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Household Survey of Health Care Utilisation and Expenditure

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NCAER

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Preface

The National Council of Applied Economic Research has conducted several surveys since 1986 to study the markets for a variety of consumer goods. As part of the fourth study in the series Market Information Survey of Households (MISH), a Household Survey of Medical Care was conducted in 1990, to elicit information on the nature of illnesses suffered, source of medical treatment and the cost of medical care. The results of the survey, published in 1992, evoked considerable interest among researchers and policy makers.

Based on this experience, the Council took up a more detailed Household Survey of Health Care Utilisation and Expenditure in the summer months of 1993, covering most of the States and Union Territories of India. The results of this survey are presented in this report.

The earlier survey of the NCAER had referred only to the treated illnesses, while the present one covered both treated and untreated illness episodes. An attempt was also made to separate the hospitalised from the non-hospitalised illness episodes. The survey collected detailed information on prevalence of illnesses, utilisation of health care services including type of provider, system of medicine, distance travelled to seek treatment and breakdown of expenditures relating to illnesses. The data is presented separately for the rural and urban areas, state-wise, by the socio-economic characteristics of the households and by gender.

The results of the survey revealed an overwhelming dependence of the population on the allopathic system of medicine. It also revealed that dependence on private health facilities is more than that on public facilities for out-patient treatment. However, for hospitalisation the dependence on public hospitals is much higher. There is a noticeable differential in the household expenditure on the treatment of illnesses, especially for hospitalisation of males and females. This sex differential is even more pronounced in the case of children.

Economics of Health is now recognised as a discipline that can address some of the important issues in planning for the health sector. The findings of this survey will be useful for formulation of policies for this important sector.

We are grateful to the Ministry of Health and Family Welfare, Government of India and the World Health Organisation for their support for this study.

I appreciate the work done by the project leader, Ms. Ramamani Sundar and her study team. Thanks are also due to Dr. S.P. Pal and Dr. Abusaleh Shariff for their comments and suggestions.

New Delhi
March 15, 1995

S.L. Rao
Director-General

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Summary and Findings

THE National Council of Applied Economic Research (NCAER) has conducted national surveys since 1986 to establish market structures for a variety of consumer goods. Along with the fourth study in the series, Market Information Survey of Households (MISH), a household survey of medical care was conducted in May-July 1990. The results of this national survey evoked considerable interest among researchers and policy makers. Drawing on the experience gained from the first survey, the NCAER launched a second round of the survey in 1993 along with the fifth Market Information Survey of Households (MISH 1993).

The second survey had several new features and is as such an improvement over the earlier one in many respects. It collected data on morbidity, health care utilisation and health expenditure in greater detail. The earlier survey[1] referred only to the treated illnesses, while the present one covered both treated and untreated illness episodes. In this study an attempt has also been made to separate the hospitalised from the non-hospitalised illness episodes. The results of this second round of Household Survey of Health Care Utilisation and Expenditure are presented in this report.

The survey collected information on the prevalence of illness, utilisation and source of health services, type of providers, system of medicine used and the distance travelled to seek treatment. A detailed break-down of expenditure associated with each illness episode was also collected. Data on illness episodes requiring hospitalisation were collected separately. The survey also gathered data on socio-economic characteristics of the households and all its members.

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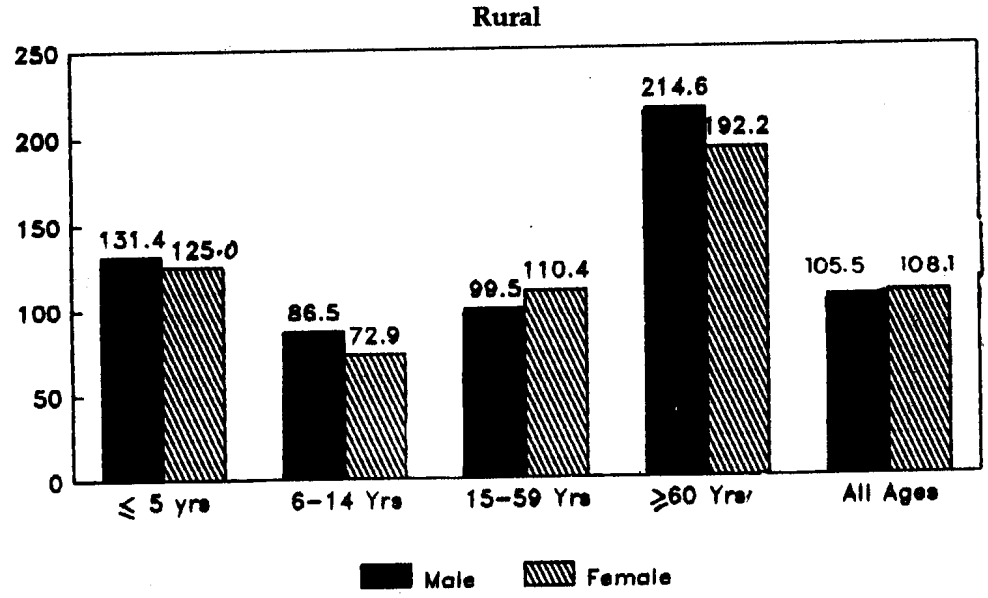
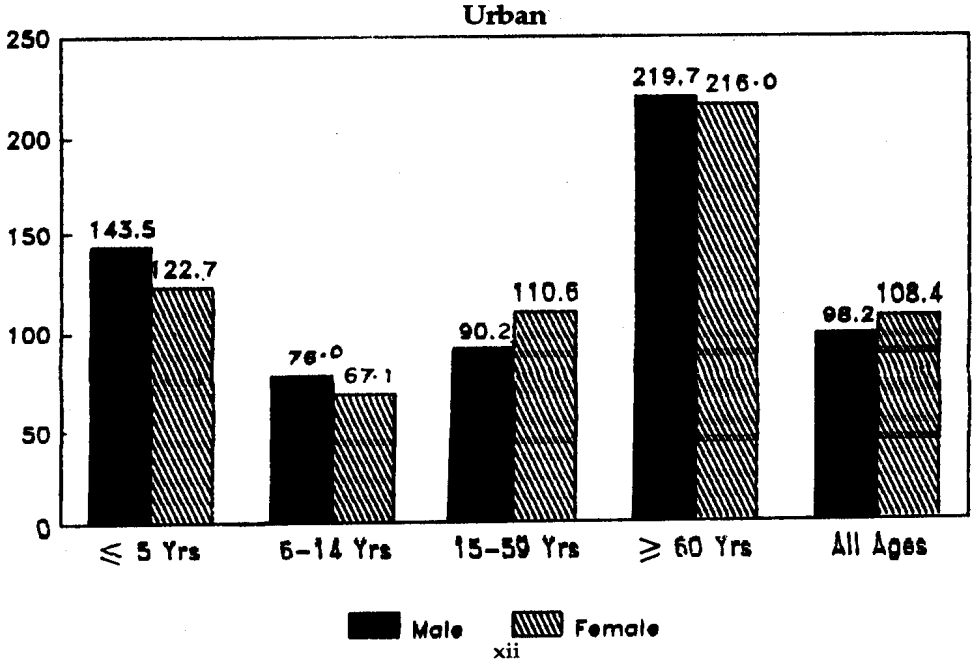
1. NCAER, *Household Survey of Medical Care*, 1992.

Prevalence Rate of Illness for the Reference Month by Age and Sex

(Per '000 Population)





The Household Survey of Health Care Utilisation and Expenditure was carried out in the summer months of May-June 1993 and covered almost all the States and Union Territories of India. The sample consists of 18,693 households spread over the rural and urban areas of the country. The study is based on household interviews carried out with the help of a detailed questionnaire and the reference period was one month preceding the date of interview.

Morbidity Profile

For the country as a whole, the reported prevalence rate of illness for the one month reference period works out to be 106.7 and 103.0 per thousand population for the rural and urban areas respectively.

The prevalence rate of treated illness works out to be 94 per thousand population for both rural and urban areas of the country. These rates are substantially higher than the prevalence rate of treated illnesses reported in the NCAER's earlier survey of 1990 which was 79.1 for the rural and 67.7 for the urban areas. The differences in the rates between the two surveys could be partly due to the increase in the reference period from two weeks to one month which could have resulted in an increase in the reporting of acute illnesses.

The survey results do not indicate any significant sex differentials in the overall prevalence of illnesses at the all-India level, although some states have reported different rates for males and females.

The prevalence rate of illness by different age groups reveals a very high morbidity rate for the 60+ age group, for both rural and urban areas. In the rural areas, the morbidity rate (per thousand population) works out to be 215 and 192 for the male and female elderly persons. In the case of the urban 60+ age group, the rates are as high as 220 and 216 per thousand population for the male and female population respectively. The high prevalence of illness among the elderly population has a very significant policy implication. It indicates that with an ageing population, the disease burden on the society and state is going to increase in the coming years.

There are wide variations in the reported prevalence rate

of illness across different states. Among the various states, Kerala has reported the highest rate of morbidity (194.8 for the rural and 183.9 for the urban areas).

Nature of Illness

Fever seems to be the most common illness among both adults and children, accounting for 30% of the reported illnesses in the rural areas and about one-fourth of the reported illnesses in the urban areas. Next in importance comes the respiratory infection which includes common cold, cough, nose and throat discomfort and bronchitis.

The prevalence rate of cardio vascular diseases like hypertension, heart ailments, paralysis is much higher for the urban adults as compared to their counterparts living in the rural areas. In the rural areas, the prevalence rate of cardiovascular diseases (per thousand population) is 4.5 and 3.1 respectively for the adult males and females. In the urban areas it is 9.0 for adult males and 7.7 for adult females. The higher prevalence of cardio vascular diseases in the urban areas probably reflects the stresses and strains of the urban life style.

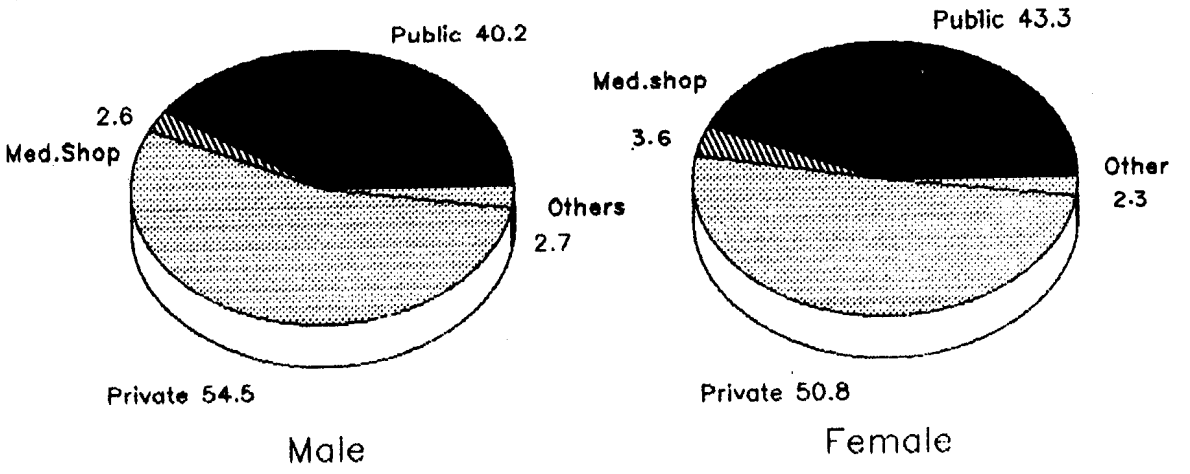
The disease pattern of the country is dominated by acute illnesses. This category accounted for 73% of the reported illnesses in the rural areas and 68.5% of the illnesses in the urban areas. The serious communicable diseases, which include typhoid, malaria, cholera, acute gastero enteritis, jaundice, chicken pox, measles, mumps and tuberculosis account for 14.5% and 13.3% of all reported illnesses respectively in the rural and urban areas.

In the advanced countries, the chronic and degenerative diseases have replaced the infectious diseases over a period of time. Acute infectious ailments which occur most often in childhood have also declined considerably. In India, the communicable diseases and acute illnesses which include diseases like respiratory infection or diarrhoea account for a high proportion of reported illnesses even now.

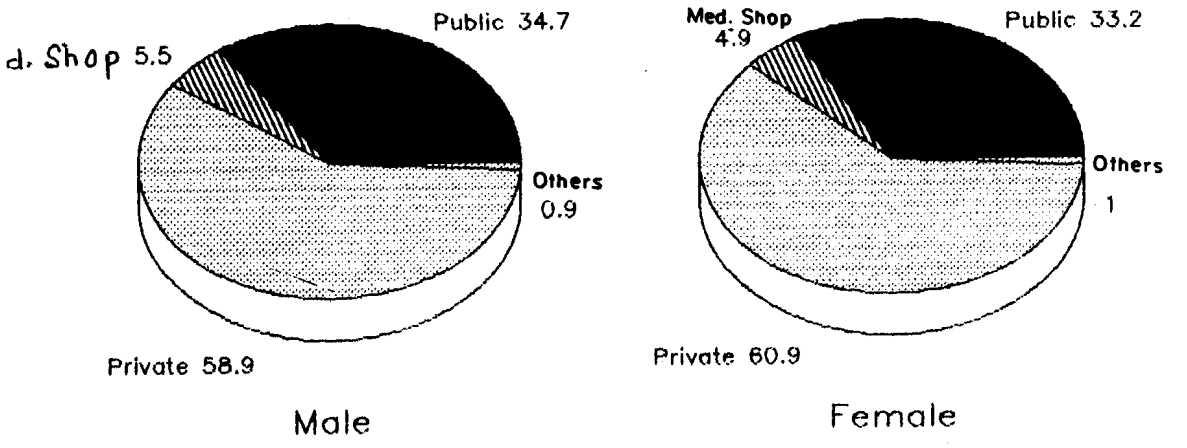
The overall morbidity level comes down with the rise in the annual household income, suggesting that with improvement in economic status, the health status of the people also improves. With the increase in the income status of the households, the

Percentage Distribution of Non-Hospitalised Illness Episodes by Type of Treatment

Rural



Urban



ery= Faith Healer and
ne Remedy

prevalence rate of serious communicable diseases and acute illnesses also comes down, and the prevalence of chronic illnesses increases. In other words, with the rise in the economic status, the diseases of poverty and malnutrition are replaced by the diseases normally prevalent among the affluent in the Western World.

Hospitalisation

The reported number of hospitalisation cases (per thousand population) are 7.1 for the rural areas and 9.7 for the urban areas. The higher rates for the urban areas perhaps indicates better access to hospital facilities in the cities.

Unlike in respect of overall reporting of illness, sex differentials are very significant in the number of hospitalisation cases. In most of the states, the number of hospitalisation cases per thousand population has worked out to be lower for the females.

Untreated Illnesses

For nearly 12% of the illness episodes in the rural areas and about 8% of the illness episodes in the urban areas, no treatment has been sought. The higher percentage of untreated illnesses in the rural areas probably reflects the poor physical and financial access to heath care in the rural parts of the country.

The most important reason for not seeking any treatment turns out to be "illness not considered serious enough".

Utilisation of Out Patient Health Care Services

The survey reveals a high dependence on the private health providers for the treatment of non-hospitalised illness episodes. The percentage of illness episodes for which treatment has been sought from the private health providers works out to be 52 for the rural areas and 59 for the urban areas.

For 42% of the illness episodes in the rural areas, treatment has been sought from the public hospitals, community health centres, primary health centres and sub-centres. In the urban areas the utilisation of public health facilities like the Government hospitals and the dispensaries run by the Government and

the local bodies accounted for 34% of the illness episodes for which treatment was sought.

The percentage of illness episodes for which medicines have been directly purchased from the Medical Shops (without consulting a doctor) works out to be 3.1 for the rural and 5.2 for the urban areas. Seeking treatment from religious persons or faith healers and the dependence on home remedies seem to be generally very low, though the percentages are marginally higher for the rural areas.

Though for most of the states, the utilisation of private health facilities has worked out to be higher, states like Himachal Pradesh, Rajasthan and the rural parts of Assam, Karnataka and Orissa seem to rely more on the public health facilities.

In both rural and urban areas, the utilisation of private health facilities is highest for the acute illnesses. Since the acute illnesses are generally of short duration and the treatment is comparatively less expensive, people may find the private treatment within reach and would consult any doctor who is easily accessible. The percentage of illness episodes for which self-medication has been resorted to, is also the highest for the acute ailments.

Both in rural and urban areas, with an improvement in the income status of the households, the utilisation of private health facilities went up. For example, in households with annual income over Rs. 54,000, the utilisation of private health facilities works out to be 69% and 75% respectively for the rural and urban areas. The respective percentages for those households with annual incomes below Rs. 18,000 are only 51 and 52 and for those with annual incomes ranging from Rs. 18,000 to Rs. 54,000, the percentages are 55 and 63.

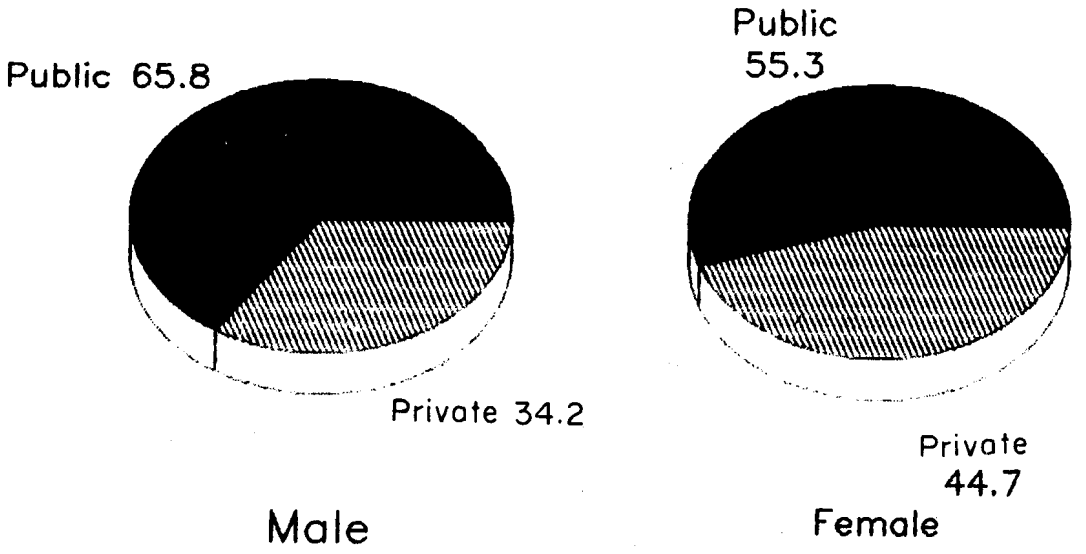
Positive association has also been found between levels of education of the household and private health care utilisation. Interestingly, the dependence on Medical Shops is comparatively higher among the well educated people (Graduate and above) of the urban areas as well as among the uneducated rural people.

The dependence on private health facilities is fairly high for the business class, the salary earners/professonals of the urban areas, and for the cultivators in rural areas.

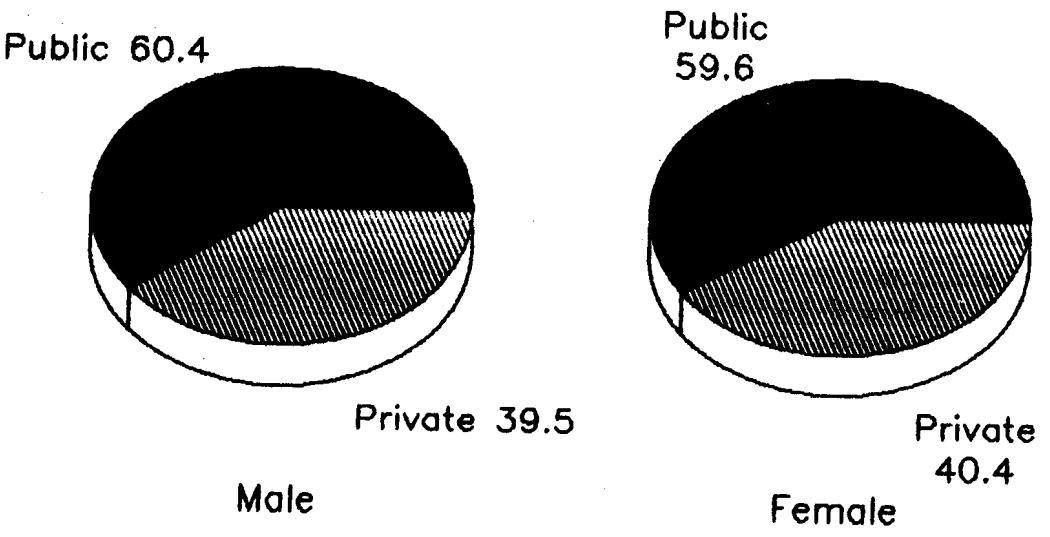
The dominance of the allopathic system of treatment over

Percentage Distribution of Hospitalisation Cases by Type of Treatment

Rural



Urban



other systems of medicine is clear from the results of the survey. At the all-India level, for more than 90% of the illness episodes, the allopathic system of treatment has been sought. The homeopathic treatment was sought by only 2% and ayurvedic treatment by only 3.8% in the rural areas. The corresponding percentages for urban areas were 2.9 and 2.2.

On an average people have travelled longer distances in the rural areas as compared to the urban areas for seeking treatment. The average distance travelled works out to 5.9 kms. for the rural areas and 2.2 kms. for the urban areas. Both in the rural and urban areas, the average distance travelled has worked out to be marginally lower for the female adults and female children as compared to their male counterparts. It is important to note that neither the private hospitals nor the private practitioners seem to have any locational advantage over the public health facilities both in the rural and urban areas.

Utilisation of Hospitalisation Facilities

In contrast to the non-hospitalised illness episodes, the dependence on public health facilities is much higher in the case of illnesses requiring hospitalisation. For 62% of the cases in rural areas and 60% of the cases in urban areas, in-patient treatment has been sought in the public hospitals.

In some of the states like Himachal Pradesh, Madhya Pradesh, Orissa and Rajasthan, the utilisation of public hospitals is very high.

