizing public hospitals and 5.3% consulting with pharmacist. A negligible percentage of 2.3 are not reporting to any health care facilities as shown in table 1.7.

For chronic illness, 64.4% of the respondents prefer public hospitals as the cost may be very high in private hospitals. Still 35.5% of total respondents (33.3% in the organized sector, 37.1% in the unorganized sector) prefer private hospitals/practitioners for quality care and improved treatment as revealed in table 1.8.

1.3.5 Health insurance in Assam:-

According to NFHS-3, in spite of the emergence of a number of health insurance programmes and health schemes, only 2 percent of households in Assam report that they have any kind of health insurance that covers at least one member of the household. Among the diverse types of programmes, the most common is privately purchased commercial health insurance (46%), followed by health insurance through employer (18%) and medical reimbursement from employer (16%). Health insurance is over five times as common in urban areas as in rural areas, and increases sharply with the wealth status of the household (National Family Health Survey -2 and 3).

Before the IRDA Act, government insurance companies like Life Insurance Corporation (LIC) and GIC (General Insurance Corporation) were chief players in the health insurance sector. The 'Mediclaim Policy' (1986) of GIC is the first initiative of the health Insurance programme in India as well as in Assam.

The Insurance Regulatory And Development Authority Act, 1999(IRDA) was one of the key policy reform in the health insurance industry which was passed by parliament of India in 1999.

This was a milestone act to allow the private insurance players into the Indian insurance sector. Accordingly, some players emerge in the health insurance industry both in the public sector and private sector.

In case of public health insurance sector, there are two major corporations in India, the General Insurance Corporation (GIC) and the Life Insurance Corporation (LIC). The GIC has four subsidiary companies as given below (Sekhar, 2014)- National Insurance Corporation (NIC), New India

Assurance Company (NIA), Oriental Insurance Company (OIC), and United India Insurance Corporation (UIIC). These are the key health insurance players in public sector of India. These companies put forward different health insurance schemes like Ashadeep Plan II and Jeevan Asha Plan II from LIC and Personal Accident Policy, Mediclaim, Jan Arogya Bima Policy, Overseas Mediclaim Policy, Critical Illness Policy, New India Assurance Bhavishya Arogya, Dreaded Disease Policy, Cancer Insurance Policy, Raj Rajweshwari Policy from GIC. Mediclaim Insurance Scheme was introduced in 1986 by the General Insurance Company (GIC). This covers reimbursement of hospitalization expenditure for sickness and injuries (Sekhar, 2014). This is still admired among the rich people, even though there are number of private players entered in health insurance industry of late. One of the major arguments against mediclaim policy is it only covers hospitalization and other expenses and not covering the out-patient care.

Another scheme Jan Arogya Bima Policy embattled for the poor but these too had partial success. In Assam, public insurance companies are foremost in both life and non-life insurance sector.

In the private sector, IRDA has so far granted license to four insurance companies to function exclusively in the health insurance segment. They are Star Health and Allied Insurance, Apollo Munich Health Insurance, Max Bupa Health Insurance, Religare Health Insurance Company Limited

Star Health was the first company having approval to undertake business exclusively in health, personal accident and travel insurance segments in 2006-07. Apollo Munich is the second company to obtain registration to endorse insurance business exclusively in the health, personal accident and travel insurance segments. Max Bupa is a new participant in the health segment and was issued certificate of registration in the year 2009-10. Religare Health Insurance Company Limited is the very new company that has encroached into the health insurance market. The performance of these companies are under the watchdog of IRDA and yet to be evaluated. Some of the other private companies are also providing health insurance schemes. These companies are Bajaj Alliance, Royal Sundaram, Birla Sun Life, HDFC Standard Life, Tata AIG health insurance, GNRC (*Guwahati* Neurological Research Centre)- Ashadeep etc. Some of the insurance schemes that are launched nationally and also implemented in the state (two are state specific) are as follows.

Employee's State Insurance Scheme (ESIS):-

The major legislation on social security for workers in India as well as in Assam is the Employees State Insurance Act 1948 (ESI Act), by the parliament.

This ratification led to the formulation of Employees State Insurance Scheme. It is maintained by the Employees State Insurance Corporation (ESIC), a wholly government-owned enterprise (Ellis, et al, 2000). It offers medical and cash benefits. Originally the ESIS scheme covered all power- using non - seasonal factories employing ten or more workers. Later, it was extended to wrap employees working in all non-power using factories with 20 or more people (Sekhar, 2014).

Central Government Health Scheme (CGHS):-

The Central Government Health Scheme (CGHS) was introduced in 1954 as a contributory health insurance scheme to offer complete medical care to the central government employees and their families. Benefits under the scheme include medical care at all levels and home visits/care as well as free medicines and diagnostic services. Benefits under the scheme contain medical care at all levels and home visits/care as well as free medicines and diagnostic services. These services are provided through public facilities including CGHS-exclusive allopathic, ayurvedic, homeopathic and unani dispensaries with some specialized treatment (with some reimbursement ceilings) being allowable at private facilities (Rao, 2004).

