

TO WHAT EXTENT DO THE POOR BENEFIT FROM PUBLIC SPENDING ON HEALTHCARE IN TAMIL NADU AND ORISSA, INDIA?

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INTRODUCTION

In India most health spending comes from households. National Health Account estimates indicate that only about 20% of total health expenditure comes from the government. Even in a progressive state like Tamil Nadu the per capita public health expenditure is only around 17% of the overall spending on health.

The Government of India has increased public spending on health with the aim of reducing the financial burden of illness on households, particularly the poorest and most vulnerable. However, ensuring that this money is efficiently spent and that it is targeted to those most in need is a challenge.

There are very few studies of healthcare utilisation in India, which would give policy makers a better understanding of what health services are used by the poor. This research examined whether health expenditure benefited the poor in Tamil Nadu and Orissa. It looked at how the benefits of public health spending were distributed across socioeconomic groups and the factors behind changes over time in the targeting of public subsidies from 1995-2004.

The policy brief provides information which will help decision makers engaged in the budgetary allocation process to make more informed and rational decisions regarding the allocation of health resources and to ensure that these resources reach the poorest sections of society for whom they are intended.

METHODS USED

- The primary sources of data on socioeconomic characteristics and health variables were the 52nd and 60th rounds of the National Sample Survey which covered 1995-1996 and 2004, respectively
- Utilisation Incidence Analysis was conducted and the population was ranked by monthly per capita expenditure
- The analysis looked at three key variables: utilisation of public facilities for out-patient care, in-patient care (measured in terms of in-patient days) and maternity services (for delivery)
- Decomposition Analysis was conducted for maternity services in rural areas for the period 1995-2004

KEY FINDINGS

Public spending on out-patient, in-patient and maternity care in Tamil Nadu became more pro-poor in the period 1995-2004. From 1995-2004 public spending on healthcare in Orissa became more pro-poor for out-patient services, but continued to be pro-rich (although to a much lesser extent) for in-patient and maternity services (see Figures 1, 2 and 3).

Overall Tamil Nadu's public maternity services were much more pro-poor than Orissa's. Between the two time periods, the use of public maternity services became more pro-poor. This pattern of public spending is mainly due to a significant fall in the use of these services by those in the upper income quintiles.

In Orissa the proportion of pregnant women using public institutions increased in the highest quintiles over the period studied and fell in the lowest two quintiles. The results appear to show that although the poorest preferred to deliver in institutional facilities, the preference for public institutions showed a marginal decline.

In Tamil Nadu the use of public maternity services became more pro-poor. Incidence increased in the lowest two quintiles and decreased in the third, fourth and fifth. The highest increase in the utilisation of public institutions for delivery was in the second quintile due to a substantial increase in the proportion of women delivering and a substantial proportion of them preferring institutional delivery. In addition, there was an increase, although marginal, in the preference of women in this quintile for delivering in public institutions.

The increase in the proportion of women delivering in the two poorest quintiles perhaps indicates that the family planning programme had a weak impact on these groups compared to higher quintiles.

In terms of in-patient care, public services in both states became pro-poor, though Tamil Nadu became more pro-poor than Orissa. It is interesting to note that the urban areas in both states became more pro-poor than the rural areas during the reference period.

The presence of a network of private healthcare providers seems to play an important role in the distribution of benefits of public spending.

For example, in Tamil Nadu there was substantial growth in the private sector for health over the study period. This could have attracted a greater proportion of those in richer quintiles to private providers of services. At the same time, there have been improvements in the public healthcare system for maternity services, which may have made these services more attractive to those in the lower quintiles.

In Orissa, the absence or slower growth of private providers has led to greater utilisation of public maternity services by those in upper quintiles. Any improvements in the public system only accentuated this trend.

Figure 1: Distribution of in-patient days, Orissa, 1995-1996 and 2004, by socioeconomic group

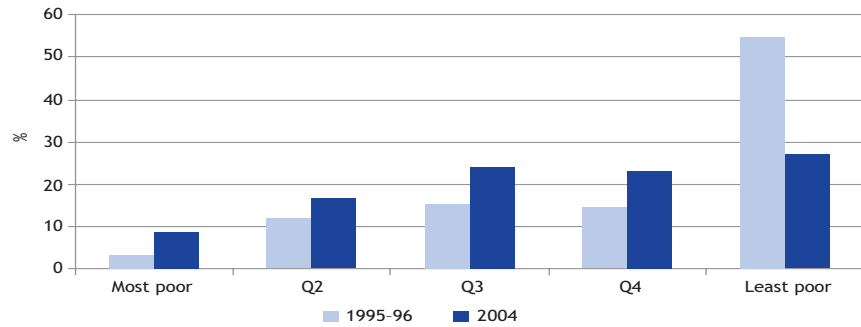


Figure 2: Distribution of maternal deliveries in public facilities, Orissa, 1995-1996 and 2004, by socioeconomic group

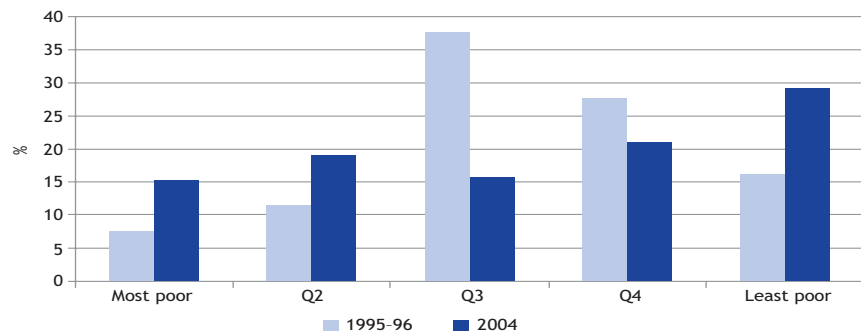
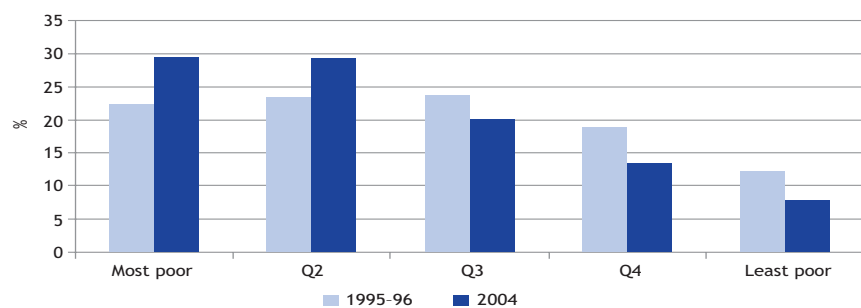


Figure 3: Distribution of maternal deliveries in public facilities, Tamil Nadu, 1995-1996 and 2004, by socioeconomic group



CONCLUSION AND POLICY RECOMMENDATIONS

- Whilst there has been a shift toward more pro-poor utilisation of services in Tamil Nadu more effort is required to make in-patient care more accessible to the poor in rural areas.
- In Orissa, the overall concern of policy makers should be to strengthen the public healthcare system by enlarging the network of public institutions. This would help to reduce geographical barriers to services. In parallel there needs to be mechanisms put in place to improve the quality and performance of public facilities.
- This study has demonstrated the usefulness of this kind of analysis in understanding how the public financing of healthcare benefits the poor. Similar studies should be conducted regularly at sub-regional and district levels, at various levels of facility and with regard to different types of services. This will help district health and programme managers in assessing their performance and identifying measures for improvement over time.

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