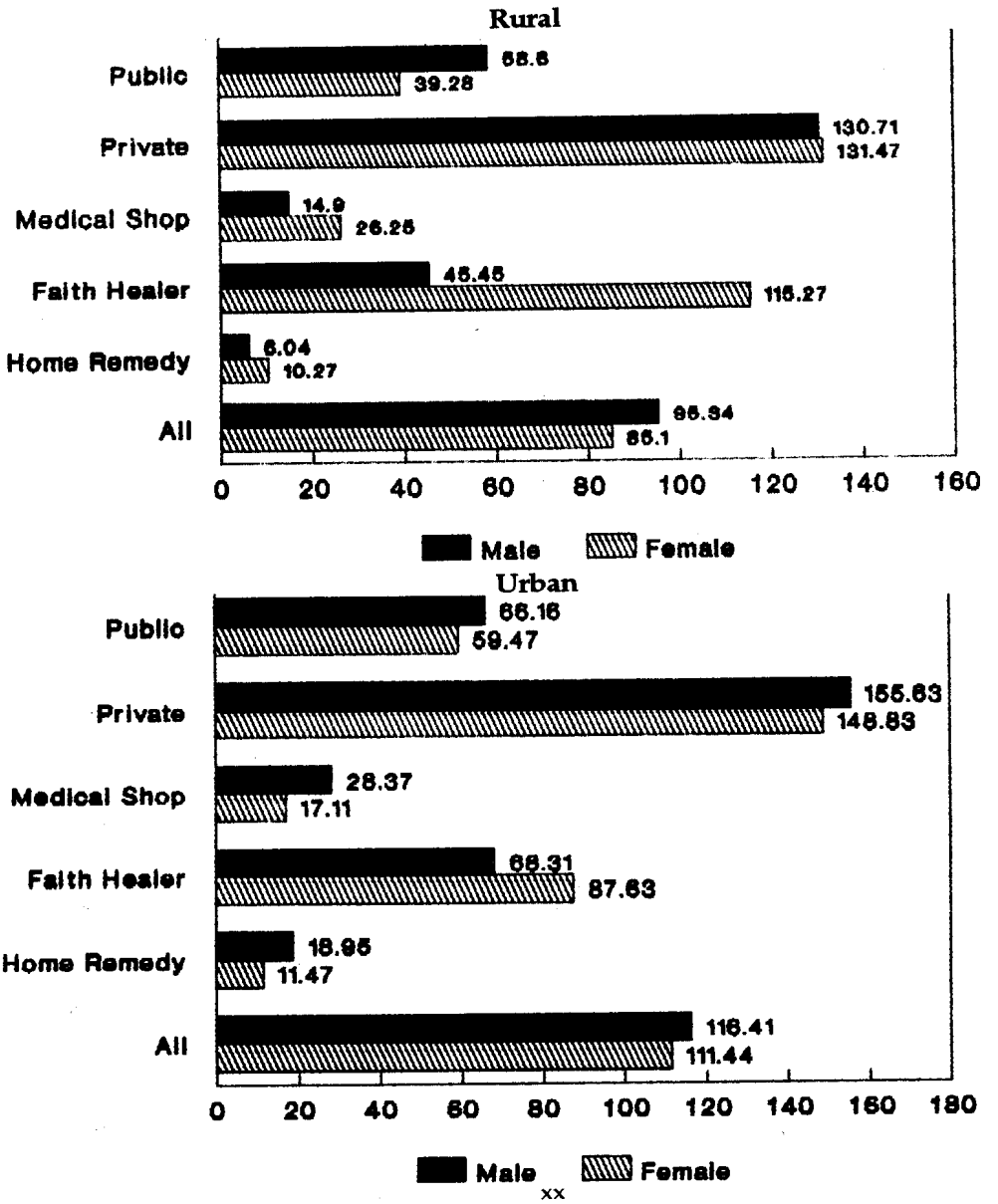
On an average people have travelled a longer distance for hospitalisation as compared to treatment of non-hospitalised illnesses. The average distance travelled has worked out to be considerably higher for the rural households,indicating that the hospitals are concentrated in the urban areas and the rural people have to travel a long distance to reach them.

Utilisation of Health Facilities for Preventive and Promotive Health Care

The survey results show that the people's dependence on public health facilities is higher for natal, intra-natal and preventive health care. More than 60% of the deliveries in both rural and urban areas have taken place in the Government

Average Expenditure Per Illness Episode by Type of Treatment (Non-Hospitalisation)

(In Rupees)



health facilities. The immunisation being done in the public health facilities account for nearly 90% of the reported number of immunisations.

Household Expenditure on Health Care

Based on the expenditure incurred by the households during the one month reference period for the treatment of illnesses, the per capita annual household expenditure on curative health care has been estimated. For the country as a whole, the per capita annual household expenditure on curative health care works out to be Rs. 204. The urban dwellers are spending more on curative health care when compared to their rural counter parts. The per capita household expenditure on curative health care works out to be Rs. 184 and Rs. 258 for the rural and urban households respectively.

The results of the survey indicate that on an average the households spend nearly 5% of their income on curative health care. The household expenditure on curative health care comes down with an increase in the income status of the households. The poor households with annual income of less than Rs.18,000 spend more than 7% of their income on the treatment of ailments, while the rich households (with annual income exceeding Rs. 54,000) spend much less (about 3%).

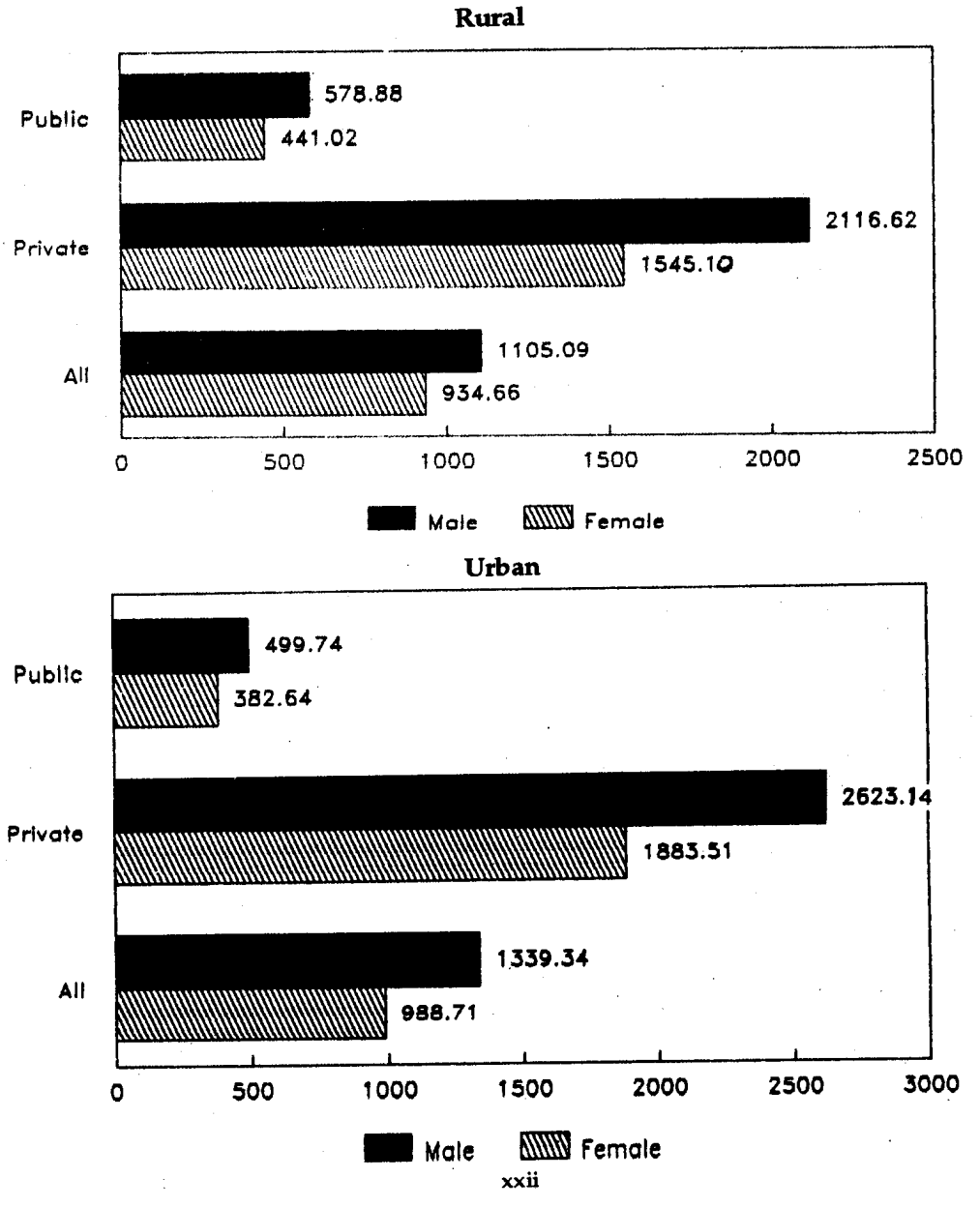
Household Expenditure on Non-Hospitalised Illnesses

The average household expenditure per illness episode has worked out to be Rs. 90 for the rural areas and Rs.114 for the urban areas. There are substantial rural-urban differentials in the average household expenditure (per illness episode) for both adults and children.

In both rural and urban areas, the average household expenditure (per illness episode) has worked out to be lower for the female adults and the female children as compared to their male counterparts. This sex differential in the household expenditure is visible not only at the all-India level but also in most of the states and the gender difference is more pronounced in the case of children. The rural households have spent Rs.114 and Rs.101 per illness episode respectively for treating the adult male and female, and the urban households have spent Rs. 134 and Rs. 126 for the same purpose. Similarly, in the case of children, the average household expenditure

Average Expenditure Per Illness Episode by Type of Treatment (Hospitalisation)

(In Rupees)



per illness episode has worked out to be lower for the female children as compared to their male counterparts. On an average the rural households have spent Rs. 60 and Rs. 45 respectively for the male and female children while the urban households have spent Rs. 77 and Rs. 61 for the same purpose.

The average expenditure on treating an illness episode is lower when the treatment was sought from the public health facilities. In the rural areas, for example, the average amount spent for treating an illness episode is Rs. 49 and Rs. 131 respectively for the public and private health facilities. The respective amounts for urban areas are Rs. 63 and Rs. 152.

Household Expenditure on Hospitalised Illnesses

The average expenditure incurred by the households for seeking treatment from the private hospitals/nursing homes is much higher as compared to the public hospitals. This could be the most important reason for the higher utilisation of public health in-patient facilities.

In the urban areas, the average household expenditure per hospitalised case works out to Rs. 453 for the public hospitals and Rs. 2319 for the private hospitals, while in the rural areas, the averages are Rs. 535 for the public hospitals and Rs.1877 for the private hospitals/nursing homes.

There is a significant sex differential in the average expenditure incurred by the households for hospitalisation both in the urban and rural areas, irrespective of the type of health facility utilised. In the rural areas, the average amount spent per hospitalisation case turns out to be Rs.1105 for the males and Rs. 935 for the females. In the urban areas, it is Rs.1339 for the males and Rs. 989 for the females.

Chapter 1

Introduction

INDIA is currently engaged in the structural adjustment of its economic system and is moving towards increased privatisation and a market oriented economy. Health and Education however, are two sectors where the state will continue to play an important role. Over the years the private health care sector has expanded widely in both rural and urban areas. Nearly 80% of the country's registered doctors work in the private sector. In addition to these practitioners of various systems of medicine, there are a large number of unqualified 'doctors' whose exact number is not known. In the big cities, the private corporate sector has entered the business of health care delivery and has opened a number of hospitals.

All these phenomena raise some crucial policy issues. What should be the right mix of private and public health care services? What are the ways and means by which the state can control and/or regulate the private health sector? What should be the role of the state as a provider of health care? Should the state concentrate mainly on the preventive and promotive aspects of health care? Should the state play a greater role at the primary level or at the tertiary level of health care? To answer any of these questions, information on the utilisation pattern of health care services in a society is necessary.

Similarly, in order to set priorities for the allocation of scarce resources for the various health programmes, it is useful to understand the pattern of morbidity across states and the morbidity burden on different sections of the society. Information on household expenditure on health care would also be a useful guide for the policy makers in assessing the possibilities of cost recovery or charging user fees from the people.

Unfortunately in India there is a dearth of information on such health issues which could help the Government in planning health programmes. Official statistics on cause of death or the data collected from the hospital in-patient and out-patient records serve only a limited purpose. Household health surveys can bridge this information gap by collecting useful data on

morbidity, utilisation of health care services and expenditure incurred on health related matters. Comprehensive health surveys covering various characteristics of the household and its members can throw light on socio-economic, demographic and other factors that influence the health status of the people. Social scientists can play a crucial role by undertaking such health research, as it has become clear from recent research that apart from medical intervention and income, social, cultural and behavioural determinants also play an important role in bringing about health transition.

Economics of health is now recognised as a discipline that can address some of the important issues in planning for the health sector. Economic tools and concepts can be applied to achieve efficient management of available resources, elimination of waste, a more rational spending pattern, raising productivity and exploring innovative ways to raise additional financial resources. Issues such as equity, policy options and demand/need for health are now taken up by economists in the planning of health care and formulation of health care policies.

In India, only a few morbidity/health surveys which can throw light on the health status of the people are available. There are some disease specific surveys such as Goiter surveys or diabetes prevalence surveys which were conducted in a specific population for the surveillance and detection of specific diseases. Besides these, there have been area specific health surveys which have covered a particular state or a region. Notable among them are the surveys conducted by the Kerala Sastra Sahitya Parishad (KSSP), for the State of Kerala, Foundation for Research on Community Health's (FRCH) studies on health expenditure for the States of Maharashtra and Madhya Pradesh, and the study of six rural districts of Madhya Pradesh, Rajasthan and U.P. by the National Council of Applied Economic Research (NCAER).

The Kerala Sastra Sahitya Parishad (KSSP), a voluntary organisation, conducted a survey of 10,000 households (covering 1001 panchayats of Kerala) in the year 1987 "to provide a comprehensive base line data on health status in rural Kerala" (Kannan, et al, 1991). The focus of the FRCH's Household Survey in the Jalgaon district of Maharashtra was on the household expenditure on health care (Duggal and Amin, 1989). There is another study by FRCH on the Household Health Expenditures in Madhya Pradesh (George, A., et al, 1993). The primary objective of the NCAER's study of the six rural districts of Madhya

Pradesh, Rajasthan and U.P. was to assess the health needs of the people and to analyse the utilisation pattern of the existing health facilities. This survey was conducted in three rounds to capture the seasonal variations in morbidity (NCAER, 1992 b).

At the national level, the National Sample Survey Organisation (NSSO) has been the only source of data on health problems based on a large sample. So far, the NSSO has carried out three sample surveys on morbidity, i.e., the 17th round, 28th round and the 42nd round. The 42nd round is the latest and the data collected during this survey pertains to the year 1986-87. This survey provides both all-India and state level data on utilisation of medical services for hospitalised and non-hospitalised illness cases and details about the average expenditure per hospitalised case by type of hospital.

The NCAER has been conducting several, national surveys since 1986 to establish market structures for a variety of consumer goods. Along with the fourth survey in the series, the Market Information Survey of Households (MISH), a household survey of medical care was conducted in May-July 1990, to elicit detailed information on the nature of illnesses suffered by the household members, source of treatment and the cost of medical care (NCAER, 1992a). The results of this national survey evoked considerable interest among researchers and policy makers.

This survey was a pioneering one and the NCAER had very little earlier experience to bank upon. It covered only the treated illnesses and no attempt was made to distinguish between the hospitalised and non-hospitalised illness episodes. Drawing on the experiences gained from the first survey, the NCAER planned and carried out the second round of the survey along with the fifth Market Information Survey of Households (MISH, 1993). The second survey had several new features and is as such an improvement over the earlier one in many respects. The results of this second round of Household Survey of Health Care Utilisation and Expenditure are presented in this report.

The Household Survey of Health Care Utilisation and Expenditure (1993) was carried out in the summer months of May-June 1993 and covered almost all the States and Union Territories of India. The sample consisted of 18,693 households spread over the rural and urban areas of the country. The data collected were based on household interviews carried out with a detailed questionnaire and the reference period for the study was one month preceding the date of interview.

The survey collected information on the prevalence of illness, utilisation of health services including type of provider, system of medicine, the distance travelled to seek treatment and a detailed break down of expenditure associated with each illness episode. Data on illness episodes requiring hospitalisation was collected separately. Besides collecting detailed health information, the survey gathered data on socio-economic characteristics of the households and on each and every member of the households.

The details about the sample design and the sample selection procedures are presented in Chapter 2 along with explanations of concepts and definitions used for the survey. In Chapter 3 the variations in prevalence rate of illness and the pattern of morbidity across states and among different sections of the society are discussed. Chapter 4, deals with the utilisation pattern of health care services for the non-hospitalised and hospitalised illness episodes and Chapter 5 with the expenditure incurred by the households for the treatment of various types of illness episodes.

Chapter 2

Sample Design and Methodology

THE Household Survey of Health Care Utilisation and Expenditure covered all the States and Union Territories of India except Manipur, Nagaland, Sikkim, Tripura, Andaman & Nicobar Islands, Arunachal Pradesh, Dadra & Nagar Haveli, Lakshadweep, Mizoram, and Jammu & Kashmir. A sample of 18,693 households was selected spread over the rural and urban areas of the country. In this chapter, the details the sample design and the sample selection procedure are presented in the first section. This is followed by an explanation of the concepts and definitions used for the survey along with their limitations. Some of the methodological issues arising out of these concepts and definitions are also discussed.

Sample Design and Sample Selection

A multistage stratified sample design is used for the present study, with village/town as first stage unit and household as second stage unit. The Universe for the study comprised both rural and urban areas of the country.

Rural Sample

All the districts in the states/union territories are covered in the survey and each of these districts is selected with probability one. From each district two villages are selected with probability proportion to the population of the village. In all 718 villages were selected for the survey.

Urban Sample

According to the 1991 Census, there were 3591 cities/towns in the states and the union territories covered by the survey. The population of these cities/towns varies from 5000 to over 10 million. There are 53 cities with population exceeding 5 lakhs. All these big cities with the population exceeding 5 lakhs were included in the sample. The remaining towns were grouped in five strata, on the basis of their population size.

From each stratum, a sample of towns was selected independently. A progressively increasing sampling fraction with increasing size class of the stratum was used for allocating sample towns in each stratum. Thus 515 cities/towns were selected as first stage unit of sample for the urban areas.

The Census operation has divided each town into a number of small blocks with a well defined boundary, having nearly equal population in each block. From each sample town/city, a sample of census blocks were selected; the number varying between 2 and 30, depending upon the size of the town. The total number of blocks selected was 1509. These blocks were selected independently in each town with equal probability.

Household Selection

All the households in the selected villages and blocks were listed through a specially designed proforma. If the number of households in a selected block or a village exceeded 150, the appropriate sampling fraction was used and the listing was limited to a maximum of 150 households only. This proforma sought information, among other things, on the household size, income, occupation of the head of the household, highest level of education in the household, religion, caste, etc.

The listed households from each village/block were classified in five income categories and after stratification, using the inverse of probability of selection of village or town and blocks, the number of households in the rural and urban areas were estimated for each state. Sample households were selected with equal probability from each stratum of income, using random number table. In all 18,693 households were selected, of which 12,339 were from the urban areas and the remaining 6354 from the rural areas. State-wise distribution of sample towns, village and households are presented in table (page 7).

Concepts, Definitions and Survey Methodology

The data for this study were collected by canvassing a precoded survey instrument. The interviewers were non-medical

State-Wise Distribution Of Sample Towns, Villages and the Households

States	*No. of Towns Selected*	*No.of Blocks Selected*	*No. of Villages Selected*	*No. of Households*		
				Urban	*Rural*	*Total*
Andhra Pradesh	44	133	46	1090	351	1441
Assam	9	22	46	182	369	551
Bihar	33	87	84	717	672	1389
Goa	4	8	4	64	32	96
Gujarat	34	101	38	841	304	1145
Haryana	16	41	32	320	263	583
Himachal Pradesh	5	11	24	83	120	203
Karnataka	35	104	40	867	325	1192
Kerala	21	59	28	490	241	731
Madhya Pradesh	46	121	90	1010	720	1730
Maharashtra	45	153	60	1287	466	1753
Meghalaya	4	9	10	74	84	158
Orissa	15	35	26	282	205	487
Punjab	19	53	24	233	116	349
Rajasthan	28	73	54	584	431	1015
Tamil Nadu	44	145	42	1217	323	1540
Uttar Pradesh	80	213	126	1802	1012	2814
West Bengal	30	104	32	870	257	1127
Pondicherry	1	3	8	24	32	56
Ghandigarh	1	4	2	32	15	47
Delhi	1	30	2	270	16	286
ALL-INDIA	**515**	**1509**	**718**	**12339**	**6354**	**18693**

persons but concepts and definitions used were explained to them and they were trained in the application of the interview technique. The respondents were mostly the heads of households. Wherever the head of the household was not available, any other responsible adult member of the household was contacted.

Period of the Survey

The survey was conducted during the summer months of May-June 1993. It is a one time survey and as such cannot reflect the seasonal variations in the morbidity pattern.

Reference Period

The length of the recall period is one of the factors influencing the reliability of illness reporting. Though two-weeks recall period is considered an ideal, many health surveys in the past have adopted the one month recall period. For example, in the FRCH Household Survey of Jalgaon district, the reference period was one month. Similarly, the NSSO's 42nd round had adopted the 30 days reference period for calculating the proportion of persons with ailments. The NCAER's Household Survey of Medical Care (NCAER, 1992a) was based on a two weeks recall period. In the present survey, the reference period was one month.

Morbidity

The survey includes both prevalence and incidence of illness during the reference month. In other words it includes all illness episodes that started during the reference month and all episodes (including chronic) that existed during the month, even if the illness episode had started before the reference period.

The survey includes the following categories of illness episodes:

(i) Episodes starting before the reference period and terminating within the reference period.

(ii) Episodes starting and terminating within the reference period.

(iii) Episodes starting within the reference month and continuing at the time of the interview.

(iv) Episodes starting before the first day of the reference period and continuing on the date of survey.

Reporting of Illness

After getting the details about the individual characteristics of all the household members, the interviewers were asked to read out the names of each and every member of the household

to find out whether he or she had suffered from any illness during the month prior to the date of the interview. If any person had suffered from more than one illness during the reference period, whether simultaneously or at different points of time within the one month reference period, these illnesses were entered as separate illness episodes.

The survey is based on lay reporting of illness and not on a clinical examination. It will not be inappropriate to mention here that the medical diagnosis itself is based on people's description of the symptoms of illness and hence it may not be incorrect to group the various symptoms under different categories/names of illnesses based on lay reporting.

In the present survey the interviewers were asked to note down the symptoms, as described by the households in detail (wherever the patient had been to a 'doctor' and the doctor had diagnosed the disease, the name of the illness was noted down). At the editing stage, the symptoms were classified/ grouped under different illness names using the World Health Organisation's Manual on Lay Reporting of Health Information (WHO,1978). These were further grouped under the following four broad categories of illnesses for the purpose of analysis:

(i) *Serious Communicable Diseases:* Typhoid, malaria, cholera/acute gasteroenterites, jaundice, mumps, measles, chicken-pox and tuberculosis.

(ii) *Acute Illnesses:* Diarrhoeal diseases, respiratory infections, non-specific fever, skin diseases, eye/ ear problems, headache/bodyache/backache, stomach problems - indigestion, gas acidity and constipation.

(iii) *Chronic Illnesses:* Aches and pains (arthritis and rheumatism), Cardio- Vascular diseases (heart ailments, hypertension),diabetes, kidney problems, breathing problems/asthma, cancer, weakness/ dizziness/anemia, mental and psychological disorder and others.

(iv) *Accidents/Injuries.*

Treatment

The survey included both treated and untreated illnesses. In the case of untreated illnesses, the reason for not seeking

treatment was also ascertained from the respondents.The survey had scope for including combinations of different systems of medicines and multiple treatment for an illness episode.