Rashtriya Swasthaya Bima Yojna (RSBY):-

Another insurance scheme launched by Central Government is Rashtriya Swasthaya Bima Yojana(RSBY) announced by the Prime Minister in 2007. RSBY is the initiative of Ministry of Labour and Employment, to provide health insurance coverage for Below Poverty Line (BPL) families with the purpose of providing protection to BPL households from financial insecurities arising out of health shocks that absorb costly investigations and hospitalization. Rashtriya Swasthaya Bima Yojana has started from 1st April 2008 onwards. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most diseases that require hospitalization (Sekhar, 2014). The scheme has coverage up to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee, but Central and State Governments pay the premium to the insurer selected on the basis of a competitive bidding. By the end of 2010-11, total 494929 households under the BPL are covered, 27 private hospitals and 21 public hospitals are enrolled in Assam, the enrollment percentage being 41.3%.

Family Welfare Linked Health Insurance Scheme:-

Family Planning Linked Insurance Scheme was introduced on 29th November, 2005 to pay attention of the cases of failure of Sterilization,

medical complications for death resulting from Sterilization, and also provide indemnity cover to the doctor / health facility performing Sterilization procedure. The scheme is in action for the last 5 years and is renewed with ICICI Lombard Insurance Company for the sixth year with effect from 01-01-2011 based on 50 lakhs sterilization acceptors. The total liability of the company is limited to Rs. 25 crore under Section-I and Rs. 1 crore under Section².

Mukhyomantri Jibon Jyoti Bima Achoni:-

In July 2005, the Government of Assam has resolute to implement the Mukhyomantri Jibon Jyoti Bima Achoni. This is a combined health insurance and personal accident insurance scheme for all citizens of the State of Assam whose names appear on the electoral list as in force when the claim is being made along with their dependents³. The employees of the Central and State Government, Public sector and Private companies and all those who have an annual gross income before tax exceeding Rs 200,000 are not entitled to the facility for health and accident coverage. Nevertheless, the employees of tea companies, who are engaged in cultivation and processing of tea in the State, are entitled to the benefit of the scheme both for health and personal accident coverage⁴.

The Government of Assam along with ICICI Lombard General Insurance Company Ltd (ILGICL) entered into an agreement for execution of the Mukhyomantri Jibon Jyoti Bima Achoni. The scheme is executed and monitored by ILGICL through its branch office in Guwahati. It aims to offer health and accident risk insurance coverage to the whole population of 3 crore at a premium of Rs 25 crore. The sum assured for each person is Rs 50,000 in case of accidental death and Rs 25,000 for any health-related possibility. There would be no third party administration and the district administration alone with Revenue Circle Officer (RCO) as the catalyst, would help out the villagers. The settlement would be made within 60 days.

From the coverage point of view, from August 2005, till July 2006 there have been roughly 4205 beneficiaries and Rs.9 crore has been disbursed. Under the scheme, the insured person can avail medical cost up to a maximum of Rs 25,000 for the treatment of certain specified diseases. In the event of death he or she can avail compensation up to a maximum of Rs 50,000. The settlement is also done early and it would be made within 60 days.

² Information is based on , report on Family Welfare Statistics In India, 2011, Statistics Division Ministry of Health and Family Welfare, Government of India

³ <http://www.hsprodindia.nic.in/searum.asp,PNum=187>

⁴ <http://www.hsprodindia.nic.in/searum.asp,PNum=187>

The district administration through RCO would help out villagers.

The coverage includes snake bite, animal bite, drowning in river, tank, pond, flood, falling and drowning in a well, earthquake, landslide, rockslide, lightning, cloud burst, fire related accident, collapse of roof, falling from a tree or high-rise building, vehicle accident, accidental explosions or firing, riot or scuffle, excluding international involvement in the said peril or someone putting oneself in needless perils other than whilst saving human life⁵ The person shall not be entitled to any other benefit after the claim is admitted under this policy and that is great limitation of the scheme.