Chapter 3

Prevalence of Illness and Pattern of Morbidity

MOST of the world's developing countries are currently at various stages of epidemiologic transition. Epidemiologic theory postulates that as mortality declines, there will be a marked shift in the distribution of major causes of death, i.e., a shift from infectious diseases to non-communicable diseases. India is in the midst of an epidemiologic transition and has an epidemiological profile of a poor as well as an affluent country (Dasgupta, et al, 1992). The country is simultaneously facing the double burden of pre-transitional and post-transitional diseases. The diseases of underdevelopment and poverty, such as, infectious diseases, nutritional deficiencies and reproductive health problems still persist and cause a substantial share of deaths. At the same time, with increase in life expectancy and urbanisation, chronic and degenerative diseases are adding to the disease burden. Over and above these diseases, the country is facing new health threats in the form of AIDS environmental pollution and behavioural problems like violence and drug abuse.

This chapter deals with some of these issues on the basis of the results of the survey on the prevalence of illness and the pattern of morbidity among different age groups of people and among the individuals belonging to different socio-economic categories. Variations in the prevalence rate of illness among different states, and between the rural and urban areas of the country are analysed to understand the disease burden on society and the people.

Prevalence Rate of Illness

State-wise reported prevalence rate of illness (per thousand population) are presented in Tables 1 and 2. For the country as a whole the reported prevalence rate of illness for the one month reference period works out to be 106.7 and 103.0 respectively for the rural and urban areas. The prevalence

rate of treated illnesses works out to be 94.1 for the rural and 94.4 for the urban areas of the country.

These rates are substantially higher (especially in the case of urban areas) than the prevalence rate of treated illnesses reported in the NCAER's earlier survey (79.06 for the rural and 67.71 for the urban areas for the year 1990). As mentioned in the previous chapter, the NCAER's first survey of Medical Care (NCAER, 1992a) had adopted a two-week reference period. In the present survey the reference period has been increased to one month. The differences in the prevalence rate of illness between the two surveys could be partly due to the increase in the reference period, which could have resulted in an increase in the reporting of acute illnesses. It is also difficult to assess to what extent the increase in the prevalence rate of treated illnesses between 1990 and 1993 is due to increase in morbidity or to increase in utilisation of health care services.

Sex-Differentials in Morbidity

The survey results do not indicate any significant sex differentials in the overall prevalence of illness at the all-India level, although some of the states have reported different rates for male and female populations. The all-India prevalence rates of illness are 105.5 for the males and 108.1 for the females of rural areas. In the case of urban population the rates are 98.2 for the males and 108.4 for the females. However, the prevalence rate of illness by sex and age group of people shows a slightly different picture (Table 3) Except for the 15-59 age group, the reported morbidity rates are much lower for the females as compared to their male counterparts, both in the case of rural and urban areas. In fact, among the children, the sex differentials are substantial.

A number of nutritional studies in India, especially the micro level studies, have found higher rates of malnutrition among women and girls than among men and boys (Sen and Sengupta, 1983; Dasgupta, 1987). One should therefore, expect the prevalence of morbidity, especially the prevalence of infectious diseases, to be higher among the females. However, there is a considerable difference in the perception of illness by males and females. In the case of women even if they are suffering from illness, they do not consider themselves ill as they cannot afford to take time off their domestic chores. As

a result the perception of illness is low for women. In the case of girl children also, especially in the rural areas, the need, ability and the permission to seek medical aid is severely restricted. Due to this perception effect, the reporting of morbidity can be much lower than the actual morbidity burden in the case of females. As a result many surveys on morbidity do not show higher prevalence of illness among the females. For example, the NSSO Survey (42nd round) did not find any sex difference in the proportion of persons who had fallen ill during the 30-day reference period. The morbidity rates were the same for both the sexes in the rural and urban areas. The results of the present survey, thus are on expected lines. However the findings of the present survey, are in contrast to the earlier survey of the NCAER which had reported substantial sex differentials in the prevalence rate of treated illnesses for both adults and children. In the earlier survey, the low reporting of illness by women and the female children was attributed to the differences in the perception of illness between the sexes. In the case of the present survey, due to improvement in the interview technique (the interviewers were asked to read out the names of each and every family member and ask whether he or she suffered from any illness), the reporting error might have come down considerably, resulting in a better reporting of diseases of the females.

Prevalence of Illness by Age Group

The reported prevalence rates of illness by different age groups of the population reveals a very high morbidity rate for the 60+ age group, for both rural and urban areas. The rates are 214.6 for the males and 192.2 for the females in rural areas for the one month reference period. In the case of urban elderly population, the rates are 219.7 for the males and 215.9 for the females. The high prevalence of illness among the elderly population has a very important policy implication. With an increase in life expectancy and a reduction in birth and death rates, the proportion of 60+ population to the total population is bound to increase over the years. The proportion of 60+ population has increased steadily from 5.6% in 1961 to 6.5% in 1991 and it is estimated to go up to 7.5% by the end of the century. Since India's population itself is very large, in terms of numbers this will be very significant. The high prevalence of morbidity among the old people indicates that

with an ageing population, the disease burden on the state and society is going to increase in the coming years. Also, since old people suffer more from chronic illnesses which require prolonged and/or expensive treatment, the financial implication of the disease burden would be significant.

The morbidity rate for both male and female children up to 5 years of age is higher than the rates for the older children and for the adults belonging to the 15-59 age group. In the rural areas, the prevalence rate of illness for the children upto 5 years of age works out to be 131.4 for the male and 125.0 for the female per thousand population. For the older children, i.e., 6-14 years of age, the morbidity rates are much lower at 86.5 for the male and 72.9 for the female. Similarly in the case of urban areas, the prevalence rate of illness for the younger children works out to be 143.5 for the male and 122.7 for the female, and for the children belonging to the 6-14 years age group the rates are lower at 76.0 for the male and 67.2 for the female. This is understandable since young children are more susceptible to infectious diseases.

It is interesting to note that the percentage of treated illness to total reported illness decreases marginally with increase in age (especially in the case of rural old women) indicating that with limited access to health care (both physical and financial) old people's illnesses are likely to get neglected.

State Level Variations

There are wide variations in the reported prevalence rate of illness across different states/regions of the country. Among the various states, Kerala has reported the highest rate of morbidity. The rates are 194.8 for the rural areas and 183.9 for the urban areas for the reference month. This is in line with the findings of a number of studies reporting higher morbidity for the state of Kerala (Panikar and Soman, 1984; Kannan, et al, 1991). The state of Kerala, that has made major strides in mortality reduction, reporting high level of morbidity has remained a puzzle for the researchers. Many explanations have been put forward to understand this 'paradox' of the co-existense of low mortality with high morbidity. The high perception of illness of the people of Kerala, is considered an important factor responsible for the reporting of high morbidity. The high literacy rate has made the people of Kerala highly

health conscious and this has led to greater utilisation of health care services. However it has been argued that high self perception of illness by itself cannot fully explain the higher reporting of illness in Kerala. Based on official data and other studies relating to Kerala, it has been concluded by researchers that the real illness burden is quite high in Kerala and that higher perception, and the recall factor are important only to the extent that they exaggerate this phenomenon (Kumar, 1993; Irudaya Rajan, 1993).

Besides Kerala other states reporting morbidity higher than the all-India average are, Andhra Pradesh, Himachal Pradesh, Karnataka, Madhya Pradesh, Orissa, Punjab, Rajasthan, Uttar Pradesh and Delhi. Some of the states like Assam, Bihar, Maharashtra and Tamil Nadu have reported very low morbidity.

A number of factors can be considered while trying to explain these variations. The variations across states in the reporting of illnesses can be due to differences in the ability of the respondents as well as the interviewers to report morbidity. Besides, in a country where economic, social and cultural conditions vary widely, the definition of morbidity is likely to be different for different people, since morbidity is to a large extent a matter of perception. However, the reporting error or the perception factor cannot fully explain the large differences in morbidity across regions/states. It could actually imply the real differences in the illness burden on the society and state.

In order to understand the real illness burden on the different states, one could look at the state-wise prevalence rate of illnesses by type of illnesses (Table 6). Though the co-efficient of variation (CV) has worked out to be high for all, the variation in the reported illnesses is much higher for the chronic illnesses. Both Kerala and Himachal Pradesh have reported a very high overall morbidity as well as a high prevalence of chronic illnesses. In both these states, the proportion of 60+ population is quite high. As we have already seen, the prevalence rate of illness is very high for the old people and for children below 5 years of age. The state of Himachal Pradesh has reported a high prevalence of chronic diseases like arthritis and rheumatism in the rural areas and cardio vascular diseases, asthma and weakness, dizziness and anemia in the urban areas. Kerala has reported a high prevalence of cardio vascular diseases, breathing problems and asthma. Most of these diseases are

associated with old age and the climatic conditions of these states.

Delhi is another state which has reported a higher prevalence of chronic diseases. Among the various chronic diseases, Delhi has a fairly high prevalence of cardio vascular diseases, a sign of affluence in the capital city. One of the reasons for Punjab reporting a higher prevalence of illness again could be the high proportion of old people in the state's population.

The state of Andhra Pradesh has also reported a high overall morbidity as well as a high prevalence of chronic illnesses. In this state also the proportion of 60+ population is fairly high. Among the various chronic diseases the state has reported higher prevalence of weakness/dizziness and anaemia.

Among the backward states, Orissa has reported very high morbidity. The morbidity profile of the state is dominated by diseases of poverty and underdevelopment. The state has reported the highest level of serious communicable diseases as well as of acute illnesses.

Other backward states which have reported fairly high morbidity are Madhya Pradesh and Rajasthan. In both, the proportion of children below 5 years of age is fairly high and both have reported a high prevalence of acute illnesses. The state of Rajasthan has also reported a high prevalence of serious communicable diseases. The other two poor states like Bihar and U.P. have very low morbidity and these states have very low prevalence of chronic illnesses also.

Some of the better off states like Maharashtra, Tamil Nadu, Haryana, and Gujarat have reported a lower prevalence of morbidity, probably indicating a better health status of the people in these states. The state of Assam has reported very low morbidity but the percentage of treated illnesses and the average duration of acute illness (Table 9) are fairly high for this state. It is quite likely that in this state due to reporting error or poor enumeration of illnesses, only illnesses of longer duration have been reported resulting in lower morbidity rate with a high average duration of illness.

In the following section, a more detailed analysis of the nature of illnesses suffered by the people and the state-wise prevalence of different types of illnesses are presented.

Nature of Illness

This study, as mentioned earlier was based on self-reporting of illness and the households were asked to describe the symptoms of the illnesses in great detail. At the editing stage, based on the nature of the problem, these symptoms were grouped under 19 illness groups based on the WHO's Manual on Lay Reporting of Health Information.

The distribution of reported illnesses by nature of illness is presented for the rural and urban areas in Tables 4 and 5 respectively. Among the various types of reported illnesses, 'Fever', which includes viral fever, flu and other non-specific fevers, seems to be the most common illness among both adults and children. Fever accounted for 30% of the reported illnesses in the rural areas and about one-fourth of the reported illnesses in the urban areas. Next in importance come, the respiratory infection which includes common cold, cough, nose and throat discomfort and bronchitis. The reporting of this infection is higher for the children than for the adults.

The data indicate that communicable diseases account for a high proportion of reported illnesses. The serious communicable diseases, which include typhoid, malaria, cholera, acute gastero-enteritis, jaundice and tuberculosis, account for 14.5% of all reported illness episodes in the rural areas and 13.3% in the urban areas.

The increase in the number of tuberculosis cases is a matter of great concern in the country. It is estimated that currently there are 12 million T.B. patients in the country. The NCAER survey shows that the prevalence rate of tuberculosis (per thousand population) is 2.9 and 1.9 respectively for the rural and urban areas. It is more prevalent among adults and in the case of adult males belonging to rural areas it is as high as 5.1 per thousand population.

The prevalence rate of cardio vascular diseases like hypertension, heart ailments, paralysis is much higher for the urban adults as compared to their counterparts living in the rural areas. This probably reflects the stresses and strains of the urban life style. It is also interesting to note that the prevalence of the cardio vascular diseases is more among men than women. The reason for this could be that the addiction to tobacco and alcohol which is associated with cardio vascular diseases is

more among men.

The state-wise prevalence rate of illness by type of illness, i.e., serious communicable, acute and chronic illnesses for the rural and urban areas is presented in Table 6. According to this categorisation the disease pattern of the country is dominated by acute illnesses. This category accounted for 73% of the reported illnesses in rural areas and 68.5% of illnesses in the urban areas. The proportion of serious communicable diseases was marginally higher in rural areas than in urban areas (14.6% and 13.6% respectively). The proportion of chronic illnesses to total reported illnesses is much higher in urban areas indicating that these diseases (especially degenerative disorders) are more an urban phenomenon.

In the advanced industrial countries, the chronic and degenerative diseases have replaced the infectious diseases and the acute infectious ailments which occur most often in childhood have declined considerably in incidence and potency. The diseases of poverty have been substituted by diseases of affluence. In India, the communicable diseases and acute illnesses which include diseases like respiratory infection or diarrhoea account for a high proportion of reported illnesses, indicating that the country has a long way to go in the epidemiological transition.

Pattern of Morbidity by Socio-Economic Characteristics of the Households

The level and the pattern of morbidity by various socio-economic characteristics of the household are presented in Table 7.

The relationship between the income status of the people and the level of morbidity is very complex, since there are a number of intermediate factors which influence the nature of the relationship. One should normally expect the prevalence of morbidity to be related negatively to income and expect a positive association between poverty and morbidity. However, as the income level of the people rises, the perception of illness might increase since the definition of illness depends to a large extent on whether they can purchase medical attention.

The results of the survey (Table 7) show that the overall morbidity level comes down with the rise in the annual household

income, indicating that with improvement of the economic status the health status of the people also improves. This corroborates the findings of the NCAER's earlier survey (NCAER, 1992a) which also showed a fall in the prevalence rate of illness with a rise in the income level of the household.

With the increase in the income status of the household, the prevalence rate of serious communicable diseases and the acute illnesses come down; while the prevalence of chronic illnesses increases with the increase in income level. Two important factors can explain this. Firstly, with the rise in the economic status, the diseases of poverty and malnutrition are replaced by the diseases of affluence. Secondly, due to mortality differentials among different income groups, the prevalence of chronic illnesses (which are generally associated with old age) may be more among the higher income households as compared to lower income households. In the higher income households, the prevalence of chronic illnesses is more because these households may have a higher proportion of old people, and in the poor or low income households those suffering from or likely to suffer from chronic illnesses may be already dead.

A similar pattern emerges, when the level of morbidity is analysed by the highest level of education in the household. Generally speaking, the increase in the educational level of the people should lead to greater awareness and better utilisation of health care services, and this should bring about a negative relationship between morbidity and education. While this may be so in a general sense, with the improvement in the educational status, the health perception of the people can also change, leading to a higher reporting of illnesses.

In the urban areas the pattern is very similar to the one found in the case of prevalence of illness by household income: the morbidity levels of serious communicable diseases and the acute illnesses falling with the rise in the educational status and the chronic illnesses increasing with the increase in the educational level of the household. However, in the case of rural households, the pattern is not very clear, although the overall morbidity comes down with the rise in the educational level and the people belonging to the highest level of education (Graduate and above) have reported the highest level of chronic illnesses.

Among the various occupational categories, people belonging to the wage earner category have reported the highest level of serious communicable diseases. The prevalence of chronic illnesses is very high for the salary earner/professional category and for the 'others' category which comprises an assorted group of people including the households headed by retired people.

Hospitalisation

The state-wise number of hospitalisation cases reported during the reference month (per thousand population) are given in Table 8. The prevalence rates of hospitalisation are 7.1 for the rural and 9.7 for the urban areas. The higher rates for the urban areas, perhaps indicates a better access to hospital facilities in the cities.

In the overall reporting of illness there was no significant sex differentials but in respect of hospitalisation cases, this is not the case. In most of the states, the number of hospitalisation cases per thousand population has worked out to be lower for the females. At the all-India level the rates are 8.4 for the males and 5.5 for the females in rural areas, and 10.9 for the males and 8.4 for the females in urban areas. In some of the states like U.P. and Rajasthan, the sex differentials are substantial for both rural and urban areas. Since hospitalisation involves high expenditure and a complete disturbance of family routine, generally, women avoid getting admitted in hospitals until and unless it is absolutely essential. Studies based on hospital records also show such sex differentials in the in-patient data. The NSS Survey (42nd round) found that the male-female ratio among the hospitalised persons was about 56 : 44.

Average Duration of Illness Episode

The duration of an illness episode can be considered as an indicator of the seriousness of an illness, i.e., the longer the duration, the greater its severity. However, a prompt curative intervention can moderate the duration of illness. Therefore, the availability of a well developed health infrastructure and the accessibility can reduce the severity as well as the length of an illness episode. Moreover, individual perceptions can also influence the length of an illness episode. This perception, in turn, depends on various socio-economic factors. For example,

in a society where the medical insurance schemes are functioning efficiently, workers can afford to take time off from their work for a longer period and hence their perception of illness would be high. On the other hand, if they are solely dependent on their daily wages, they can hardly afford to be away from their work.

Table 9 gives the state-wise average duration of the reported illnesses for the rural and urban areas. These averages have been calculated only for the illnesses belonging to the serious communicable diseases and acute illnesses categories. The data does not show any significant sex differential or rural and urban differences in the average duration of illnesses. The average duration of illnesses for the country as a whole has worked out to be 10.8 days for the rural areas and 10.1 days for the urban areas.

The average duration of illnesses is 11.4 days for the males and 10.1 for the females in the rural areas. In the urban areas the averages are 10.4 days for the males and 9.8 days for the females. Thus the average duration of illnesses is marginally lower for the females both in the case of rural and urban areas.

Among the various states, the average duration of illness is the highest for rural Kerala. Even in the case of urban Kerala, the figure is higher than the all-India average. As we have already seen, the reported level of morbidity is also the highest for Kerala. The reporting of high morbidity along with the long duration of illnesses, inspite of a fairly well developed health infrastructure implies, a high morbidity burden as well as a high self perception of illness among the people of Kerala.

Another state for which the average duration of illness has worked out to be fairly high is Himachal Pradesh and as we have already seen, this state has also reported a very high prevalence of morbidity.

The states like Assam and West Bengal had reported a very low prevalence of morbidity but the duration of illness has worked out to be very high, probably indicating that only serious illnesses have been reported and the minor illnesses have been left out. On the other hand, the states like Andhra Pradesh and Orissa had reported a high prevalence of morbidity but the duration of illness is quite low, indicating a better reporting of illnesses. The backward state of U.P. reporting a

low prevalence of morbidity as well as a low average duration of illness, perhaps reflects a low perception of illness among the people of U.P.

Chapter 4

Utilisation of Health Care Services

THE utilisation of health care services depends on the availability of quality health care services at a reasonable distance and on the ability of the people to utilise the health services effectively. Thus, the provision of appropriate health infrastructure is a necessary but, not a sufficient condition for health care utilisation. A number of factors such as economic status, caste, occupation, education and gender have a great influence on the "perceived need" for medical care and affect the access to health care facilities. In this survey an attempt was made to study the pattern of utilisation of health care services for various types of diseases by socio-economic characteristics of the households, and the analysis was made across all states and for the rural and urban areas.

First, the types of illnesses for which no treatment has been sought was taken up to understand the reasons for not seeking any medical help. This was followed by an analysis of the pattern of utilisation of health care services for the treated illnesses. The non-hospitalised illnesses and the illnesses which required hospitalisation were studied separately, since the pattern of utilisation is very different in both cases. An attempt has also been made to understand the use of health services for promotive and preventive health care by analysing the utilisation of health facilities for deliveries, abortion/miscarriages and immunisation.

Untreated Illness

As already stated, all the reported illness episodes were not treated. For nearly 12% of the illness episodes in the rural areas and about 8% of the illness episodes in the urban areas, no treatment was sought. The higher percentage of untreated illnesses in the rural areas probably reflects the lack of physical access to health care and the financial constraints that prevail in the rural parts of the country.

Duration of Illness

More than 50% of the untreated illness episodes had lasted for less than or equal to 3 days indicating that they were minor illnesses (Table 10). However, in the case of rural areas, one-fourth of the untreated illnesses lasted for more than a week, though in the urban areas only about 18% of the untreated illness episodes exceeded the duration of a week.

Reasons for 'No Treatment'

The most important reason for not seeking treatment, turns out to be "illness not considered serious enough". This is the respondents' perception of seriousness of the illness and it need not really indicate whether these illnesses were serious or not. For nearly two-thirds of the untreated illness episodes in rural and 80% of the untreated illness in the urban areas "illness not considered serious enough" is given as the reason for not seeking any treatment (Table 11). The lack of financial resources available for seeking health care has also come out as an important reason. Lack of medical facilities in close proximity was given as the reason by about 13% of the rural households which did not seek treatment.

Untreated Illness by Socio-Economic Characteristics of the Households

The distribution of untreated illnesses by various socio-economic characteristics of the households are presented in Table 12. The percentage of untreated illness comes down, with an increase in the income status of the households indicating that economic reasons do play an important role in the decision to seek treatment. The perceived need for treatment depends largely on the ability of the person to seek treatment.

The distribution of untreated illnesses by the educational level of the household also reveals more or less a similar pattern. However, the differences in the percentages of untreated illness are more marked in the rural areas than in the urban areas. Education enhances health consciousness as well as creates greater awareness about the availability of health care facilities. Since the general level of awareness and the availability of facilities are poorer in rural areas, the percentage of untreated illness is very high for the lower educational categories, i.e.,

'No formal education' and 'Primary' level education.

The distribution of untreated illness by the occupation of the head of the households, does not show a very clear pattern. The percentage of untreated illness is the highest for the wage earner category. The rural-urban differentials in the percentage of untreated illness are quite significant for the cultivator and the wage earner categories. For the salary earner/professional category, there is hardly any difference in the percentage of untreated illness between the rural and urban areas of the country.

Non-Hospitalised Illness Episodes

This section deals with the pattern of utilisation of health care services by the type of health care providers and the nature of illnesses across all states and for the rural and urban areas of the country, for the non-hospitalised illness episodes.

Type of Treatment

The percentage distribution of reported illness episodes (not requiring hospitalisation) by types of treatment are presented in Table 13 for the rural and urban areas of the country respectively. The table shows a high dependence on the private health providers among the health seekers. The percentage of illness episodes for which treatment has been sought from the private health providers works out to be 51.8 for the rural areas and 58.8 for the urban areas. Thus the dependence on the private sector is marginally higher among the urban people and the dependence on the public health care facilities is marginally higher in the rural areas. However, as much as 41.6% of the illness episodes in the rural areas have sought treatment from the public institutions such as public hospitals, community health centres, primary health centres and the sub-centres. The utilisation of PHCs/CHCs accounted for 20% of the illness episodes. In the urban areas the utilisation of public health facilities like the Government hospitals and the dispensaries run by the Government and the local bodies accounted for 33.8% of the illness episodes seeking treatment.

In India, it is not uncommon to find people buying medicines directly from the chemist shops without consulting a doctor. This kind of self-medication is found to be marginally higher in the urban areas, though the percentages are very low. The

percentage of illness episodes for which medicines have been directly purchased from the medical shops works out to be 3.1 for the rural and 5.2 for the urban areas. Seeking treatment from religious persons or faith healers and the dependence on home remedies seem very low, though the percentages are marginally higher for the rural areas.

Thus in spite of a well developed public infrastructure, the public health care system is far from being the only instrument for providing health care. The private sector seems to play an important role in providing curative health care. A number of surveys on the utilisation pattern have indicated the high dependence on the private sector. For example the NSSO's (42nd round) survey found that the dependence on private health providers for the non-hospitalised cases was as high as 69% for the country as a whole.

Inter-State Variations in Health Care Utilisation Pattern

The state-wise variations in the pattern of utilisation are given in Tables 14 and 15. Though for most of the states the utilisation of private health facilities has worked out to be high, the states like Himachal Pradesh, Rajasthan and the rural parts of Assam, Karnataka and Orissa seem to rely more on the public health facilities. The higher utilisation of public health services by Himachal Pradesh was brought out in the NCAER's earlier survey as well. (NCAER,1992a). Himachal Pradesh being a hilly region, and a difficult terrain, the availability of private health facilities may be poor and hence people rely more on the public health facilities. This must be true of rural Assam also where the utilisation of public health services is quite high. In the case of rural Orissa treatment has been sought from the public health facilities for nearly 70% of the illness episodes. This high dependence on the public services in this backward state of Orissa could be because of the poor economic status of the people who cannot afford private treatment. The non-availability of any other alternative facility could be an additional factor. It is interesting to note that the dependence on home remedies is the highest for rural Orissa. For nearly 9% of the illness episodes only home remedies have been resorted to. The tribal population of Orissa are known for their indigenous medicines. In fact, rural Orissa has reported the highest dependence on indigenous systems of medicine (Table 25) for the treatment of illnesses.

The utilisation of public facilities seem higher wherever the private sector is not well developed and the public facilities are the only services within the reach of the people. The states where the public health system is functioning efficiently, may also register higher utilisation of public health care services. For example, a survey conducted by the NCAER (NCAER, 1992b) found the utilisation of public services provided at the level of PHC to be very high in the rural parts of Tonk district of Rajasthan and this was attributed mainly to the better services in public facilities as reflected by low population coverage per PHC. In this district 83% of the patients visiting the PHCs had expressed full satisfaction with the available services.

Although Kerala has a well developed public health infrastructure, there is greater reliance on the private sector in the state. In Kerala, though the share of the health sector in the total Government expenditure has been rising steadily over time, the Government facilities are not able to cope up with the growing demand for health care; in fact the private expenditure on health in Kerala is reported to be one of the highest in the country (Panikar, 1992). Kerala has a large number of hospitals and dispensaries in the private sector. The high dependence on the private health services in Kerala has also been brought out by the KSSP's study and by the Kerala Fertility Survey. According to the KSSP's study, utilisation of private hospitals is high even among the poor people.

Type of Treatment by Nature of Illness

In both rural and urban areas the utilisation of private health facilities is highest for the acute illnesses (Table 16). In the urban areas for nearly 60% of the acute illness episodes treatment has been sought from the private health care providers. Since the acute illnesses are generally of short duration and the treatment is comparatively less expensive (Table 33) people may find the private treatment within reach and would consult any doctor who is easily accessible. The percentage of illness episodes for which self-medication has been resorted to, is also the highest for the acute ailments.

In the rural areas, the utilisation of public health facilities is very high for accidents and injuries, i.e., 60% and 70% respectively for the male and female population. This is understandable since in the rural areas, the public hospitals

may be the only facility available for this category of illnesses. Also in the case of major accidents (especially medico legal cases), the Government hospitals are the only choice. Since only out-patient cases are analysed in this section, the accidents and injuries category includes minor injuries also. In the urban areas, both the private and the public health facilities are being utilised for the treatment of accidents and injury cases. In fact, for 11.4% of the cases, the females living in the urban areas have taken only home treatment. This probably indicates that these were minor injuries.

As compared to the rural areas, the utilisation of private facilities is much higher in the urban areas for all the four categories of illnesses for both the sexes. In other words, irrespective of the type of illnesses, the urban people seem to rely more on the private health care services compared to the rural.

Type of Treatment by Socio-Economic Characteristics of the Household

In both rural and urban areas, with an improvement in the income status of the household, the utilisation of public health facilities comes down and the utilisation of private health facilities goes up (Table 17). For the highest income category, i.e., the households with annual incomes over Rs. 54,000 the utilisation of private facilities is fairly high; the percentages being 69.3 and 74.6 respectively for rural and urban areas. Though the ability to pay for the private treatment could be the main reason for the high income people going in for private health care services, social prestige also affects the decision. The people belonging to higher income brackets may think that it is beneath their dignity to go in for free treatment.

The utilisation of health services by the highest level of education in the household also reveals more or less a similar pattern, especially for the urban areas. With an increase in the level of education, the utilisation of private health facilities goes up and the utilisation of public health facilities comes down. Interestingly self medication in the form of purchasing the medicines directly from the chemist shops without consulting any doctor is comparatively high among the well educated people (Graduates and above) of the urban areas as well as

among the uneducated rural people. The well educated people indulging in this kind of self medication, show their 'confidence' in dealing with their ailments. One of the reasons for the higher utilisation by medical shops by the educated urban people could be lack of time to visit a health provider and the easy accessibility of the chemist shops in the cities. On the whole, the dependence on 'non-professional' treatment is as high as 11.3% for the uneducated people belonging to the rural areas.

The utilisation of health facilities by the occupation of the head of the household shows that the dependence on private health facilities works out to be fairly high for the business, and the salary earner/professional categories of the urban areas. Here again, apart from affordability, time constraint must also be influencing the people's decision to go in for the private health care provider. In the rural areas, the utilisation of private health facilities is the highest for the cultivator class. For the wage-earner category, it is more or less the same as in the urban areas. On the whole, for all the occupational categories the utilisation of private facilities has worked out to be higher.

Reasons for Choice of Treatment

In Table 18 the reasons for the choice of treatment are presented for the rural and urban areas. Most of the people who have sought treatment from the public health facilities have done so, because in these facilities, the services are available free. As expected, both in the rural and urban areas, "free/ inexpensive" has turned out to be the most important reason for utilising the public health facilities.

In the rural areas, for nearly three-fourths of the illness episodes seeking treatment from the Government hospitals "free/inexpensive" has been given as a reason for the choice. In the case of PHCs/CHCs, "free/inexpensive" was the reason for choice for 68.7% of the illness episodes and in the case of treatment from ANM/MPHW/Anganwadis, free/inexpensive has been cited as a reason for choice for 63.3% of the illness episodes. In addition to this reason, nearness/being close by has also come out as an important reason for people seeking medical help from the PHCs/CHCs or from the ANM/MPHW/ Anganwadis.

Both in the urban and rural areas, 'good reputation' has

come out as an important reason for seeking treatment from the private health facilities. The percentage of illness episodes for which 'good reputation' has been given as a reason for choice is 35.0 and 46.5 respectively in the rural and urban areas. In addition to this 'close by' has also come out as an important reason for opting for treatment from the private providers; the percentages are 35.5 and 33.9 respectively for the rural and urban areas.

Thus, it is clear that free/inexpensive is the predominant reason for seeking treatment from public health facilities. In the case of private health facilities 'good reputation' and 'close by' have turned out to be two important reasons for the choice of treatment. However, it is necessary to point out that when people choose a private provider because of his/her reputation, it is the user's judgment. It need not be the correct judgment of the quality of health care. Generally, it is a human tendency to devalue what is available free and people may even choose to go to unqualified private practitioners, since they consider them to be superior to the 'qualified' doctors at the Government health facilities.

Both in the rural and urban areas, people buy medicines directly from the medical shops because they are available close by and the timings are suitable. Those who have gone to faith healers or religious persons have done so because of their belief that it is the only possible cure for the ailment. For example for jaundice, measles or chicken pox people generally go to faith healers or religious persons, because they feel that there is no medical treatment available for such diseases. In the case of illness episodes for which only home remedies have been resorted to, the reasons are either because the home remedies are inexpensive or because the illness episodes were not considered serious enough to seek outside treatment. In the rural areas, for some illness episodes (27.3%) only home treatment has been given because no other facility is available nearby.

Average Distance Travelled for Seeking Treatment

Table 19 shows the average distance travelled for seeking treatment from various types of health facilities for the rural and urban areas. On an average people have travelled longer distances in the rural areas as compared to the urban areas.

The average distance travelled for seeking treatment works out to be 5.9 kms. for the rural and 2.2 kms. for the urban areas.

Both in the rural and urban areas the average distance travelled has worked out to be marginally lower for the female adults and the female children as compared to their male counterparts.

It is interesting to note that neither the private hospitals nor the private practitioners seem to have any locational advantage over the public health facilities both in the rural and urban areas. In the rural areas the average distance travelled (per illness episode) for seeking treatment has worked out to be 12.6 kms. for the private hospitals and 10.0 kms. for the public hospitals. Similarly, the average distance has worked out to be higher for seeking treatment from the private practitioners as compared to the PHCs/CHCs. In the urban areas, both the private and the public facilities seem to be available at more or less the same distance. Inspite of this and the free treatment available at the public health facilities, there is a higher utilisation of private health services. This indicates that people have preferred to go to the private providers because they consider them to be superior to the public providers and are not satisfied with the available services at the public health facilities.

The average distance travelled for purchasing the medicines directly from the medical shops has worked out to be very small. This must be one of the reasons why people indulge in self medication of this sort.

Hospitalisation Cases

The state-wise percentage distribution of hospitalisation cases by type of treatment are presented in Table 20. In contrast to the non-hospitalised illness episodes the dependence on public health facilities is much higher in the case of illnesses requiring hospitalisation. For 62% of the cases in rural areas and for 60% of the cases in urban areas, treatment has been sought in the public hospitals. The NSSO's 42nd round also found more or less the same pattern of treatment of indoor cases in public institutions i.e. 59.74% of cases in rural areas and 60.26% in urban areas.

What could be the reason for the people's preference for public institutions in case of hospitalisation? The most important reason could be the large expenditure involved in seeking treatment in a private hospital as an indoor patient (Table 39). The difference in expenditure between the public and private hospitals is very high and hence people find the public services more affordable. Moreover, in many rural areas the public hospitals could be the only available service nearby. This is probably the reason for the near total dependence on public services in the case of rural Assam, Himachal Pradesh and Orissa.

According to the figures published in the Health Information of India, 1992, though nearly 57% of the hospitals are privately owned, these private nursing homes account for only 32% of the beds available in the country. Most of these private nursing homes are small in size. Moreover, some of the states like Himachal Pradesh, Madhya Pradesh, Orissa and Rajasthan have very few hospitals/nursing homes in the private sector. Since in these states, the public hospitals are the only facility available the utilisation of public hospitals is also high. On the other hand in the states like Gujarat, Maharashtra and Kerala, the private nursing homes are comparatively more in number, and the percentage of illness episodes being treated at the private institutions has worked out to be higher for these states.

Reasons for Choice of Treatment

As indicated by the reasons for choice of treatment (Table 21), people opt for the public hospitals because they find them less expensive. Both in the case of rural and urban areas, inexpensive/free seems to be the most important reason for preferring treatment in the Government hospitals. However, this reason seems less important in rural areas as compared to the urban areas since as many as 29% of the users of public hospitals in the rural areas have mentioned 'good reputation' as a reason for their choice. The non-availability of any other facility nearby accounted for another 10.9% of the cases. Thus in the rural areas, apart from economic considerations, people seem to go in for the public hospitals since these are the only facility of good reputation available nearby, whereas in urban areas, as many as 77.7% had gone in for the public hospitals because they are inexpensive or free. This is understandable

since some of the "private hospitals" in the urban areas are very expensive. Only 10% have given "good reputation" as a reason for opting for the public hospitals.

In the case of private hospitals/nursing homes "good reputation" has turned out to be the most important reason for the preference for more than 50% of the cases. This again is the user's perception and need not reflect the reality. In addition to this reason, closeness and non-availability of any other facility nearby have also been considered while opting for treatment in a private hospital.

Average Distance Travelled for Seeking Treatment

The state-wise, average distance travelled for hospitalisation are presented for the rural and urban areas in Table 22. On an average people have travelled a longer distance for hospitalisation as compared to treatment of non-hospitalised illnesses. The average distance is considerably higher in rural areas indicating that the hospitals are concentrated in the urban areas and the rural people have to travel a long distance. This could be one of the reasons for lower prevalence of hospitalisation cases as well as lower percentage of reported illnesses being hospitalised, in the rural areas. For some of the states like Rajasthan and Himachal Pradesh, the average distance travelled has worked out to be very high for the rural areas. For the country as a whole, there is not much difference in the average distance between private and public hospitals for both rural and urban areas, though for some of the states the average worked out to be very different for the public and private hospitals.

Utilization of Health Facilities for Deliveries and Immunisation

The survey results show that for preventive and promotive health care, people depend more on public health facilities. Table 23 shows the distribution of reported number of delivery and abortion/miscarriage cases during the reference month by the type of health facility utilised. More than 60% of the deliveries in both rural and urban areas have taken place in the Government health facilities which include the Government hospitals, maternity centres, CHCs and the PHCs. The financial consideration could be an important reason for people opting for the Government facility. The difference in per delivery

expenditure between the public and private hospital is quite significant (Table 43). Another 26% of the delivery cases in the urban areas has taken place in the private nursing homes/ hospitals. In the rural areas only 15% of the deliveries took place at the private health facilities.

A high percentage of deliveries especially in the rural areas, has taken place in homes. The home deliveries account for 23.4% and 11.2% respectively of the deliveries in the rural and urban areas of the country. One of the reasons for high neo-natal mortality in the country is the unhygienic conditions in which deliveries take place. The home deliveries without any assistance from trained birth attendants can prove to be very dangerous for both the mother and child.

In the case of abortions and miscarriages, the pattern of utlisation is slightly different. The dependence on private sector is fairly high in the urban areas. Even in the rural areas nearly 42% of the cases were handled by the private nursing homes. What could be the reason for this? In the case of abortion, since it is intentional (as against miscarriage which is accidental), women may like to keep it a secret and hence may refer to go to a private clinic where they may have personal contacts. In rural areas, no treatment outside the home has been sought in the case of about 18% of miscarriages/abortions. This percentage is only 1.7 in the urban areas.

The total dependence on the public health facilities for preventive health care is clear from Table 24. Since the launching of the Universal Immunisation Programme in the Year 1985, the public health facilities, both in the rural and urban areas have taken a number of steps to improve the access to immunisation. The immunisation done in the public health facilities account for nearly 90% of the reported number of immunisation cases. In the rural areas, the PHCs and the sub-centres account for more than 80% of the immunisation cases. This indicates that the sub-centres and the PHCs/CHCs play an important role in the immunisation programme. Even in the urban areas, people seem to depend on the Government hospitals and on Government or Municipal dispensaries; only 12.3% of the cases were handled in the private sector.

System of Medicine

India has a number of indigenous systems of medicine. In the pre-colonial period, the ayurveda system was the most prominent system of medicine. During the colonial period, there was a transition from the traditional to the modern imported systems of medicine. This transition was originally confined to the urban areas and the rural population continued to depend on the traditional systems of medicine which included tribal and folk medicine, unani and ayurveda. Over the years, the allopathy system of medicine has turned out to be the most dominant among the various systems. However, in recent years, there has been a revival of interest among the people not only in siddha/ayurveda and in homeopathy but also in other systems like naturopathy, and acupuncture. The trend is towards a holistic approach to health care.

The present survey had also collected information on the system of treatment sought by people for treating their ailments. The state-wise distribution of non-hospitalised illness episodes by the system of treatment sought are presented for the rural and urban areas respectively in Tables 25 and 26.

The dominance of the allopathic treatment over other systems of medicine is very well depicted by the results of the survey. At the all-India level, for more than 90% of the illness episodes, the allopathic system of treatment has been sought and this percentage is marginally higher for the urban areas. The illness episodes for which homeopathic treatment has been resorted to worked out to be 2.0% and 2.9% respectively in the rural and urban areas. Ayurvedic/siddha, the traditional Indian systems of medicine seem slightly more popular in the rural areas as compared to the urban parts of the country. The percentages are 3.8 and 2.2 respectively in the rural and urban areas.

It is important to note here that a number of private practitioners in the unorganised sector practice allopathic medicine, even though they are qualified in other systems of medicine. In other words, treatment of illness under allopathic system of medicine does not necessarily mean that they are being treated by `allopathic doctors'. It is not uncommon to see some of the doctors combining more than one system of medicine. The survey results showed that for 2.0% and 1.2% of the illness episodes respectively in the rural and urban

areas, a combination of two systems (mostly in addition to allopathy, either homeopathy or ayurveda or even rituals) has been used for treatment of ailments. The combination need not be prescribed by the 'doctor', sometimes people themselves resort to more than one system of medicine.

The strong preference for the allopathic system of medicine among the people has been well established by a number of surveys. The NSSO's survey (42nd round) found that the allopathic system was used in respect of nearly 96% of non-hospitalised cases both in the rural and urban areas. A recent NCAER survey of rural districts of Madhya Pradesh, U.P. and Rajasthan (NCAER, 1992b) also revealed the popularity of allopathic medicines. More than 90% of illness episodes were treated under this system of medicine.

Though for the country as a whole the percentage of illness episodes seeking homeopathic or ayurvedic systems of treatment has worked out to be very low, the pattern is slightly different for some of the states especially in the rural parts (Tables 25 and 26). For example, in the case of rural Assam, for nearly 10% of the illness episodes homeopathic treatment has been sought. In fact, homeopathic treatment seems popular in urban West Bengal where 11.3% of the illness episodes have been treated under this system. The ayurveda system seems fairly popular in the rural parts of Maharashtra, Orissa, Haryana, Bihar and Kerala.

Chapter 5

Household Expenditure on Health Care

IN India, the public outlay on health care has not kept pace with the health needs of the people. There has been a progressive reduction in the proportion of budgetary allocation of resources to the health sector in the successive Five Year Plans, with a marginal improvement in the Seventh Plan (*Health Information of India,* 1992). Government spending on the health sector works out to be less than 2% of the country's GDP (Tulasidhar, V.B., 1992). The WHO has recommended that governments must spend atleast 5% of their GDP on health care. The per capita public sector expenditure on health (including water supply) was a meagre amount of Rs. 64 for the year 1990-91 (Duggal, R., 1992). As against this, the household expenditure on health care is considerably higher. According to the present survey the per capita annual household expenditure on curative health care works out to be about Rs. 204.

The results of the survey indicate that on an average the households spend nearly 5% of their income on curative health care and this percentage is marginally higher for the rural households as compared to the urban households as presented in the table (page 38). The household expenditure on curative health care as a proportion of their income comes down with an increase in the income status of the households. The poor households seem to spend more than 7% of their income on the treatment of ailments while the rich households spend only 2.7%.

As mentioned earlier the per capita annual household expenditure on curative health care works out to be Rs. 204 and the per capita expenditure increases with the increase in the household's income status. This indicates that though the prevalence of illness is lower for the rich households they spend more on the treatment of ailments. The per capita expenditure on health care is generally higher for the urban households and the rural-urban differential in the per capita household expenditure is substantial for the rich households.

Household Expenditure on Curative Health Care*

(In Rs.)

Household Income Group	*Average Annual Household Income*	*Average Annual Household Health Expenditure*	*Expenditure as Percentage of Income*	*Per Capita Annual Expenditure*
		Rural		
≤18,000	*10946*	855.84	*7.82*	*167.81*
18001-54000	29033	1195.44	4.12	206.36
³ 54000	76039	1722.33	2.27	246.10
TOTAL	*18716*	*988.40*	*5.28*	*183.87*
		Urban		
≤ 18,000	12832	908.18	7.08	194.58
18001-54000	32147	1352.33	4.21	262.66
> 54,000	78504	2313.20	2.95	406.81
TOTAL	*30184*	*1294.09*	*4.29*	*257.64*
		Total		
≤ 18,000	11303	865.75	7.66	172.53
18001-54000	30233	1255.93	4.15	226.51
> 54,000	77431	2055.84	2.66	328.53
TOTAL	**21931**	**1074.10**	**4.90**	**203.56**

* Estimates are based on the expenditure incurred by the households during the one month reference period for the treatment of illnesses.

The following sections deal with the expenditure incurred by the households for the treatment of various types of ailments by the type of health care facilities utilised. The household expenditure on treatment of hospitalised and non-hospitalised illness episodes are analysed separately. This chapter also throws some light on the amount spent by the households on other health care services such as, deliveries, abortions, miscarriages and immunisation of children.

Non-Hospitalised Illness Episodes

The state-wise average household expenditure per illness episode for adults and children are presented in Tables 27 and 28 respectively for rural and urban areas. For the country as a

whole, the average household expenditure per illness episode has worked out to be Rs. 90 for the rural areas and Rs.114 for the urban areas.The expenditure incurred by the households for the treatment of ailments includes the fees paid to the doctors, the cost of medicine, cost of diagnostic tests and the transport costs to commute to the health facilities. In addition to these expenses, the households have to provide special diet to the sick persons and incur certain incidental expenses such as paying bribes and tips to get better attention at the health facilities. In some households rituals are performed to pray for the speedy recovery of the sick persons. While calculating the average household expenditure for the treatment of illnesses, all these costs have been taken into account.

Rural-Urban Differentials

There is a substantial rural-urban differential in the average household expenditure (per illness episode) for both adults and children. The rural households have spent Rs. 114 and Rs. 101 (per illness episode) for treating the adult male and female while the urban households have incurred an expenditure of Rs. 134 and Rs. 126 for the treatment of the adult male and female. Similarly, in the case of children, the average household expenditure per illness episode has worked out to be Rs. 60 and Rs. 45 for the rural male and female children. These averages are much lower than the average expenditure incurred by the urban households for the treatment of children. The urban households have spent Rs. 77 and Rs. 61 respectively for the treatment of the male and female children. These figures indicate that like other expenditures, the medical expenses are also higher in the urban areas and on an average the urbanites spend more on the treatment of illnesses. As we have already seen, even the per capita expenditure on health care has worked out to be higher for the urban households.

Children vs Adults

It is clear from Tables 27 and 28 that the expenditure per illness episode has worked out to be much lower for the children up to 14 years of age, when compared to the adults. This is in line with the findings of NCAER's earlier survey of Medical Care (NCAER, 1992a). Even the FRCH's study of the Jalgaon district of Maharashtra found the average household expenditure for the children to be lower. Children generally

suffer more from acute illnesses which are of shorter duration while the chronic illnesses are more prevalent among the adults (Tables 4 and 5). The chronic illnesses are of longer duration and the treatment of most of these ailments are expensive (Table 33). Hence the average expenditure per illness episode has worked out to be lower for the children.