Ashadeep Health Insurance Scheme by GNRC Hospitals Ltd:-

It is a scheme where any person can get super-speciality treatment at a discount of 50 to 100 per cent, for a nominal membership fee. Ashadeep (June, 2006) is an pioneering insurance scheme that, through cards, offers various health memberships to individuals, families and groups at low-priced rates. Dr. N. Borah ,Chairman of GNRC Group of Institution has state that it is the first health 'card-based' insurance scheme in India. This card is in fact different in many ways. It has observed phenomenal success during the last few years due to some features. As compared to other insurance schemes where the settlement of the hospital bills is done through the TPA (Third Party Administration), here, these are done directly. Thus the whole hassle of bill settlement is absent, as Ashadeep offers its services only at GNRC hospitals, According to Ayashkanta Chakraborty, Marketing Head, GNRC⁶.In addition, it is a cashless operation. There is also no bar on those with pre-existing diseases. If anybody is a cardholder, of any age can avail the facilities. The card can be also used for any number of hospital visits. Captivatingly, Ashadeep has been able to partly address the problem of unemployment in the region. Anyone who is interested can participate in the mission by selling this card and can earn suitably, in addition to making healthcare affordable and accessible⁷. The statistics related to performance under the scheme is not assessable as it is a private health insurance scheme and authority is reluctant to provide any sort of information in this regard.

SECTION IV

1.4.1 CONCLUSION

⁵ <http://www.hsprodindia.nic.in/searnum.asp.PNum=187>

⁶ Informations are obtained from official website of GNRC- hospital, Guwahati

⁷ <http://archivehealthcare.financialexpress.com/200803/strategy02.shtml>

According to Draft National Health Policy, 2015 non communicable disease and injuries now account for 50.9% of the nation's burden of disease and that the national health programmes recommend very limited coverage and range of treatment for non-communicable disease. In our present study also we have observed that incidence of both seasonal and chronic disease is quite high and expenditure made is also quite high. Draft National Health Policy, 2015 also states that situation of North-East states are extremely vulnerable in the context of specialized medical conditions such as epilepsy, cardiology, nephrology, oncology etc. This upsetting situation is due to lack of region focused, revolutionary, locally relevant, visionary health policies. Even as the Draft Policy expresses the target to deal with the issue of creation of qualified manpower pool, it fails to recognize the scale of the gap and dismal consequences as well as the urgency to respond. Considering the grim situation, additional state specific policies are required taking into consideration of regional realities and requirements. Those health services which are liberally accessible are overcrowded. Due to some constraints like forced dependence on unqualified medical practitioners, unavailability of doctors on time etc, people are not able to use the various state sponsored programmes effectively though these schemes are available for the people of the state. Again we see the lack of consciousness in the part of beneficiaries to take the advantage of available health care schemes and insurance policies and most of the people are not aware of the concept of health insurance and how they can utilize it to safeguard from financial vulnerability arising out of sudden medical emergency. Therefore, it is the responsibility of the state and other related Non - Government Organisations to organize awareness camp about the existing diseases and encourage people to come under any of the health insurance schemes of their interest.

1.4.2 NEED/IMPORTANCE AND LIMITATION OF THE STUDY

Health Insurance in Assam is not much common among the people, so its coverage also not that satisfactory. But some evidences show that steadily, the health insurance coverage is increasing specially the urban part of Assam and mainly in the capital city, Guwahati. It may be because of the fact that people become aware of the high health care cost, incoming of the private players in insurance field and government universal health care/insurance schemes along with involvement of community based health insurance schemes. The main reasons behind the less coverage of health insurance in Assam are lack of knowledge of health insurance among the people and the high cost of the private health insurance premium which bigger part of the people couldn't afford.

Therefore some supplementary criteria such as the proportion of the population which is covered for basic health service, the range and availability of services, indicators of service quality and indicators of health of population should be used for judging the suitability of health policy and the extent to which policy goals have been met. A comparison of per capita health expenditure of labour households in organised and unorganised sectors of Guwahati would give an insight into the role of existing health insurance as a source of mobilising additional resources and a mechanism in providing health care services to investors and their family members. In this context, the present study can throw lights to understand the attitude of the workers in both formal and informal sector and towards health care spending and utilization and suggest ways to improve the financial protection against the heavy burden of medical cost through proper utilization of existing health insurance schemes.

However, some limitations exist like, the sample survey for the present study, may not be a representation of the true picture of Assam which would otherwise have been possible in the case of a census survey. Moreover, labour in both organized and unorganized sectors differs according to their level of skills and occupations have not been looked into this study. Thus scope for further research in this area will be worth mentioned.

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APPENDIX

Table1.1 Morbidity prevalence in the households during the reference year

Any sickness reported	Organised sector	Unorganized sector	Total
yes	59(46.8%)	85(36.3%)	144(40%)
no	67(53.2%)	149(63.7%)	216(60%)
Total	126(100%)	234(100%)	360(100%)

Source: survey data, 2014-15

Table: 1.2 Illness pattern during the reference month

Illness pattern	frequency	percent
Injuries & accidents	3	2.3
Digestive system disorder	8	6.0
Respiratory disorder	9	6.8

Pain and aches	1	.8
Infections including fever	105	78.9
Others	7	5.3
total	133	100