Sex-Differentials

In both rural and urban areas the average household expenditure (per illness) has worked out to be lower for the female adults and the female children as compared to their male counterparts. This sex differential in the household expenditure is visible not only at the all India level but also in most of the states and the gender difference is more pronounced in the case of children. It is interesting to recall that the survey results did not show any gender difference in the reporting of illnesses (Chapter 2). In contrast to this, the earlier NCAER survey found a substantial sex difference in the reporting of illness and little bias against women in the amount spent per illness (though in the case of children, the average expenditure per illness episode was marginally higher for the male children).

An important reason for this could be that in the earlier report since the reporting of illness was poor for women and the female children, only serious illnesses would have got reported and hence the amount spent per illness episode would have been greater. While in the present survey since the reporting of illness for women has improved, even the non-serious illnesses would have been reported. Hence the average expenditure per illness episode has worked out to be lower as compared to that for their male counterparts.

The present survey results show discrimination against both the female children and adults in the form of lower expenditure for treating an illness episode. In spite of not having any gender difference in the type of health care services utilised (public vs private), the amount spent per illness episode has worked out to be lower for the female children and the female adults. This probably indicates discrimination against women in the intra-household allocation of resources for medical care.

Gender differences of this kind in the cost of treatment have been found by a number of studies. The study of the Health

Impact of the Indira Gandhi Nahar Project (Sundar, R., 1994) found a vast difference in the average cost of treatment for boys and girls. The average cost of treatment per illness episode worked out to be Rs. 174 for boys and only Rs. 100 for girls. Such gender differences in the expenditure on medical care, were also brought out by a study of Punjab villages where about two and a half times more expenditure was incurred on medicine for boys than for girls during infancy and during 0-4 years the ratio of expenditures on medicine for boys to that of girls was 1.2 : 1 (Das Gupta, 1987). The FRCH's household survey of cost of health care in Jalgaon district has also revealed a vast difference in the cost of health care between men and women (Duggal and Amin, 1989).

State-level Variations

Both in the rural and urban areas, there are wide variations across states in the amount spent per illness episode for treating ailments. In the rural areas the average household expenditure (per illness episode) works out to be the highest for the state of Kerala; (the amount spent is as high as Rs.172 per illness episode) closely followed by Andhra Pradesh. For some of the poor states like Rajasthan, U.P. and Madhya Pradesh the amount spent per illness episode has worked out to be quite low; the respective averages are Rs. 60, Rs. 62 and Rs. 64. However, in the case of urban households, there is not so much variation across states in the amount spent per illness episode. Delhi households have spent the highest amount (Rs. 161 per illness episode), closely followed by Haryana. The poor states like U.P., Rajasthan and Madhya Pradesh have spent comparatively lesser amounts per illness episode.

However even for the better off states like Tamil Nadu, Maharashtra or Punjab the average household expenditure per illness episode has worked out to be quite low.

These variations across states in the average amount spent per illness episode could be partly explained by the differences in the type of health facilities utilised (Tables 14 and 15). In the state, where the dependence on private health provider is higher, the amount spent per illness episode has worked out to be fairly high. For example, in the rural areas, the average household expenditure (per illness episode) has worked out to be high for the states of Kerala, Andhra Pradesh and Gujarat

and in these states, the utilisation of private health facilities is fairly high. Similarly, in the urban areas, the household expenditure per illness episode has worked out to be very high for Delhi, Haryana, Bihar, Maharashtra and West Bengal and in these states the dependence on private health facilities is also higher as compared to other states. On the other hand, some of the states like Tamil Nadu and Rajasthan and the rural areas of Assam, Orissa and Punjab have relied more on the public health facilities and hence the amount spent per illness episode has turned out to be fairly low. In the case of U.P., though the utilisation of private facility is high the average expenditure per illness episode has worked out to be low indicating the poor paying capacity of the people.

Household Expenditure by Type of Treatment

In Tables 29 and 30, the state-wise details about the household expenditure per illness episode are presented for the rural and urban areas, by types of health care services utilised. It is clear from the tables that on an average the urban households have spent a larger amount (per illness episode) for all categories of treatment.

The average expenditure per illness episode works out to be the lowest for home remedies--the averages are Rs. 8.00 and Rs.15 respectively for the rural and urban areas. The expenditure per illness has worked out to be considerably low even for the illness for which medicines have been purchased directly from the medical shops. The average amount spent works out to be Rs. 21 for the rural and Rs. 23 for the urban areas. Since generally self-medication is resorted to only for the minor ailments, the amount spent has turned out to be quite low. There are very few illness episodes for which the households have relied solely on the faith healers or religious persons. Though for the country as a whole the average amount spent per illness episode for getting 'treatment' from religious persons/faith healers has worked out to be moderate at Rs. 66 for the rural areas and Rs. 77 for the urban areas, in some cases the households have spent a huge amount especially in the rural areas.

Both in the rural and the urban areas, as expected the average expenditure (per illness episode) has worked out to be much lower for the illnesses for which treatment has been sought from the public health facilities when compared to the

expenditure incurred for treatment from the private health services. In the rural areas, the average expenditure per illness episode works out to be Rs. 49 and Rs. 131 respectively for seeking treatment from the public and private health facilities. In the urban areas, these averages turned out to be Rs. 63 and Rs. 152 respectively. This is understandable, since in the public health facilities, generally no consultation fee is charged and even the medicines and the clinical tests are 'supposed' to be available free of cost. However, in reality people have to invariably buy medicines from outside since the public facilities do not have enough stock of all the medicines (ICMR, 1991). The NCAER's recent survey of Primary Health Care Services (NCAER, 1994) revealed that the Government's expenditure on drugs and supplies is less than Rs. 5 per capita for the sample rural districts of West Bengal, U.P., Tamil Nadu and Gujarat. This amount is hardly adequate to meet the requirements. Hence even when people seek treatment from the public health facilities, they may have to purchase the medicines from outside. In addition to this, the households have to spend on transport, special diet, etc.

In the rural areas, the average expenditure per illness episode for seeking treatment from the public health facilities has worked out to be the highest for Himachal Pradesh i.e., Rs. 125. Himachal Pradesh being a hilly region, the transport cost has worked out to be fairly high (Table 37) for the rural areas of the state.

It is interesting to note that the variations in expenditure (per illness episode) across states is much lower in the urban areas as compared to the rural areas for treatment by both public and private facilities.

Average Expenditure by Duration of Illness

As already mentioned the duration of an illness episode can be considered as an indicator of the seriousness of an illness. The longer the duration, the greater is its severity. As a result the amount spent on the treatment of ailments should also go up with an increase in the length of the illness episodes. In Tables 31 and 32, the state-wise average household expenditures per illness episode are presented by duration of illness, respectively for the rural and urban areas. It is clear from the tables that the average amount spent increases systematically as the duration of illness episodes increases from less than or equal to 5 days to

more than 30 days. In the rural areas, the average expenditure (per illness episode) works out to be as low as Rs. 33 for the illness episodes which lasted for less than/equal to 5 days and the expenditure goes up to Rs. 347 for the illness episodes which continued for more than 30 days. Similarly in the urban areas, the households have spent on an average Rs. 45 for the treatment of illness episodes which lasted for less than or equal to 5 days and have spent Rs. 355 for the major illnesses which continued for more than a month. The same pattern of increase in the expenditure by the duration of illness episodes is noticeable for all the states.

Average Household Expenditure by Nature of Illnesses

The amount spent for the treatment of illnesses would depend on the nature of ailments as well as on the type of treatment sought. In Table 33 details about the expenditure incurred by the households for the four categories of illnesses, i.e., serious communicable diseases, acute illnesses, chronic illnesses and accidents/injuries are presented.

For all the four categories of illnesses, the amount spent per case works out to be more for the urban areas as compared to the rural areas with the exception of chronic illnesses, where the amount spent is marginally higher for the rural areas.

Among the various categories of illnesses, the amount spent on the treatment of acute illnesses turned out to be the lowest. For the treatment of acute illnesses, on an average the households have incurred an expenditure of Rs. 56 and Rs. 72 per illness episode, in the rural and urban areas. There is a substantial difference in the amount spent on the treatment of acute illnesses and other types of illnesses.

The average household expenditure per illness episode works out to be the highest for the accidents/injury cases in the urban areas and for serious communicable diseases in the rural areas. In the case of serious communicable diseases, the average household expenditure per illness episode works out to be Rs. 172 and Rs. 198 respectively for the rural and urban areas.

In the case of chronic illnesses, only the amount spent during the one month reference period has been included and the amount works out to be Rs. 208 and Rs. 201 respectively for the rural and urban areas.

While there is no significant sex difference in the amount spent (per illness episode) by the households for the treatment of acute illnesses, in the case of chronic illnesses and the serious communicable diseases, there is a substantial gender difference in the household expenditure, especially among the children. On an average the households have spent a much lower amount on the treatment of women and the female children. This probably shows that when the amount involved is more, the households do discriminate against females in the allocation of resources.

Household Expenditure by Socio-economic Characteristics

Table 34 shows the average amount spent by the households, belonging to different income classes on the treatment of various types of illnesses. The amount spent per illness episode increases systematically with an increase in the income status of the households, for all the four categories of illnesses i.e. serious communicable diseases, acute illnesses, chronic illnesses and accidents/injury cases. These differences in the expenditure among the different income classes, are more pronounced in the urban areas as compared to the rural areas. This probably indicates that where facilities are available, households with money are able to purchase better quality health care. In the case of urban households there is a substantial difference in the amount spent per illness episode between the lowest (≤ Rs. 18,000) and the highest income (> Rs. 54,000) category. One of the reasons for this difference in the amount spent is the higher utilisation of private health facilities by the households belonging to the upper income categories.

In Table 35, the average expenditure incurred by the households for the treatment of illnesses are presented by the highest level of education in the household and by the type of illnesses. For all the educational categories, the amount spent per illness episode has worked out to be higher for the urban households as compared to the rural households.

For all the four categories of illnesses, with an increase in the educational level of the households, the amount spent per illness episode also shows an increasing trend, but the rise in expenditure is not as directly related as was the case in respect of income, especially for the rural areas. On the whole, the households belonging to the lower educational level seem to

have spent lesser amount on the treatment of illnesses compared to the households with higher educational status. In the urban areas, the households belonging to the highest educational category (i.e. graduates and above) have spent a much higher amount for the treatment of all the four types of illnesses as compared to households with lower educational status.

The average expenditure incurred by the households by occupation of the head of the household (Table 36) shows that both in the rural and urban areas, there is not much variation in expenditure across different occupational categories except in the case of accidents/injuries. In the urban areas, the average amount spent per illness episode works out to be lowest for the wage earner category. The households belonging to the salary earner/professional category and the business category have spent more or less the same amount per illness episode. In the urban areas, the cultivator category includes the households where the head of the household is a land owner and other family members are engaged in other occupations. For these households, the amount spent per household has worked out to be the highest, while in the rural areas, the average expenditure per illness episode has worked out to be more or less the same for the households headed by cultivators, wage earners and the salary earners. For the business households and the households belonging to 'others' category, the average expenditure has worked out to be higher.

Break-up of Expenditure

In Tables 37 and 38, the item-wise break-up of average expenditure incurred per illness episode by the households is presented for the rural and urban areas separately. In the rural areas, the 'fees and medicine' component accounted for 71.3% of the total amount spent per illness episode. Fees paid to the health provider and the medicine costs are clubbed together since in many cases, the 'doctors' also dispense the medicines and the households are unable to separate the medicine cost and the fees from the total amount paid to the 'doctors'. In the case of urban households, the 'fees and medicine' component accounts for a higher proportion of the total expenditure, i.e., 77.6% of the expenditure incurred by the household goes in for this item.

As already mentioned, in the rural areas longer distances

have to be travelled for seeking treatment than in the urban areas. Hence, the transport cost forms a much higher proportion of the total expenditure in the rural areas. Out of the total amount spent by the households, as much as 14.5% has gone in for the transport cost, while in the case of urban households, the transport cost accounted for only 6.5% of the total expenditure incurred per illness episode. In the case of rural Himachal Pradesh, the transport cost formed nearly one-fourth of the total expenditure. Some of the other states for which the transport cost formed a higher proportion are: rural parts of Gujarat (21.0%), Karnataka (21.8%), Maharashtra (21.5%) and Tamil Nadu (22.6%).

As against this, the urban households seem to have spent proportionately more on the clinical tests when compared to the rural households. In the urban areas, the expenditure on clinical tests formed 6.9% of the amount spent per illness episode while in the case of rural households, this percentage was lower at 4.4. As compared to the rural areas, the urban households have spent proportionately lesser amounts on rituals and on bribes/tips.

Household Expenditure on Hospitalised Illnesses

For seeking treatment as in-patients people seem to prefer the public health facilities and the most important reason for the higher utilisation of public hospitals turned out to be that they are less expensive than the private facilities. This is obvious from Table 39 which shows that the average expenditure incurred by the households for seeking treatment from the private hospitals/nursing homes is much higher than the expenditure incurred for seeking treatment from the public hospitals. The difference between the public and private hospitals is much more pronounced in the urban than in the rural areas.

In the urban areas, the average household expenditure per hospitalised case works out to be Rs. 453 and Rs. 2319 respectively for seeking treatment from the public and the private hospitals. In the rural areas, the averages are Rs.535 for the public hospitals and Rs. 1877 for the private hospitals.

The average expenditure per hospitalised illness episode by nature of illness (Table 40) shows that for all the four categories of illnesses, there is a substantial difference in the expenditure

between the public and the private health facilities.

There is a significant sex differential in the average expenditure incurred by the households for hospitalisation both in the rural and urban areas, irrespective of the type of health facility utilised. In the rural areas, the average amount spent per hospitalisation case has worked out to be Rs. 1105 for the males and Rs. 935 for the females; in the urban areas, it was Rs.1339 and Rs. 989 respectively for the males and females.

The average expenditure incurred by the households by type of illnesses shows that in the urban areas for all the four categories of illnesses the average expenditure was lower for the females than for the males. In the rural areas the sex differentials are obvious only for the chronic illnesses and for accidents and injuries. Thus in the case of hospitalisation there is a gender discrimination not only in the form of fewer females reporting hospitalisation but also in the form of lesser expenditure for the treatment of hospitalised cases for females than for males.

The break-up of expenditure incurred by the households for hospitalisation (Table 41) shows that nearly half the amount is spent in the form of fees and medicines. As expected the households in the rural areas have spent a higher proportion of the total expenditure (per hospitalisation case) on transport when compared to their counterparts in the urban areas. For the rural households the transport costs accounted for 12.1% of the total amount spent per hospitalisation case, while for the urban households this percentage was much lower at 4.8. Both the urban and rural households have spent nearly 9% of the total expenditure for clinical tests. The actual amount as well as the proportion of expenditure on hospitalisation charges are much higher for the urban households. The hospitalisation charges formed 21% of the total expenses in the case of urban households, whereas the rural households spent only 14.6% of the total expenditure on hospitalisation charges.

Household Expenditure on Other Health Care

It has already been seen that for preventive health care, there is a near total dependence on the public health facilities. Only a very small percentage of children have gone to the private health provider for immunisation. Under the Universal Immunisation Programme, since immunisation facilities are

easily available at the public health facilities, the households have incurred hardly any expenditure for immunising their children against preventable diseases (Table 42). The average expenditure incurred by the households (per immunisation) works out to be around Rs. 4 for utilising the public health services. This small amount is spent mostly on transport to commute to the health facilities. In the case of households utilising the services of private health providers, the average amount spent (per immunisation) works out to be Rs. 48 and Rs. 37 respectively for the rural and urban areas. In the rural areas, the average amount spent is more because of higher transport cost.

In Table 43, the average expenditure incurred by the households for deliveries and abortion/miscarriage cases are presented by the type of health care facilities utilised. In the case of home deliveries, the households have spent only a nominal amount and this could be one of the reasons for not utilising any health facility. The amount spent works out to be Rs. 76 and Rs. 52 respectively, for the rural and the urban households. This amount is usually spent on special diet, rituals and payment to birth attendants, if any.

There is a substantial difference in the average amount spent for deliveries between the public and private health services On an average the rural households have spent (per delivery) Rs. 257 and Rs. 1497 respectively for utilising the public and private health facilities. For the urban households, these averages work out to be Rs. 231 and Rs. 1858.

Household Expenditure by System of Treatment

Among the various systems of medicine, the allopathic system has turned out to be the most popular system of medicine. It is interesting to note that inspite of the allopathic system of medicine being more expensive than the other systems of medicine (Table 44), for nearly 90% of the illness episodes the households have relied on this system of medicine.

The average amount spent per illness episode works out to be Rs. 92 and Rs. 114 respectively in the rural and urban areas, for utilising the allopathic system of medicine. As against this, the households utilising the homeopathic system of medicine have incurred an average expenditure of Rs. 70 and Rs. 83 respectively in the rural and urban areas.

The indigenous systems of medicine, ayurveda/siddha seem to be comparatively very inexpensive in the rural areas. The rural households that have relied on these indigenous systems of medicine, have spent on an average Rs. 38 while the urban households have paid Rs. 97 per illness episode.

The amount spent (per illness episode) works out to be very high for utilising a combination of more than one system of medicine. As mentioned earlier, only for a small percentage of illness episodes have the households utilised a combination of systems and for these illness episodes the average expenditure works out to be Rs. 130 and Rs. 165 respectively for the rural and urban areas.

Table 1 : State-wise Prevalence Rate* of Illness by Sex – Rural ✓

(Per '000 Population)

State	Male			Female			All		
	Prevalence Rate of Illness	*Prevalence Rate of Treated Illness*	*Treated Illness as Percentage of Total Illness*	*Prevalence Rate of Illness*	*Prevalence Rate of Treated Illness*	*Treated Illness as Percentage of Total Illness*	*Prevalence Rate of Illness*	*Prevalence Rate of Treated Illness*	*Treated Illness as Percentage of Total Illness*
Andhra Pradesh	135.9	121.9	89.7	115.5	107.9	93.5	126.6	115.5	91.3
Assam	90.2	86.0	95.3	80.8	72.7	90.0	86.0	80.2	93.2
Bihar	98.3	81.4	82.8	97.7	87.5	89.8	98.0	84.2	85.7
Gujarat	71.6	67.2	93.7	80.8	72.7	90.0	75.8	69.7	92.0
Haryana	78.9	71.4	90.6	70.7	64.6	91.3	75.4	68.6	91.1
Himachal Pradesh	127.2	124.0	97.3	167.2	157.2	94.0	146.3	139.7	95.5
Karnataka	123.0	100.0	81.4	110.1	95.6	86.8	116.6	97.8	83.9
Kerala	201.6	196.3	97.4	187.8	182.1	96.9	194.8	189.3	97.2
Madhya Pradesh	114.7	106.2	92.6	116.3	101.6	87.3	115.4	104.1	90.2
Maharashtra	65.4	60.0	91.7	68.4	54.5	79.6	66.8	57.3	85.8
Orissa	159.4	129.2	81.0	229.2	183.2	80.0	191.4	154.0	80.4
Punjab	155.8	155.8	100.0	106.4	104.5	98.2	132.0	131.0	99.3
Rajasthan	109.0	95.5	87.6	119.6	110.2	92.2	113.7	102.2	89.7
Tamil Nadu	78.0	71.8	92.2	79.0	68.7	87.0	78.3	70.4	89.7
Uttar Pradesh	109.6	95.3	86.9	110.6	93.8	84.8	110.0	94.6	86.0
West Bengal	77.8	59.4	76.3	87.2	86.2	99.0	82.0	71.6	87.3
ALL-INDIA	**105.5**	**92.9**	**88.1**	**108.1**	**95.6**	**88.4**	**106.7**	**94.1**	**88.2**
Coefficient of Variation %	33.35	32.77		39.18	38.30		34.29	35.29	

* Prevalence rates have been worked out for the one month reference period in all the tables.

Note: All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi.

Table 2 : State-wise Prevalence Rate of Illness by Sex--Urban

(Per '000 Population)

State	Male			Female			All		
	Prevalence Rate of Illness	*Prevalence Rate of Treated Illness*	*Treated Illness as Percentage of Total Illness*	*Prevalence Rate of Illness*	*Prevalence Rate of Treated Illness*	*Treated Illness as Percentage of Total Illness*	*Prevalence Rate of Illness*	*Prevalence Rate of Treated Illness*	*Treated Illness as Percentage of Total Illness*
Andhra Pradesh	135.0	118.2	87.6	146.6	120.3	82.0	140.4	119.2	84.9
Assam	64.0	63.0	98.5	65.3	61.8	94.7	64.5	62.5	97.0
Bihar	106.2	101.0	95.0	98.2	89.0	90.7	102.4	95.5	93.2
Gujarat	74.5	71.0	95.3	95.0	83.8	88.3	84.3	77.2	91.5
Haryana	77.2	75.3	97.4	101.2	96.2	95.2	87.9	84.5	96.2
Himachal Pradesh	163.9	148.4	90.6	211.5	188.9	89.3	186.3	167.5	89.9
Karnataka	89.7	75.6	84.3	106.4	98.5	92.5	97.5	86.3	88.5
Kerala	191.8	170.0	88.6	176.1	153.4	87.1	183.9	161.6	87.9
Madhya Pradesh	127.0	122.7	96.6	119.5	113.6	95.1	123.4	118.4	95.9
Maharashtra	77.8	74.4	95.7	79.5	75.8	95.3	78.6	75.2	95.5
Orissa	163.0	157.2	96.4	178.6	159.2	89.0	170.4	158.2	92.7
Punjab	120.6	108.5	95.0	175.4	165.2	94.2	175.4	165.2	92.3
Rajasthan	139.7	129.0	92.3	175.6	160.2	91.2	156.2	143.2	91.7
Tamil Nadu	76.5	71.2	92.9	74.7	67.3	90.2	75.6	69.3	91.5
Uttar Pradesh	78.1	69.8	89.4	82.9	73.2	88.4	80.3	71.4	88.9
West Bengal	74.4	70.4	94.6	89.2	82.9	93.0	81.5	76.4	93.7
Delhi	95.2	89.2	93.7	146.2	143.0	97.8	118.3	113.6	96.0
ALL-INDIA	**98.2**	**90.7**	**92.4**	**108.4**	**98.6**	**90.9**	**103.0**	**94.4**	**91.7**
Coefficient of Variation %	*35.38*	*34.22*		*36.25*	*35.42*		*35.88*	*34.79*	

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry and Chandigarh.

Table 3 : Prevalence Rate of Illness by Age and Sex

(Per '000 Population)

Age Group (Years)	*Male*			*Female*		
	Prevalence of Illness	*Prevalence of Treated Illness*	*Treated As % of Total Illness*	*Prevalence of Illness*	*Prevalence of Treated Illness*	*Treated As % of Total Illness*
			RURAL			
≤ 5	131.4	116.4	88.6	125.0	113.6	90.9
6 - 14	86.5	78.3	90.5	72.9	65.9	90.3
15 - 59	99.5	86.5	86.9	110.4	97.3	88.2
≥ 60	214.6	192.0	89.4	192.2	160.4	83.5
TOTAL	**105.5**	**92.9**	**88.2**	**108.1**	**95.5**	**88.4**
			URBAN			
≤ 5	143.5	134.6	93.8	122.7	115.0	93.6
6 - 14	76.0	70.4	92.7	67.2	60.9	90.7
15 - 59	90.2	83.0	92.0	110.5	100.2	90.5
≥60	219.7	202.0	91.8	215.9	194.5	90.2
TOTAL	**98.2**	**90.5**	**92.3**	**108.4**	**98.5**	**90.9**

Table 4 : Prevalence Rate of Illness by Nature of Illness for Adults and Children – Rural

(Per '000 Population)

Nature of Illness	*Adults*		*Children*		*Total*
	Male	*Female*	*Male*	*Female*	
Serious Communicable Diseases					
Typhoid, Malaria, Cholera, Acute Gastroenteritis, Jaundice	12.5	10.4	16.3	13.5	12.6
Mumps, Measles, Chickenpox, T.B.	5.1	2.6	0.9	0.4	2.9
Acute Illness					
Diarrhoeal diseases	4.9	5.5	12.0	11.8	7.4
Respiratory infection	9.1	9.3	15.0	16.6	11.3
Non-specific fever	30.0	31.5	39.3	32.8	32.5
Eye/Ear problems	6.8	7.0	3.7	2.2	5.6
Headache/Bodyache/Backache	4.1	9.0	1.6	1.6	4.8
Stomach problems — Indigestion, Gas, Acidity, Constipation	6.9	11.5	3.1	3.8	7.2
Others	2.6	7.2	1.4	0.9	3.5
Accident and injuries	4.3	1.1	1.7	0.4	2.3
Skin diseases*	3.7	1.7	3.1	5.0	3.2
Chronic Illness					
Aches and pains — Arthrities, Rheumatism	2.2	2.0	0.0	0.0	1.4
Cardio Vascular diseases — BP/ Heart ailments/Paralysis	4.5	3.1	0.4	0.0	2.6
Diabetes/Kidney problems	1.2	1.3	0.1	0.0	0.9
Breathing problems/Asthama	2.8	4.1	0.1	0.0	2.3
Cancer	0.8	1.0	0.3	0.0	0.7
Weakness/Dizziness/Anaemia	2.7	5.1	0.6	1.0	2.8
Mental/Psychological disorder	0.8	0.2	0.0	0.1	0.4
Others	3.0	3.0	0.4	0.3	2.1
ALL ILLNESS	**108.0**	**116.6**	**100.3**	**90.4**	**106.6**

* Includes some chronic skin diseases also.

Table 5 : Prevalence Rate of Illness by Nature of Illness for Adults and Children — Urban

(Per '000 Population)

Nature of Illness	*Adults*		*Children*		*Total*
	Male	*Female*	*Male*	*Female*	
Serious Communicable Diseases					
Typhoid, Malaria, Cholera, Acute Gastroenteritis, Jaundice	11.4	11.2	15.7	11.3	11.8
Mumps, Measles, Chickenpox, T.B.	2.7	2.2	0.7	0.6	1.9
Acute Illness					
Diarrhoeal diseases	5.0	6.8	11.7	10.3	7.6
Respiratory infection	10.1	12.3	16.6	17.0	12.8
Non-specific fever	21.7	26.1	32.2	29.8	25.9
Eye/Ear problems	4.9	6.1	3.8	3.3	4.9
Headache/Bodyache/Backache	4.3	7.5	1.1	2.4	4.6
Stomach problems — Indigestion, Gas, Acidity, Constipation	5.7	8.8	2.9	2.3	5.8
Others	2.1	7.6	0.7	0.6	3.7
Accident and injuries	5.0	1.5	2.7	0.8	2.9
Skin diseases*	2.9	3.1	2.9	1.8	2.8
Chronic Illness					
Aches and pains — Arthrities, Rheumatism	2.3	3.1	0.0	0.0	1.9
Cardio vascular diseases — BP/ Heart ailments/Paralysis	9.0	7.7	0.3	1.0	6.1
Diabetes/Kidney problems	3.3	2.7	0.0	0.1	2.2
Breathing problems/Asthama	2.7	3.2	0.7	0.5	2.3
Cancer	0.5	0.7	0.1	0.0	0.4
Weakness/Dizziness/Anaemia	3.4	4.6	1.3	1.3	3.2
Mental/Psychological disorder	0.8	1.3	0.2	0.0	0.8
Others	1.9	1.5	1.4	0.6	1.5
ALL ILLNESS	**99.7**	**118.0**	**95.0**	**83.7**	**103.1**

* Includes some chronic skin diseases also.

Table 6 : State-wise Prevalence Rate of Illness by Type of Illness

(Per '000 Population)

State	Rural				Urban			
	Serious Communicable Diseases	*Acute Illness*	*Chronic Illness*	*Total*	*Serious Communicable Diseases*	*Acute Illness*	*Chronic Illness*	*Total*
Andhra Pradesh	14.6	83.4	28.6	126.6	8.7	105.9	25.8	140.5
Assam	22.5	50.5	13.0	86.0	16.6	36.3	11.6	64.5
Bihar	18.3	72.0	7.7	98.0	17.3	74.4	11.0	102.6
Gujarat	21.0	49.6	5.2	75.8	18.8	52.8	12.7	84.3
Haryana	9.6	52.3	13.6	75.5	10.6	65.9	11.4	87.9
Himachal Pradesh	20.1	91.3	35.0	146.3	11.7	112.2	62.5	186.3
Karnataka	15.6	82.0	19.0	116.7	15.8	61.2	20.5	97.5
Kerala	18.8	111.4	64.7	194.9	8.7	125.6	49.6	184.0
Madhya Pradesh	9.6	99.0	6.8	115.4	17.2	89.8	16.4	123.4
Maharashtra	8.7	49.8	8.4	66.9	16.2	45.8	16.6	78.6
Orissa	30.3	140.7	20.6	191.5	25.9	116.0	28.5	170.4
Punjab	12.9	111.1	7.9	132.0	18.1	105.6	22.2	145.8
Rajasthan	21.8	82.6	9.3	113.8	23.7	115.0	17.4	156.1
Tamil Nadu	9.6	62.3	6.6	78.5	10.6	48.0	17.1	75.7
Uttar Pradesh	15.4	84.1	10.5	110.0	10.2	60.0	10.1	80.3
West Bengal	15.2	53.8	13.1	82.1	11.4	52.2	17.9	81.5
Delhi	—	—	—	—	9.1	79.1	30.1	118.3
ALL-INDIA	**15.6**	**77.9**	**13.2**	**106.7**	**14.0**	**70.6**	**18.4**	**103.0**
Coefficient of *Variation %*	*35.69*	*33.49*	*90.38*	*34.29*	*35.25*	*36.89*	*63.19*	*35.88*

Note: All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigharh and Delhi rural.

Table 7 : Prevalence Rate of Illness by Socio-Economic Characteristics of the Household

(Per '000 Population)

	Rural				*Urban*			
	Serious Communicable Diseases	*Acute Illness*	*Chronic Illness*	*Total*	*Serious Communicable Diseases*	*Acute Illness*	*Chronic Illness*	*Total*
Annual Household Income (Rs.)								
≤18000	16.6	83.4	11.9	111.8	17.3	80.3	17.7	115.3
18001–54000	14.0	69.8	15.5	99.3	12.5	67.3	18.5	98.4
>54000	12.3	59.3	16.0	87.6	10.3	56.5	19.7	86.4
Highest Level of Education in the Household								
No Formal Education	16.3	97.7	12.8	126.7	18.3	107.8	18.9	145.0
Primary	19.4	74.4	10.5	104.3	18.4	74.9	16.8	110.2
Higher Secondary	13.9	73.6	13.5	101.0	14.8	70.8	17.2	102.8
Graduate	15.2	78.9	17.3	111.4	10.4	63.5	20.8	94.7
Occupation of the Household Head								
Cultivator	3.9	75.4	11.7	100.9	12.6	62.0	13.5	88.1
Wage Earner	19.0	80.4	12.9	112.0	16.3	77.1	15.1	108.5
Salary Earner/ Professionals	14.1	83.5	16.9	114.4	13.3	69.8	18.8	102.0
Business	13.6	75.2	11.5	100.3	13.4	69.0	17.3	99.7
Others	17.1	81.5	21.3	119.9	13.4	68.5	25.0	107.0
ALL	**15.6**	**77.9**	**13.2**	**106.7**	**14.0**	**70.6**	**18.4**	**103.0**

Table 8 : State-wise Reported Number of Hospitalisation Cases by Sex

(Per '000 Population)

State	Rural			Urban		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Andhra Pradesh	19.9	15.3	17.8	18.8	15.5	17.2
Assam	7.1	4.1	5.7	0.5	2.2	1.2
Bihar	7.2	5.7	6.5	6.1	10.9	8.3
Gujarat	3.4	6.5	4.7	10.4	4.5	7.6
Haryana	9.5	2.1	6.3	9.5	10.5	10.0
Himachal Pradesh	14.3	9.8	12.2	31.6	11.5	22.1
Karnataka	6.1	6.1	6.1	12.4	12.0	12.2
Kerala	26.4	29.0	27.7	18.4	7.1	12.7
Madhya Pradesh	5.7	3.4	4.7	3.0	5.3	4.1
Maharashtra	7.6	3.2	5.5	15.4	12.6	14.1
Orissa	4.0	10.3	6.9	12.2	7.8	10.2
Punjab	22.2	5.7	14.2	12.4	16.6	14.3
Rajasthan	12.3	4.2	8.7	12.6	5.7	9.5
Tamil Nadu	2.4	0.5	1.5	8.6	4.2	6.4
Uttar Pradesh	10.3	3.7	7.4	10.2	3.7	7.3
West Bengal	0.8	0.4	0.6	3.5	3.6	3.5
Delhi	–	–	–	13.0	18.2	15.4
ALL-INDIA	**8.4**	**5.5**	**7.1**	**10.9**	**8.4**	**9.7**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi rural.

Table 9 : State-wise Average Duration of Illness (Communicable and Acute Illnesses Only)

(In Days)

State	*Rural*			*Urban*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Andhra Pradesh	10.6	8.6	9.8	8.5	8.1	8.3
Assam	14.6	10.2	12.7	12.5	17.8	14.2
Bihar	11.3	10.7	11.0	10.7	9.9	10.3
Gujarat	11.4	14.2	12.7	8.2	8.7	8.5
Haryana	10.4	8.2	9.5	10.3	7.9	8.9
Himachal Pradesh	15.9	10.7	13.2	11.5	17.0	14.7
Karnataka	17.7	12.5	15.2	10.0	10.9	10.4
Kerala	19.2	15.0	17.1	12.1	10.8	11.4
Madhya Pradesh	11.0	10.4	10.8	9.3	9.6	9.4
Maharashtra	11.0	9.5	10.2	11.8	12.3	12.0
Orissa	6.5	6.6	6.5	11.2	8.2	9.5
Punjab	14.0	12.2	13.2	9.2	9.5	9.3
Rajasthan	13.0	9.5	11.4	9.4	7.2	8.3
Tamil Nadu	10.2	9.3	9.8	11.9	10.3	11.2
Uttar Pradesh	8.6	7.3	8.0	8.9	7.8	8.4
West Bengal	13.0	15.3	14.2	15.3	14.2	14.7
Delhi	–	–	–	11.8	10.7	11.2
ALL-INDIA	**11.4**	**10.1**	**10.8**	**10.4**	**9.8**	**10.1**

Note : All-India figures includes the States/Union Territories of Goa, Meghalaya, Pondicharry, Chandigarh and Delhi rural.

Table 10 : Percentage Distribution of Untreated Illnesses by Duration of Illness

Duration	*Rural*			*Urban*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
1 Day	8.0	6.3	7.2	13.2	15.2	14.3
2 – 3 Days	44.3	43.3	43.8	38.2	39.9	39.1
4 – 7 Days	23.4	23.2	23.3	31.4	27.0	29.0
> 7 Days	24.4	27.3	25.7	17.1	18.0	17.6
ALL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 11 : Percentage Distribution of Untreated Illnesses by Reasons for No Treatment

Reasons	*Rural*			*Urban*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Illness not considered serious enough	63.3	69.2	66.0	79.5	80.8	80.2
No medical facility near by	11.5	15.8	13.4	1.6	1.7	1.6
Financial constraints	21.7	11.1	16.8	8.6	11.6	10.2
Time constraints	0.0	0.2	0.1	0.3	1.0	0.7
Others	3.5	3.7	3.7	10.0	4.9	7.3
ALL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 12 : Percentage Distribution of Untreated Illnesses by Socio-Economic Characteristics of the Household

	Rural			*Urban*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Annual Household Income (Rs.)						
≤ 18,000	13.2	12.3	12.8	8.4	11.1	9.7
18,001-54,000	9.3	10.3	9.8	7.8	8.0	7.9
> 54,000	8.3	8.0	8.2	4.1	6.6	5.3
Highest Level of Education in the Household						
No formal education	19.3	18.9	19.1	8.3	14.3	11.4
Primary	14.6	12.2	13.5	9.9	10.5	10.1
Higher Secondary	9.4	9.1	9.2	6.7	8.6	7.7
Graduate and above	7.4	9.6	8.4	8.2	8.3	8.3
Occupation of the Household Head						
Cultivators	13.3	12.0	12.7	8.6	9.3	9.2
Wage earner	12.7	14.5	13.2	8.4	11.5	9.9
Salary earner/ Professional	9.8	6.1	7.9	8.4	8.8	8.6
Business	12.1	11.4	11.7	6.4	8.0	7.2
Others	5.3	7.0	6.1	6.3	7.6	6.9
ALL	**11.9**	**11.6**	**11.8**	**7.6**	**9.1**	**8.4**

Table 13 : Distribution of Non-Hospitalised Illness Episodes by Type of Treatment

(Percentage)

Type of Treatment	*Adults*		*Children*		*Total*		*Total*
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	
			RURAL				
Government Hospital	20.1	19.8	11.4	12.3	17.1	17.6	17.4
PHC/CHC	18.9	20.5	21.9	22.0	19.9	21.0	20.4
ANM/MPHW/Anganwadi	2.7	3.8	4.3	7.0	3.2	4.7	3.9
Private Hospital/ Nursing Home	6.3	7.0	3.8	2.7	5.5	5.7	5.6
Private Practitioner	46.1	43.4	51.5	47.3	47.9	44.5	46.3
Charitable Trust	1.0	0.7	1.3	0.0	1.1	0.5	0.8
Medical Shop	2.9	3.1	2.1	5.1	2.6	3.7	3.1
Faith Healer/ Religious Person	0.2	0.1	1.5	0.8	0.7	0.3	0.5
Home Remedy	1.8	1.6	2.2	2.8	2.0	2.0	2.0
ALL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			URBAN				
Government Hospital	27.7	26.5	21.0	21.4	25.6	25.3	25.5
Government / Municipal Dispensaries	8.5	7.3	10.4	9.9	9.1	7.9	8.5
Private Hospital / Nursing Home	10.9	11.7	7.4	6.9	9.8	10.7	10.2
Private Practitioner	45.5	47.5	54.1	53.9	48.2	49.0	48.6
Charitable Trust	1.0	1.3	0.4	0.9	0.8	1.2	1.0
Medical Shop	5.5	4.6	5.7	6.2	5.5	4.9	5.2
Faith Healer / Religious Persons	0.3	0.2	0.2	0.3	0.3	0.2	0.2
Home Remedy	0.6	0.9	0.8	0.5	0.7	0.8	0.8
ALL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 14 : State-wise Distribution of Non-Hospitalised Illness Episodes by Type of Treatment for Male and Female – Rural

(Percentages)

State	Male						Female					
	Public Facility	*Private Facility*	*Medical Shop*	*Faith Healer/ Religi-ous Person*	*Home Remedy*	*Total*	*Public Facility*	*Private Facility*	*Medical Shop*	*Faith Healer/ Religi-ous Person*	*Home Remedy*	*Total*
Andhra Pradesh	41.5	57.9	0.6	0.0	0.0	100.0	32.6	60.7	6.7	0.0	0.0	100.0
Assam	66.8	29.3	2.3	0.0	1.6	100.0	57.5	42.0	0.6	0.0	0.0	100.0
Bihar	34.8	49.5	9.6	1.4	4.7	100.0	39.0	46.0	9.5	0.0	5.7	100.0
Gujarat	36.8	62.2	0.0	1.0	0.0	100.0	36.7	59.8	1.2	0.0	2.3	100.0
Haryana	36.9	54.2	4.2	0.0	4.7	100.0	40.7	58.6	0.0	0.6	0.0	100.0
Himachal Pradesh	43.6	56.4	0.0	0.0	0.0	100.0	56.5	40.0	0.8	0.0	2.7	100.0
Karnataka	65.0	35.0	0.0	0.0	0.0	100.0	54.6	45.2	0.2	0.0	0.0	100.0
Kerala	25.9	71.7	0.0	0.0	2.4	100.0	37.2	61.2	1.6	0.0	0.0	100.0
Madhya Pradesh	31.1	65.0	1.7	0.0	2.2	100.0	37.0	58.4	3.0	0.7	0.9	100.0
Maharashtra	46.1	51.3	0.0	0.0	2.5	100.0	41.6	55.0	0.0	0.0	3.4	100.0
Orissa	68.6	14.4	2.2	5.4	9.3	100.0	72.1	11.3	8.1	0.0	8.5	100.0
Punjab	42.2	57.8	0.0	0.0	0.0	100.0	42.6	57.4	0.0	0.0	0.0	100.0
Rajasthan	67.5	30.7	1.6	0.0	0.3	100.0	65.2	30.1	2.0	0.0	2.7	100.0
Tamil Nadu	41.9	51.7	3.2	0.0	3.2	100.0	57.1	35.3	3.5	4.1	0.0	100.0
Uttar Pradesh	28.2	67.2	4.3	0.3	0.0	100.0	33.8	62.9	2.8	0.0	0.5	100.0
West Benga!	18.5	80.2	0.0	1.3	0.0	100.0	21.2	74.6	4.3	0.0	0.0	100.0
ALL–INDIA	**40.2**	**54.5**	**2.6**	**0.7**	**2.0**	**100.0**	**43.3**	**50.8**	**3.7**	**0.3**	**2.0**	**100.0**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi.

Table 15 : State–wise Distribution of Non-Hospitalised Illness Episodes by Type of Treatment for Male and Female – Urban

(Percentage)

State	Male						Female					
	Public Facility	*Private Facility*	*Medical Shop*	*Faith Healer/ Religi-ous Person*	*Home Remedy*	*Total*	*Public Facility*	*Private Facility*	*Medical Shop*	*Faith Healer/ Religi-ous Person*	*Home Remedy*	*Total*
Andhra Pradesh	37.3	52.1	10.4	0.1	0.1	100.0	30.1	62.8	5.4	0.0	1.7	100.0
Assam	50.0	46.7	3.3	0.0	0.0	100.0	49.0	51.0	0.0	0.0	0.0	100.0
Bihar	26.7	60.1	11.8	0.9	0.6	100.0	25.7	63.6	10.7	0.0	0.0	100.0
Gujarat	38.7	57.7	2.5	0.0	1.1	100.0	31.6	63.2	2.7	0.0	2.5	100.0
Haryana	34.7	54.2	4.2	0.0	4.7	100.0	40.7	58.6	0.0	0.6	0.0	100.0
Himachal Pradesh	60.8	39.2	0.0	0.0	0.0	100.0	63.6	36.5	0.0	0.0	0.0	100.0
Karnataka	43.6	43.6	12.8	0.0	0.0	100.0	47.7	50.3	2.0	0.0	0.0	100.0
Kerala	43.5	51.8	4.7	0.0	0.0	100.0	41.4	52.5	5.6	0.0	0.5	100.0
Madhya Pradesh	32.2	61.7	4.3	0.0	1.8	100.0	35.6	60.6	3.3	0.0	0.5	100.0
Maharashtra	30.0	68.0	2.0	0.0	0.0	100.0	35.1	62.4	1.7	0.7	0.0	100.0
Orissa	41.1	41.5	16.7	0.0	0.7	100.0	42.5	48.0	8.9	0.0	0.6	100.0
Punjab	18.2	78.7	1.5	0.0	1.7	100.0	28.8	69.8	1.4	0.0	0.0	100.0
Rajasthan	57.0	35.1	6.8	0.0	1.2	100.0	46.5	38.2	14.3	1.0	0.0	100.0
Tamil Nadu	41.2	51.7	3.3	1.2	2.5	100.0	32.4	60.2	5.9	0.2	1.2	100.0
Uttar Pradesh	19.3	78.1	2.6	0.0	0.0	100.0	16.1	76.2	5.7	0.7	1.3	100.0
West Bengal	33.8	63.7	2.4	0.0	0.0	100.0	27.3	68.5	3.0	0.0	1.1	100.0
Delhi	21.5	73.2	2.6	2.6	0.0	100.0	26.4	71.1	1.6	0.0	1.0	100.0
ALL–INDIA	**34.7**	**58.9**	**5.5**	**0.3**	**0.7**	**100.0**	**33.2**	**60.9**	**5.0**	**0.2**	**0.8**	**100.0**

Note : All-India figures include the State/Union Territores of Goa, Meghalaya, Pondicherry, Chandigarh.