Source: survey data, 2014-15

Table: 1.3. Illness pattern (chronic/otherwise) during the reference year

Illness pattern	Frequency	Percent
Sugar problem/diabetes	35	9.4
Blood pressure	42	11.3
Nurological	10	2.7
Gastroenteritis	31	8.4
Eye problem	9	2.4
Cardio problem	6	1.6
Gynaological	4	1.1
Others	18	4.9
Total	155	41.8

Source: Survey Data, 2014-15

Table 1.4.Bi variate distribution of cost of health care and health care facility used for short term illness(in Rs)

Expenditure heads		Public Facilities	Private practitioners/hospitals	No treatment sought/Home remedy	Pharmacy	Total
DOCTOR_FEE	Sum	867	19050	0	0	19917
MEDICINE	Sum	21675	38735	0	1115	61525
LABORATORY	Sum	8430	21300	---	--	29730
SURGERY	Sum	4000	20700	----	---	24700
HOSPITAL	Sum	135	17000	---	---	17135
TRANSPORT	Sum	4030	16000	---	200	20230
SPCL_FOOD	Sum	350	2000	---	---	2350

Source: Survey data,2014-15

Table1.5. Bi variate distribution of cost of health care and health care facility used for long term illness(in Rs)

		Public Facilities	Private practitioners/hospitals	Total
DOCTOR_FEE	Sum	2758	17700	20458
MEDICINE	Sum	52570	43655	96225
LABORATORY	Sum	22130	24460	46590
SURGERY	Sum	28150	39500	67650
HOSPITAL	Sum	---	14000	14000
TRANSPORT	Sum	7380	28240	35620
SPCL_FOOD	Sum	750	1700	2450

Source: Survey data,2014-15

Table1.6. Sector wise distribution of proportion of cost of treatment under different head

Expenditure heads	Organised sector (%)	Unorganised sector(%)
doctor fee	20	10.8
medicine	6.2	7.9
laboratory	6.5	22.6
surgery	40.8	45.1
hospital	9.3	11.0
transport	15.9	1.9
special food	1.4	0.7

Source: Survey Data, 2014-15

Table1.7 Sector wise source of treatment for the illness for short duration during the reference month

Source of treatment	Organised		Unorganised		Total	
	N	%	N	%	N	%
Public Facilities	30	22.6	35	26.3	65	48.9
Private practitioners/hospitals	18	13.5	36	27.1	54	40.6
No treatment sought/Home remedy	1	.8	2	1.5	3	2.3
Pharmacy	4	3.0	7	5.3	11	8.3
Total	53	39.8	80	60.2	133	100.0

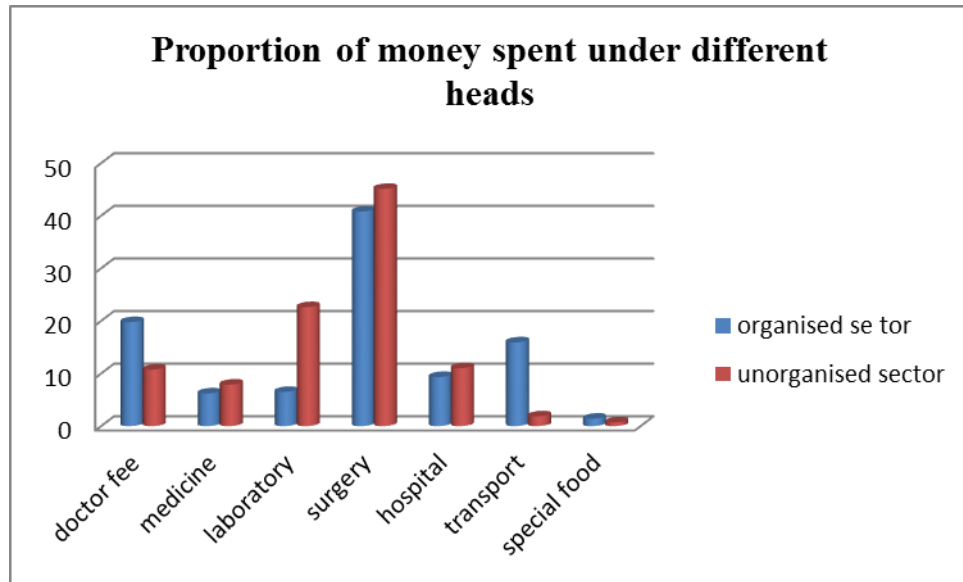
Source: Survey data 2014-15

Table.1.8. Sector wise preferred source of treatment for chronic illness

Source of treatment	Organised sector	Unorganized sector	Total
Public hospitals/dispensaries	44(66.7%)	56(62.9%)	100(64.5%)
Private hospitals/practitioners	22(33.3%)	33(37.1%)	55(35.5%)
Total	66(100%)	89(100%)	155(100%)

Source: Survey data 2014-15

Chart1: Sector wise cost of treatment under different heads



Source: based on table 1.6