Table 16 : Distribution of Non-Hospitalised Illness Episodes by Type of Treatment and by Nature of Illness

(Percentages)

Nature of Illness	*Male*						*Female*					
	Public Facility	*Private Facility*	*Medical Shop*	*Faith Healer/ Religious Person*	*Home Remedy*	*Total*	*Public Facility*	*Private Facility*	*Medical Shop*	*Faith Healer/ Religious Person*	*Home Remedy*	*Total*
					RURAL							
Serious Communicable Illness	43.8	49.8	—	3.7	2.7	100.0	53.8	43.0	—	1.9	1.4	100.0
Acute Illness	38.0	56.8	3.5	0.1	1.7	100.0	40.9	52.0	4.7	0.1	2.3	100.0
Chronic Illness	46.2	51.0	0.9	—	1.9	100.0	45.4	53.1	1.0	0.5	—	100.0
Accident/Injuries	60.3	31.6	—	—	8.1	100.0	70.1	29.9	—	—	—	100.0
ALL ILLNESS	**40.2**	**54.5**	**2.6**	**0.7**	**2.0**	**100.0**	**43.3**	**50.8**	**3.6**	**0.3**	**2.0**	**100.0**
					URBAN							
Serious Communicable Illness	39.9	56.9	1.4	1.0	0.9	100.0	42.3	55.7	0.9	0.6	0.5	100.00
Acute Illness	32.3	59.7	7.4	—	0.6	100.0	30.5	62.3	6.6	0.1	0.5	100.00
Chronic Illness	37.4	58.4	2.9	0.7	0.7	100.0	37.7	58.8	1.3	0.9	1.3	100.00
Accident/Injuries	49.0	50.7	0.3	—	—	100.0	33.9	54.7	—	—	11.4	100.00
ALL ILLNESS	**34.7**	**58.8**	**5.5**	**0.3**	**0.7**	**100.0**	**33.2**	**60.9**	**0.5**	**0.2**	**0.8**	**100.00**

Table 17 : Distribution of Non-Hospitalised Illness Episodes by Type of Treatment and Socio-Economic Characteristics of the Household

(Percentages)

	Rural					*Urban*				
	Public Facility	*Private Facility*	*Medical Shop*	*Others*	*Total*	*Public Facility*	*Private Facility*	*Medical Shop*	*Others*	*Total*
Annual Household Income (Rs.)										
≤ 18,000	43.4	50.9	2.9	2.8	100.0	41.7	52.3	5.0	1.0	100.0
18,001–54,000	39.8	54.5	3.8	1.9	100.0	30.5	62.8	5.7	1.0	100.0
> 54,000	27.6	69.3	2.0	1.1	100.0	20.7	74.6	4.0	0.7	100.0
Highest Level of Education in the Household										
No Formal Education	48.5	40.2	4.9	6.4	100.0	44.5	50.3	2.8	2.4	100.0
Primary	48.5	50.8	2.6	1.0	100.0	44.2	48.9	5.8	1.2	100.0
Higher Secondary	37.8	57.6	2.7	1.9	100.0	35.3	59.2	4.6	0.8	100.0
Graduate and Above	42.6	52.0	3.3	2.1	100.0	24.9	67.6	6.7	0.8	100.0
Occupation of the Household Head										
Cultivator	39.8	54.5	3.8	1.8	100.0	34.6	60.6	4.0	1.6	100.0
Wage Earner	43.2	50.8	1.9	4.2	100.0	42.5	51.7	4.3	1.6	100.0
Salary Earner/Professional	42.3	52.1	3.5	2.2	100.0	29.8	62.7	6.5	1.0	100.0
Business	42.3	52.3	4.4	0.9	100.0	28.6	66.0	4.9	0.5	100.0
Others	45.4	50.9	2.1	1.7	100.0	39.6	55.2	4.5	0.7	100.0
TOTAL — ALL	**41.7**	**52.7**	**3.1**	**2.5**	**100.0**	**33.9**	**59.9**	**5.2**	**1.0**	**100.0**

Table 18 : Reasons for Choice of Treatment by Type of Treatment for Non-Hospitalised Illness Episodes

(Percentages)

Type of Treatment	*Inexpensive/ Free*	*Close By*	*No Other Facility Near By*	*Time Suitable*	*Good Reputation*	*Others*	*Total*
			RURAL				
Government Hospital	74.6	5.5	6.5	1.3	10.5	1.6	100.0
PHC/CHC	68.7	15.3	9.3	1.4	4.1	1.3	100.0
ANM/MPHW/ Anganwadi	63.3	17.7	6.2	1.0	12.0	0.0	100.0
Private Doctor/ Nursing Home	4.2	35.5	18.1	5.6	35.0	1.6	100.0
Medical Shop	23.0	40.8	3.6	15.7	1.5	15.4	100.0
Faith Healer/ Religious Person	18.7	0.0	4.8	2.1	19.5	55.0	100.0
Home Remedy	39.2	1.3	27.3	7.4	4.8	20.1	100.0
ALL	**33.2**	**24.8**	**13.5**	**4.2**	**21.8**	**2.5**	**100.0**
			URBAN				
Government Hospital	77.0	9.7	3.0	1.1	7.8	1.3	100.0
Government/Municipal Dispensaries	68.1	15.9	4.2	2.9	7.3	1.7	100.0
Private Doctor/ Nursing Home	5.4	33.9	5.3	7.4	46.5	1.6	100.0
Medical Shop	15.4	37.4	2.8	11.7	8.5	24.3	100.0
Faith Healer/ Religious Person	11.3	0.0	3.2	0.0	0.0	85.6	100.0
Home Remedy	46.0	12.7	2.2	1.6	0.0	37.5	100.0
ALL	**29.8**	**26.2**	**4.5**	**5.6**	**30.9**	**3.2**	**100.0**

Table 19 : Average Distance Travelled for Seeking Out-Patient Treatment by Type of Treatment

(In Kms.)

Type of Treatment	*Adult*		*Children*		*Total*
	Male	*Female*	*Male*	*Female*	
			RURAL		
Government Hospital	12.4	8.9	8.4	6.8	10.0
PHC/CHC	4.6	2.8	3.1	4.1	3.6
ANM/MPHW/Anganwadi	3.1	2.1	1.5	0.2	1.7
Private Hospital/ Nursing Home	13.3	15.7	4.0	4.0	12.6
Private Practitioner	5.5	5.8	4.9	4.0	5.3
Medical Shop	0.7	2.7	0.9	2.4	1.8
Faith Healer/Religious Person	1.6	2.7	1.1	4.2	2.0
ALL	**7.0**	**6.2**	**4.6**	**4.0**	**5.9**
			URBAN		
Government Hospital	3.5	3.2	1.6	2.5	3.1
Government/Municipal Dispensaries	2.1	1.9	2.1	1.0	1.9
Private Hospital/ Nursing Home	2.8	3.7	1.4	1.5	2.9
Private Practitioner	1.9	2.0	1.7	1.3	1.8
Medical Shop	0.6	0.3	0.2	0.3	0.4
Faith Healer/Religious Person	0.0	5.6	0.0	0.0	1.8
ALL	**2.4**	**2.4**	**1.6**	**1.5**	**2.2**

Table 20 : State-wise Distribution of Hospitalisation Cases by Type of Treatment

(Percentages)

State	Rural			Urban		
	Public	*Private*	*Total*	*Public*	*Private*	*Total*
Andhra Pradesh	30.6	69.4	100.0	56.1	43.9	100.0
Assam	100.0	0.0	100.0	100.0	0.0	100.0
Bihar	59.3	40.7	100.0	63.1	37.0	100.0
Gujarat	32.2	67.8	100.0	27.2	72.8	100.0
Haryana	73.5	26.5	100.0	65.9	34.1	100.0
Himachal Pradesh	100.0	0.0	100.0	69.7	30.3	100.0
Karnataka	61.1	38.9	100.0	57.8	42.2	100.0
Kerala	64.7	35.3	100.0	64.2	35.8	100.0
Madhya Pradesh	72.2	27.8	100.0	72.7	27.3	100.0
Maharashtra	30.5	69.5	100.0	58.8	41.2	100.0
Orissa	98.1	1.9	100.0	68.7	31.3	100.0
Punjab	95.3	4.7	100.0	67.2	32.8	100.0
Rajasthan	78.1	21.9	100.0	88.8	11.2	100.0
Tamil Nadu	14.6	85.4	100.0	49.6	50.4	100.0
Uttar Pradesh	64.9	35.1	100.0	59.7	40.3	100.0
West Bengal	100.0	0.0	100.0	76.8	23.2	100.0
Delhi	—	—	—	69.8	30.2	100.0
ALL - INDIA	**62.0**	**38.0**	**100.0**	**60.1**	**39.9**	**100.0**

Note : All - India figures include the States / Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and rural Delhi.

Table 21 : Reasons for Choice of Treatment by Type of Treatment for Hospitalisation Cases

Reasons	Rural			Urban		
	Public	Private	Total	Public	Private	Total
Inexpensive/Free	53.9	5.0	35.3	77.7	6.1	49.2
Close By	1.7	12.7	5.9	6.3	15.1	10.0
No Other Facility Near By	10.9	20.0	14.4	3.5	12.3	7.0
Timing Suitable	0.8	4.4	2.2	1.1	9.2	4.3
Good Reputation	29.0	50.8	37.3	10.0	55.4	28.1
Others	3.7	7.1	5.0	1.4	1.9	1.6
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

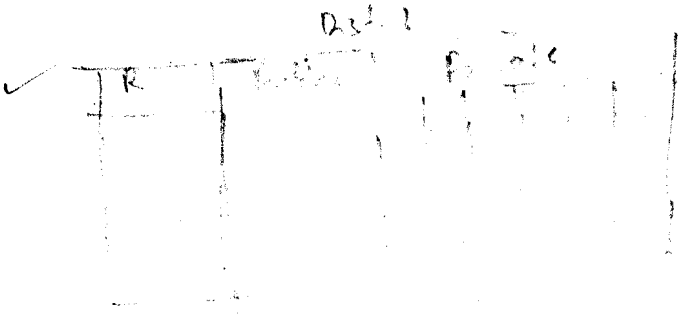


Table 22 : Average Distance Travelled for Seeking In-Patient Treatment by Type of Treatment

(Kms.)

State	*Rural*			*Urban*		
	Public	*Private*	*Total*	*Public*	*Private*	*Total*
Andhra Pradesh	13.9	12.8	13.1	2.3	2.4	2.3
Assam	6.7	0.0	6.7	5.3	0.0	5.3
Bihar	8.7	11.6	9.9	7.1	3.2	5.6
Gujarat	13.6	24.0	19.5	1.8	5.0	4.1
Haryana	15.2	22.2	17.1	2.7	2.2	2.5
Himachal Pradesh	35.0	0.0	35.0	3.3	5.6	4.0
Karnataka	22.5	15.1	19.6	7.1	11.0	8.7
Kerala	26.3	19.5	23.9	8.1	3.4	6.4
Madhya Pradesh	40.3	73.8	50.8	6.4	6.6	6.4
Maharashtra	2.8	10.3	8.4	5.9	6.0	5.9
Orissa	7.8	2.0	7.7	2.5	5.5	3.5
Punjab	9.0	15.0	9.3	3.5	5.4	4.1
Rajasthan	21.6	42.8	26.0	3.6	4.3	3.7
Tamil Nadu	50.0	21.4	25.6	7.9	9.2	8.6
Uttar Pradesh	21.8	13.4	19.0	8.4	6.0	7.5
West Bengal	9.5	0.0	9.5	1.9	4.4	2.5
Delhi	—	—	—	10.6	15.4	12.0
ALL-INDIA	**18.6**	**18.7**	**18.7**	**5.7**	**6.2**	**5.9**

Note : All-India figures included the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and rural Delhi.

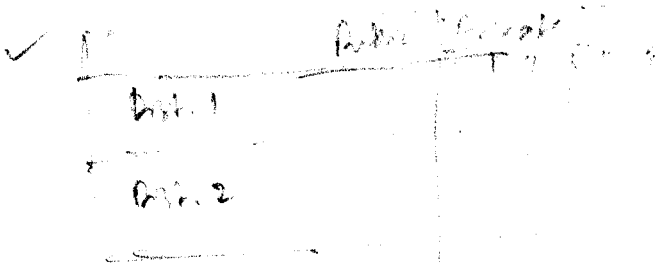


Table 23 : Distribution of Delivery/Abortion Cases by Type of Health Care

(Percentage)

Type of Health Care	*Delivery*		*Abortion/Miscarriage*	
	Rural	*Urban*	*Rural*	*Urban*
Home Delivery	23.4	11.2	18.0	1.7
Public	61.6	63.0	40.2	30.6
Private	15.0	25.9	41.8	67.7
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**

Table 24 : Distribution of Immunization Cases by Type of Health Facility

Type of Health Facility	*Rural*			*Urban*		
	Boys	*Girls*	*Total*	*Boys*	*Girls*	*Total*
Govt Hospital	12.0	13.1	12.5	48.1	47.0	47.6
PHC/CHC	55.5	45.4	50.9	—	—	—
Sub-Centre	25.9	31.2	28.3	—	—	—
Govt/Municipal Dispensary	—	—	—	38.7	41.8	42.1
Private Hospital/ Nursing Home	6.6	10.3	8.3	13.2	11.2	12.3
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 25 : State-wise Distribution of Non-Hospitalised Illness Episodes by System of Medical Treatment – Rural

(Percentages)

State	*Allo-pathy*	*Homeo-pathy*	*Ayur-veda/ Siddha*	*Unani*	*Any Combi-nation*	*Rituals*	*Others*	*All*
Andhra Pradesh	96.6	0.9	0.0	0.9	0.6	0.0	0.9	100.0
Assam	85.7	9.9	3.4	0.9	0.0	0.0	0.0	100.0
Bihar	90.2	2.4	6.7	0.0	0.0	0.8	0.0	100.0
Gujarat	91.9	5.9	1.6	0.0	0.0	0.6	0.0	100.0
Haryana	86.2	0.0	8.3	0.0	5.2	0.3	0.0	100.0
Himachal Pradesh	93.5	0.0	3.1	0.0	3.4	0.0	0.0	100.0
Karnataka	95.8	2.0	0.0	0.0	2.1	0.0	0.1	100.0
Kerala	84.7	4.4	5.8	0.0	5.1	0.0	0.0	100.0
Madhya Pradesh	94.5	0.7	2.8	0.4	0.9	0.7	0.0	100.0
Maharashtra	82.7	0.4	11.3	0.0	5.5	0.0	0.0	100.0
Orissa	84.6	0.3	10.8	0.4	0.1	2.5	1.2	100.0
Punjab	97.3	1.4	0.0	0.0	1.4	0.0	0.0	100.0
Rajasthan	94.3	1.4	3.7	0.0	0.6	0.0	0.0	100.0
Tamil Nadu	88.7	2.0	2.0	0.0	2.0	2.0	3.3	100.0
Uttar Pradesh	92.6	2.2	1.5	0.0	3.5	0.2	0.0	100.0
West Bengal	90.0	3.6	0.7	0.0	2.6	0.8	2.4	100.0
ALL-INDIA	**90.9**	**2.0**	**3.8**	**0.2**	**2.0**	**0.6**	**0.5**	**100.0**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi.

Table 26 : State-wise Distribution of Non-Hospitalised Illness Episodes by System of Medical Treatment -- Urban

(Percentages)

State	*Allo-pathy*	*Homeo-pathy*	*Ayur-veda/ Siddha*	*Unani*	*Any Combi-nation*	*Rituals*	*Others*	*All*
Andhra Pradesh	96.9	1.0	1.0	0.0	0.5	0.1	0.5	100.0
Assam	90.8	7.3	1.8	0.0	0.0	0.0	0.0	100.0
Bihar	90.1	7.8	0.6	0.0	1.0	0.6	0.0	100.0
Gujarat	91.2	2.5	5.2	0.0	1.2	0.0	0.0	100.0
Haryana	89.9	0.0	4.1	0.0	6.1	0.0	0.0	100.0
Himachal Pradesh	97.2	0.0	2.8	0.0	0.0	0.0	0.0	100.0
Karnataka	95.4	2.0	1.2	0.0	1.4	0.0	0.0	100.0
Kerala	91.0	4.8	2.8	0.0	1.4	0.0	0.0	100.0
Madhya Pradesh	95.8	0.9	2.1	0.8	0.4	0.0	0.0	100.0
Maharashtra	92.6	1.5	2.9	0.0	2.3	0.4	0.4	100.0
Orissa	89.2	5.6	5.2	0.0	0.0	0.0	0.0	100.0
Punjab	94.9	0.7	2.3	0.0	2.1	0.0	0.0	100.0
Rajasthan	97.7	0.1	1.6	0.0	0.1	0.5	0.0	100.0
Tamil Nadu	96.1	0.6	1.3	0.0	0.6	0.7	0.6	100.0
Uttar Pradesh	90.4	4.7	2.1	0.0	2.2	0.3	0.3	100.0
West Bengal	83.5	11.3	1.6	0.0	1.5	0.0	0.2	100.0
Delhi	96.8	0.8	1.2	0.0	0.0	1.1	0.0	100.0
ALL-INDIA	**3.2**	**2.9**	**2.2**	**0.1**	**1.2**	**0.3**	**0.2**	**100.0**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh.

Table 27 : State-wise Average Expenditure Per Illness Episode for Adults and Children by Sex for Non-Hospitalised Illnesses -- Rural

(In Rupees)

State	*Adults*		*Children*		*Total*
	Male	*Female*	*Male*	*Female*	
Andhra Pradesh	166.67	214.40	73.40	74.34	171.81
Assam	91.70	60.92	32.01	29.68	66.04
Bihar	160.52	138.21	38.71	61.64	114.73
Gujarat	188.42	182.45	47.35	64.59	149.14
Haryana	130.36	135.74	87.52	35.16	109.07
Himachal Pradesh	135.48	103.62	119.42	97.32	115.42
Karnataka	134.71	132.91	174.17	39.55	130.27
Kerala	210.32	153.54	191.20	65.48	171.52
Madhya Pradesh	85.56	74.92	42.40	36.65	64.48
Maharashtra	146.22	107.61	44.82	26.23	90.71
Orissa	76.92	65.36	39.12	29.24	58.43
Punjab	79.75	46.91	85.51	76.36	70.46
Rajasthan	59.92	57.31	97.64	41.20	59.91
Tamil Nadu	45.86	52.42	41.75	42.78	45.90
Uttar Pradesh	72.98	70.77	43.68	32.11	62.06
West Bengal	76.28	90.65	88.11	58.33	79.74
ALL-INDIA	**113.65**	**101.43**	**60.06**	**44.79**	**90.48**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi rural.

Table 28 : State-wise Average Expenditure Per Illness Episode for Adults and Children by Sex for Non-Hospitalised Illnesses – Urban

(In Rupees)

State	*Adults*		*Children*		*Total*
	Male	*Female*	*Male*	*Female*	
Andhra Pradesh	136.35	138.72	75.48	106.65	126.25
Assam	84.70	119.90	130.82	86.99	106.52
Bihar	149.14	196.78	142.91	91.73	157.25
Gujarat	117.01	124.86	85.81	80.29	111.00
Haryana	195.71	168.45	135.34	44.26	154.14
Himachal Pradesh	64.29	116.98	74.99	59.96	90.93
Karnataka	178.14	157.77	65.76	46.87	145.56
Kerala	108.28	78.19	47.44	41.09	80.57
Madhya Pradesh	75.35	75.29	60.45	48.19	68.82
Maharashtra	174.05	152.24	65.30	59.63	136.60
Orissa	154.60	153.40	91.01	107.03	136.75
Punjab	91.11	143.34	116.95	19.74	116.84
Rajasthan	119.97	90.40	45.06	39.72	87.95
Tamil Nadu	118.27	79.08	41.25	33.81	80.37
Uttar Pradesh	127.68	112.01	82.15	58.43	100.50
West Bengal	159.89	137.68	88.47	61.94	132.33
Delhi	179.25	172.32	146.17	68.05	161.15
ALL-INDIA	**134.08**	**126.40**	**77.18**	**60.71**	**113.93**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh.

Table 29 : State-wise Average Expenditure Per Illness Episode by Type of Treatment for Non-Hospitalised Illnesses -- Rural

(In Rupees)

State	*Public*	*Private*	*Medical Shop*	*Faith Healer/ Religious Person*	*Home Remedy*	*Total*
Andhra Pradesh	95.04	227.34	85.87	—	—	171.81
Assam	45.30	106.51	45.78	—	—	66.04
Bihar	66.74	183.04	14.21	40.00	19.16	114.73
Gujarat	78.03	196.26	100.00	100.00	—	149.14
Haryana	49.29	159.31	18.00	101.00	—	109.07
Himachal Pradesh	124.75	109.96	10.00	—	—	115.42
Karnataka	45.48	274.41	20.00	—	—	130.27
Kerala	30.19	240.64	175.00	—	—	171.52
Madhya Pradesh	36.16	83.68	15.35	191.24	—	64.48
Maharashtra	52.84	126.97	—	—	2.27	90.71
Orissa	59.76	115.60	9.69	16.00	7.65	85.43
Punjab	62.42	76.37	—	—	—	70.46
Rajasthan	30.81	128.76	15.66	—	4.80	5 9.91
Tamil Nadu	33.36	61.87	20.00	91.43	—	45.90
Uttar Pradesh	26.61	81.82	13.51	20.00	—	62.06
West Bengal	72.57	82.49	20.00	201.00	—	79.74
ALL-INDIA	**49.08**	**130.06**	**21.24**	**65.82**	**8.00**	**90.48**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi rural.

Table 30 : State-wise Average Expenditure Per Illness Episode by Type of Treatment for Non-Hospitalised Illnesses -- Urban

(In Rupees)

State	*Public*	*Private*	*Medical Shop*	*Faith Healer/ Religious Person*	*Home Remedy*	*Total*
Andhra Pradesh	49.13	188.43	23.12	15.00	0.80	126.25
Assam	87.62	129.02	32.27	—	—	106.52
Bihar	66.79	220.23	34.86	50.00	—	157.25
Gujarat	79.93	138.90	25.70	—	13.34	110.00
Haryana	52.59	212.25	35.13	—	—	154.14
Himachal Pradesh	62.51	140.53	—	—	—	90.93
Karnataka	63.63	240.70	29.58	—	—	145.56
Kerala	59.15	104.61	17.03	—	—	80.57
Madhya Pradesh	43.23	87.78	14.91	—	1.32	68.82
Maharashtra	74.10	169.85	55.33	50.00	—	136.60
Orissa	83.10	219.18	33.20	—	10.42	136.75
Punjab	92.23	125.27	89.91	—	—	116.84
Rajasthan	60.18	150.77	6.60	180.00	—	87.95
Tamil Nadu	26.98	124.12	12.02	22.85	17.00	80.37
Uttar Pradesh	76.99	115.15	18.35	38.20	37.49	100.50
West Bengal	81.22	161.23	26.32	—	15.00	132.33
Delhi	99.18	188.43	15.51	100.00	—	161.15
ALL-INDIA	**62.90**	**152.19**	**23.02**	**77.21**	**14.95**	**113.93**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry and Chandigrah.

Table 31 : State-wise Average Expenditure Per Illness Episode by Duration of Illness for Non-Hospitalised Illnesses – Rural

(In Rupees)

State	*≤ 5 Days*	*6-10 Days*	*11-20 Days*	*21-30 Days*	*> 30 Days*	*Total*
Andhra Pradesh	58.76	130.36	169.90	255.71	789.35	151.02
Assam	23.80	30.59	89.84	105.46	284.11	64.71
Bihar	48.93	78.07	137.59	201.40	577.73	111.48
Gujarat	46.71	76.37	181.00	451.33	420.00	148.56
Haryana	55.15	108.62	223.42	201.88	151.80	107.18
Himachal Pradesh	27.83	45.90	100.66	240.06	150.00	101.93
Karnataka	33.06	41.88	175.95	106.37	411.00	119.48
Kerala	44.92	36.01	52.77	171.32	233.74	90.41
Madhya Pradesh	17.21	31.00	84.70	169.16	200.55	55.05
Maharashtra	15.26	67.69	107.42	176.45	357.79	78.33
Orissa	32.08	72.14	85.60	95.46	396.13	58.12
Punjab	40.01	44.57	86.96	233.59	125.54	64.58
Rajasthan	27.28	41.07	112.94	278.96	103.16	57.83
Tamil Nadu	18.47	40.29	58.43	83.07	154.06	44.86
Uttar Pradesh	28.60	50.36	100.50	192.47	377.59	57.16
West Bengal	25.82	51.97	82.51	100.92	249.47	76.78
ALL-INDIA	**32.71**	**56.59**	**109.95**	**176.02**	**346.93**	**79.32**

Note : All-India figures include the State/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi.

Table 32 : State-wise Average Expenditure Per Illness Episode by Duration of Illness for Non-Hospitalised Illnesses -- Urban

(In Rupees)

State	*≤ 5 Days*	*6-10 Days*	*11-20 Days*	*21-30 Days*	*> 30 Days*	*Total*
Andhra Pradesh	53.02	109.49	250.40	280.58	434.24	119.37
Assam	44.19	61.34	112.91	181.27	162.50	102.34
Bihar	61.57	147.54	230.57	254.45	716.31	146.43
Gujarat	45.71	101.08	228.84	182.41	—	98.22
Haryana	100.62	122.30	326.28	176.86	1121.90	153.67
Himachal Pradesh	24.88	31.66	141.70	150.95	200.00	92.55
Karnataka	46.21	65.27	148.89	301.91	512.44	114.10
Kerala	27.81	40.25	76.14	106.95	92.81	62.77
Madhya Pradesh	21.38	38.22	74.43	131.84	280.59	50.43
Maharashtra	49.26	103.53	186.47	297.53	378.88	126.58
Orissa	56.73	108.58	137.23	303.34	321.33	115.89
Punjab	43.21	49.98	138.66	416.46	632.96	110.58
Rajasthan	35.00	94.09	152.83	141.60	449.37	83.43
Tamil Nadu	28.87	61.89	114.56	165.98	165.31	74.58
Uttar Pradesh	41.08	78.21	167.47	302.88	646.51	93.98
West Bengal	35.15	52.48	89.98	180.39	438.46	127.99
Delhi	88.19	121.77	270.26	244.84	207.79	148.21
ALL-INDIA	**45.27**	**81.62**	**163.18**	**217.34**	**385.45**	**102.51**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry and Chandigarh.

Table 33 : Average Expenditure Per Illness Episode by Nature of Illness for Non-Hospitalised Illnesses

Nature	*Adults*			*Children*			*Total*
	Male	*Female*	*Total*	*Male*	*Female*	*Total*	
			RURAL				
Serious Communicable Disease	204.18	180.83	194.67	154.36	84.65	126.46	171.56
Acute Illness	67.67	66.05	66.84	36.72	36.13	36.46	56.05
Chronic Illness	220.02	198.56	208.81	250.07	114.46	178.75	207.77
Accident/Injury	119.16	131.28	122.68	140.40	109.32	133.21	124.91
ALL	**113.65**	**101.43**	**107.61**	**60.06**	**44.79**	**53.45**	**90.48**
			URBAN				
Serious Communicable Disease	219.17	234.45	226.36	150.56	104.70	133.75	198.39
Acute Illness	73.33	86.11	80.38	54.91	50.78	53.11	71.83
Chronic Illness	212.42	196.60	204.49	185.40	108.43	148.62	201.46
Accident/Injury	412.40	169.17	330.61	137.79	300.28	146.51	287.59
ALL	**134.08**	**126.40**	**130.04**	**77.18**	**60.71**	**70.24**	**113.93**

Table 34 : Average Expenditure Per Illness Episode by Annual Household Income and Nature of Illness for Non-Hospitalised Illnesses

(In Rupees)

Annual Household Income	*Serious Communicable Diseases*	*Acute Illness*	*Chronic Illness*	*Accident/ Injury*	*All Illness*
			RURAL		
≤ 18,000	162.83	51.33	203.90	104.16	82.02
18,001-54,000	188.74	60.31	211.37	168.11	102.10
> 54,000	195.43	109.20	215.95	270.10	142.75
ALL	**171.56**	**56.05**	**207.77**	**124.91**	**90.48**
			URBAN		
≤ 18,000	187.13	56.93	169.72	77.52	92.76
18,001-54,000	201.03	76.80	205.84	465.62	120.72
> 54,000	237.17	107.41	265.28	557.95	160.89
ALL	**198.39**	**71.83**	**201.46**	**287.59**	**113.93**

Table 35 : Average Expenditure Per Illness Episode by Highest Level of Education in the Household for Non-Hospitalised Illnesses

(In Rupees)

Educational Level	*Serious Communi-Cable Diseases*	*Acute Illness*	*Chronic Illness*	*Accident/ Injury*	*Total*
		RURAL			
No Formal Education	142.78	41.30	137.17	44.83	64.59
Primary	180.14	49.14	147.79	157.17	84.28
Higher Secondary	184.76	64.11	235.85	131.23	100.84
Graduation & Above	142.25	52.58	220.10	139.75	91.95
ALL	**171.56**	**56.05**	**207.77**	**124.91**	**90.48**
		URBAN			
No Formal Education	163.80	49.86	180.51	21.83	77. 21
Primary	161.77	40.55	216.03	91.31	85.16
Higher Secondary	203.24	71.95	170.72	293.05	110.12
Graduation & Above	214.85	89.95	243.18	405.52	140.73
ALL	**198.39**	**71.83**	**201.46**	**287.59**	**113.93**

Table 36 : Average Expenditure Per Illness Episode by Occupation of the Household Head for Non-Hospitalised Illnesses

(In Rupees)

Occupation	*Serious Communi-Cable Diseases*	*Acute Illness*	*Chronic Illness*	*Accident/ Injury*	*All Illness*
		RURAL			
Cultivator	174.13	54.50	191.51	112.27	85.62
Wage Earner	146.65	51.77	221.38	115.27	86.37
Salary Earner/Professional	151.52	57.51	172.25	173.75	88.43
Business	216.17	84.78	128.75	87.19	106.99
Others	248.28	54.73	297.89	350.00	118.15
ALL	**171.56**	**56.05**	**207.77**	**124.91**	**90.48**
		URBAN			
Cultivator	155.13	82.05	255.99	546.16	125.23
Wage Earner	206.43	53.99	156.49	111.64	90.11
Salary Earner/Professional	195.77	79.17	212.29	502.82	122.87
Business	210.00	74.57	235.72	247.97	122.36
Others	184.99	74.27	173.46	143.98	111.30
ALL	**198.39**	**71.83**	**201.46**	**287.59**	**113.93**

Table 37 : State-wise Breakup of Average Expenditure Per Illness Episode for Non-Hospitalised Illnesses – Rural

(In Rupees)

State	*Fees & Medicine*	*Clinical Tests*	*Special Diet*	*Rituals*	*Transport*	*Bribes, Tips & Miscel-laneous*	*Total Expen-diture*
Andhra Pradesh	132.29	10.69	10.35	0.23	17.85	0.39	171.81
	(77.0)	(6.2)	(6.0)	(0.1)	(10.4)	(0.2)	(100.0)
Assam	49.62	2.18	1.89	0.69	10.81	0.86	66.04
	(75.1)	(3.3)	(2.9)	(1.0)	(16.4)	(1.3)	(100.0)
Bihar	86.05	6.42	11.70	1.18	7.28	2.10	114.73
	(75.0)	(5.6)	(10.3)	(1.0)	(6.3)	(1.8)	(100.0)
Gujarat	102.05	1.24	14.00	0.55	31.31	0.00	149.14
	(68.4)	(0.8)	(9.4)	(0.4)	(21.0)	—	(100.0)
Haryana	73.22	9.94	15.53	0.49	9.89	0.00	109.07
	(66.1)	(9.1)	(14.2)	(0.5)	(9.1)	—	(100.0)
Himachal Pradesh	64.46	5.24	8.23	8.11	28.99	0.39	115.42
	(54.9)	(4.5)	(7.1)	(7.0)	(25.2)	(0.3)	(100.0)
Karnataka	93.11	4.21	3.14	0.00	28.39	1.42	130.27
	(71.5)	(3.2)	(2.4)	—	(21.8)	(1.1)	(100.0)
Kerala	125.67	12.76	6.99	0.04	25.97	0.09	171.52
	(73.3)	(7.4)	(4.1)	—	(15.1)	(0.1)	(100.0)
Madhya Pradesh	42.04	1.83	6.29	1.36	11.89	1.07	64.48
	(65.2)	(2.8)	(9.8)	(2.1)	(18.4)	(1.7)	(100.0)
Maharashtra	58.80	1.99	9.39	0.41	19.47	0.63	90.71
	(64.8)	(2.2)	(10.4)	(0.4)	(21.5)	(0.7)	(100.0)
Orissa	41.71	2.14	5.11	1.11	8.16	0.19	58.43
	(71.3)	(3.7)	(8.8)	(1.9)	(14.0)	(0.3)	(100.0)
Punjab	46.58	9.68	2.23	1.97	7.33	2.67	70.46
	(66.1)	(13.7)	(3.2)	(2.8)	(10.4)	(3.8)	(100.0)
Rajasthan	40.08	0.76	7.91	0.18	10.58	0.40	59.91
	(66.8)	(1.3)	(13.2)	(0.3)	(17.7)	(0.7)	(100.0)
Tamil Nadu	26.66	1.23	4.43	1.56	10.36	1.68	45.90
	(58.1)	(2.7)	(9.6)	(3.4)	(22.6)	(3.6)	(100.0)
Uttar Pradesh	46.99	1.67	4.95	0.19	8.20	0.06	62.06
	(75.7)	(2.7)	(7.9)	(0.3)	(13.3)	(0.1)	(100.0)
West Bengal	56.15	2.54	12.76	1.18	6.57	0.52	79.74
	(70.4)	(3.2)	(16.0)	(1.5)	(8.2)	(0.7)	(100.0)
ALL-INDIA	**64.51**	**3.95**	**7.34**	**0.80**	**13.10**	**0.77**	**90.48**
	(71.3)	**(4.4)**	**(8.1)**	**(0.9)**	**(14.5)**	**(0.8)**	**(100.0)**

Notes : 1. Figures in brackets indicate percentage to total.
2. All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi.

Table 38 : State-wise Breakup of Average Expenditure Per Illness Episode for Non-Hospitalised Illnesses -- Urban

(In Rupees)

State	*Fees & Medicine*	*Clinical Tests*	*Special Diet*	*Rituals*	*Transport*	*Bribes, Tips & Miscel-laneous*	*Total Expen-diture*
Andhra Pradesh	103.63	5.21	10.61	0.00	6.66	0.15	126.25
	(82.1)	(4.1)	(8.4)	—	(5.3)	(0.1)	(100.0)
Assam	71.14	5.79	21.12	0.00	8.48	0.00	106.52
	(66.8)	(5.4)	(19.8)	—	(8.0)	—	(100.0)
Bihar	118.67	9.26	20.20	0.43	8.54	0.15	157.25
	(75.4)	(5.9)	(12.9)	(0.3)	(5.4)	(0.1)	(100.0)
Gujarat	88.86	6.39	6.72	0.35	8.62	0.06	111.00
	(80.0)	(5.8)	(6.0)	(0.3)	(7.8)	(0.1)	(100.0)
Haryana	112.13	13.77	16.41	2.76	8.68	0.39	154.14
	(72.8)	(8.9)	(10.7)	(1.8)	(5.6)	(0.2)	(100.0)
Himachal Pradesh	61.79	7.52	7.20	5.22	8.78	0.41	90.93
	(68.0)	(8.3)	(7.9)	(5.7)	(9.7)	(0.4)	(100.0)
Karnataka	109.60	12.35	8.15	0.71	14.12	0.64	145.56
	(75.3)	(8.5)	(5.6)	(0.5)	(9.7)	(0.4)	(100.0)
Kerala	65.47	4.07	3.78	0.04	6.52	0.69	80.57
	(81.2)	(5.1)	(4.7)	(0.1)	(8.0)	(0.9)	(100.0)
Madhya Pradesh	51.25	5.05	6.81	0.14	5.20	0.37	68.82
	(74.5)	(7.3)	(9.9)	(0.2)	(7.6)	(0.5)	(100.0)
Maharashtra	105.76	6.61	14.47	0.33	9.22	0.21	136.6
	(77.4)	(4.8)	(10.6)	(0.2)	(6.7)	(0.3)	(100.0)
Orissa	100.77	11.58	12.47	0.00	11.81	0.12	136.75
	(73.7)	(8.5)	(9.1)	—	(8.6)	(0.1)	(100.0)
Punjab	81.12	16.41	6.65	2.71	8.08	1.15	116.84
	(69.3)	(14.0)	(5.7)	(2.2)	(6.8)	(1.0)	(100.0)
Rajasthan	63.23	10.64	9.13	0.60	4.36	—	87.99
	(71.8)	(12.1)	(10.4)	(0.7)	(5.0)	—	(100.0)
Tamil Nadu	61.57	6.56	4.07	0.54	6.72	0.90	80.37
	(76.6)	(8.2)	(5.1)	(0.7)	(8.3)	(1.1)	(100.0)
Uttar Pradesh	81.46	4.40	7.37	0.84	6.38	0.05	100.50
	(81.0)	(4.4)	(7.3)	(0.8)	(6.4)	(0.1)	(100.0)
West Bengal	110.81	10.37	7.09	0.16	3.61	0.29	132.33
	(83.7)	(7.8)	(5.4)	(0.1)	(2.7)	(0.3)	(100.0)
Delhi	125.14	12.8	11.31	1.82	9.95	0.12	161.15
	(77.7)	(7.9)	(7.0)	(1.1)	(6.2)	(0.1)	(100.0)
ALL-INDIA	**88.42**	**7.89**	**9.31**	**0.56**	**7.42**	**0.31**	**113.93**
	(77.6)	**(6.9)**	**(8.2)**	**(0.5)**	**(6.5)**	**(0.3)**	**(100.0)**

Notes : 1. Figures in brackets indicate percentage to total.
2. All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi.

Table 39 : State-wise Average Expenditure Per Illness Episode for Hospitalisation by Type of Treatment

(In Rupees)

	Rural			*Urban*		
	Public	*Private*	*Total*	*Public*	*Private*	*Total*
Andhra Pradesh	474.07	1388.60	1108.48	628.48	1954.61	1211.08
Assam	448.70	—	448.70	577.23	—	577.23
Bihar	205.11	2872.32	1298.46	392.63	1495.80	800.22
Gujarat	912.32	1076.91	1023.92	496.08	2295.51	1806.53
Haryana	690.31	2257.55	1105.86	579.34	2392.14	1197.70
Himachal Pradesh	659.01	—	659.01	460.64	1730.38	845.10
Karnataka	293.19	2252.59	1055.14	465.27	2263.93	1224.60
Kerala	493.48	2430.79	1177.92	342.92	2153.87	991.24
Madhya Pradesh	420.10	1172.51	629.29	412.25	2690.55	1035.33
Maharashtra	664.85	112.72	981.51	461.98	1976.32	1085.61
Orissa	407.59	1385.00	426.21	580.87	1041.04	725.05
Punjab	434.21	762.50	449.62	372.81	1357.31	696.03
Rajasthan	437.57	1897.65	757.30	465.81	845.07	508.29
Tamil Nadu	500.00	1857.66	1658.96	150.07	2396.47	1282.93
Uttar Pradesh	949.10	2304.58	1424.38	299.66	2405.68	1147.61
West Bengal	359.11	—	359.11	398.46	2844.14	966.86
Delhi	—	—	—	550.01	5832.15	2145.74
ALL-INDIA	**535.20**	**1877.21**	**1044.49**	**452.55**	**2318.84**	**1196.87**

Note : All-India figures include the States/Union Territories of Goa, Meghalaya, Pondicherry. Chandigarh and Delhi rural.

Table 40 : Average Expenditure Per Illness Episode for Hospitalisation Cases by Type of Treatment and Nature of Illness

(In Rupees)

Nature of Illness	*Male*			*Female*		
	Public	*Private*	*Total*	*Public*	*Private*	*Total*
			RURAL			
Serious Communicable Diseases	578.30	1065.57	701.50	263.40	1381.24	858.69
Acute Illness	301.59	967.05	500.53	479.12	893.16	651.33
Chronic Illness	720.71	2782.42	1741.05	520.58	2374.19	1273.30
Accident/Injury	616.06	2907.29	1741.05	710.56	500.00	660.44
ALL	**578.88**	**2116.62**	**1105.09**	**441.02**	**1545.10**	**934.66**
			URBAN			
Serious Communicable Diseases	265.38	2064.84	616.27	261.47	1370.93	596.22
Acute Illness	278.20	1916.61	881.55	248.22	1597.66	843.09
Chronic Illness	760.03	3233.65	1931.65	550.45	2377.80	1338.48
Accident/Injury	547.48	2039.62	1239.07	478.52	832.64	584.46
ALL	**499.74**	**2623.14**	**1339.34**	**382.64**	**1883.51**	**988.71**

Table 41 : Breakup of Average Expenditure Per Illness Episode for Hospitalisation Cases

(In Rupees)

Nature of Illness	*Fees/ Medicine*	*Clinical Test*	*Surgery*	*Hospitalisation*	*Special Diet*	*Rituals*	*Transport*	*Bribes/ Tips & Miscellaneous*	*Total*
				RURAL					
Serious Communicable Diseases	387.24	31.37	—	101.73	127.08	0.29	99.5	6.56	753.76
	(51.4)	(4.2)	—	(13.5)	(16.8)	(0.0)	(13.2)	(0.9)	(100.0)
Acute Illness	311.67	18.11	36.52	89.35	36.05	1.08	79.16	8.00	579.94
	(53.7)	(3.1)	(6.3)	(15.4)	(6.2)	(0.2)	(13.7)	(1.4)	(100.0)
Chronic Illness	718.71	156.8	72.2	233.05	52.48	0.9	166.61	19.9	1419.85
	(50.6)	(11.1)	(5.1)	(16.4)	(3.7)	(0.1)	(11.7)	(1.3)	(100.00
Accident/Injury	909.54	204.41	101.66	192.12	100.53	4.23	175.33	15.3	1703.12
	(53.4)	(12.0)	(6.0)	(11.2)	(5.9)	(0.3)	(10.3)	(0.9)	(100.0)
ALL ILLNESS	**539.97**	**89.73**	**43.49**	**152.85**	**79.4**	**1.11**	**125.93**	**12.02**	**1044.49**
	(51.7)	**(8.6)**	**(4.2)**	**(14.6)**	**(7.6)**	**(0.1)**	**(12.1)**	**(1.1)**	**(100.0)**
				URBAN					
Serious Communicable Diseases	320.62	26.47	—	123.40	92.82	3.40	38.38	3.53	608.61
	(52.7)	(4.3)	—	(20.3)	(15.2)	(0.6)	(6.3)	(0.6)	(100.0)
Acute Illness	412.22	58.48	104.08	175.04	46.20	6.97	51.70	3.94	858.63
	(48.0)	(6.8)	(12.1)	(20.4)	(5.4)	(0.8)	(6.0)	(0.5)	(100.0)
Chronic Illness	866.32	173.45	134.64	354.02	80.79	1.68	67.42	14.42	1692.73
	(51.1)	(10.2)	(8.0)	(20.9)	(4.8)	(0.1)	(4.0)	(0.9)	(100.0)
Accident/Injury	554.04	105.07	86.82	263.33	62.41	5.54	65.23	10.53	1153.00
	(48.1)	(9.1)	(7.5)	(22.8)	(5.4)	(0.5)	(5.7)	(0.9)	(100.00
ALL ILLNESS	**602.81**	**106.45**	**93.22**	**251.57**	**72.38**	**3.84**	**57.45**	**9.15**	**1196.87**
	(50.4)	**(8.9)**	**(7.8)**	**(21.0)**	**(6.0)**	**(0.3)**	**(4.8)**	**(0.8)**	**(100.0)**

Note: Figures in brackets indicate percentages to total.

Table 42 : Average Expenditure Per Immunisation by Type of Health Care

(In Rupees)

	Rural			*Urban*		
	Boys	*Girls*	*All*	*Boys*	*Girls*	*All*
Public	3.27	4.70	3.91	5.16	3.11	4.19
Private	49.41	46.35	47.68	41.36	30.03	36.53
TOTAL	**6.31**	**8.99**	**7.53**	**9.95**	**6.12**	**8.15**

Table 43 : Average Expenditure Per Delivery/Abortion by Type of Health Care

(In Rupees)

	Delivery		*Abortion*	
	Rural	*Urban*	*Rural*	*Urban*
Home Delivery	76.23	52.32	7.77	
Public	256.57	230.79	192.94	98.83
Private	1497.08	1858.26	588.46	1048.03
TOTAL	**400.04**	**631.7**	**324.86**	**739.92**

Table 44 : Average Expenditure Per Illness Episode by Nature of Illness and System of Treatment

(In Rupees)

Nature of Illness	*Allopathy*	*Homeopathy*	*Ayurveda/ Sidha*	*Unani*	*Any Combination*	*Rituals*	*Total*
			RURAL				
Serious Communicable Diseases	180.82	114.00	87.84	94.99	148.52	58.56	170.14
Acute Illness	57.05	45.01	23.11	40.00	76.84	34.57	55.71
Chronic Illness	210.70	186.80	94.02	—	212.37	276.97	207.07
Accident/Injury	130.35	—	48.62	—	—	—	124.91
ALL ILLNESS	**91.62**	**70.40**	**38.33**	**78.14**	**130.23**	**63.68**	**89.94**
			URBAN				
Serious Communicable Diseases	200.67	142.78	128.97	0.00	240.94	47.33	196.77
Acute Illness	71.83	62.26	60.28	7.33	111.69	10.00	71.69
Chronic Illness	204.33	134.63	160.70	—	201.74	113.28	200.03
Accident/Injury	288.63	—	26.44	—	551.78	—	284.45
ALL ILLNESS	**114.27**	**82.65**	**97.05**	**7.33**	**165.44**	**80.00**	**113.50**

Annexure

Results of NCAER's 1990 and 1993 Surveys : A Comparison

Table A.1 : Prevalence Rate of Illness Per '000 Population

	*1990**	*1993***	
	Treated† Illnesses	*All Illnesses*	*Treated Illnesses*
	RURAL		
Adults — Male	105.34	108.0	94.3
Female	59.80	116.6	102.1
Children — Male	93.95	100.3	90.0
Female	45.72	90.4	82.1
ALL	**79.06**	**106.7**	**94.1**
	URBAN		
Adults — Male	88.07	99.7	91.6
Female	46.62	118.0	107.1
Children — Male	90.78	95.0	88.5
Female	40.49	83.7	76.9
ALL	**67.70**	**103.0**	**94.4**

* Prevalence Rates are calculated for two-week reference period.

** Prevalence Rates are calculated for one month reference period.

† 1990 Survey included only treated illnesses.

Table A.2 : Distribution of Illness Episodes by Type of Treatment

(Percentage)

	1990*	1993	
	All Illnesses	*Non-Hospitalised Illnesses*	*Hospitalised Illnesses*
	RURAL		
Public	38.3	41.7	62.0
Private	55.5	52.7	38.0
Medical Shop	2.5	3.1	—
Home Remedy		2.0	—
Others	3.7	0.5	—
TOTAL	100.0	100.0	100.0
	URBAN		
Public	39.1	34.0	60.1
Private	54.8	59.8	39.9
Medical Shop	4.7	5.2	—
Home Remedy		0.7	—
Others	1.4	0.3	—
TOTAL	100.0	100.0	100.0

* Data on Hospitalised and Non-Hospitalised Illnesses are not available separately.

Table A.3 : Average Household Expenditure Per Illness Episode

(Rs.)

	1990	*1993*
	RURAL	
Adults -- Male	151.79	234.25
Female	212.26	156.36
Children -- Male	96.59	76.06
Female	87.23	77.06
ALL	**151.81**	**160.29**
	URBAN	
Adults -- Male	159.02	298.43
Female	161.00	200.86
Children -- Male	99.02	144.69
Female	82.56	78.80
ALL	**142.60**	**241.89**

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