

**URBAN POOR AND UNMET NEED FOR PUBLIC HEALTH SERVICES
IN MUMBAI, INDIA**

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Biography

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T. R Dilip MSc. M.Phil, PhD. is a demographer by training. He currently works as a Research Officer at the Centre for Enquiry Into Health and Allied Themes (CEHAT), Mumbai and is engaged in research on Health Policy and Financing Issues. Areas of research include measurement issues in health, population aging, and analysis of broader issues relating of health and population policies and programmes.

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Ravi Duggal, MA - Sociology, DBM – Management, is currently the Coordinator of Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai. He has been engaged in health services research for over two decades and has done pioneering studies in health financing, and on the private health sector in India. He has also played a lead role in developing a national database of the health sector in India, which includes time-series data on all aspects of health services from 1951 onwards. His current area of work includes health policy and health systems research in the context of right to health and healthcare, health sector reforms, regulation of the private sector, as well as empirical research on reproductive health. For the latter he is Co-coordinating a national multi-centric project on various dimensions of abortion in India. He has earlier been a WHO National Consultant for Health Policy and Financing in the Ministry of Health of the Central Government. He has 15 books/reports and over 80 papers/articles published to his credit.

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Urban Poor and Unmet Need for Public Health Services in Mumbai, India

Summary

This study looks at the unmet need for public health care services in Mumbai, a metropolitan city in India and one of the most populous city in the world, where about 49 percent of the population is poor. Analysis is based on the data from a survey of health seeking preferences and choices, covering a sample of 1035 households in the study area. The research brings out the utility of the urban health care system, mainly provided by the municipal corporation. One methodological issue is that the utilisation pattern does not necessarily reflect their actual choice of health care. Non availability of public health care services has limited their right to access public health care services. It was found that 44 percent and 67 percent of the households were having unmet need for inpatient and outpatient public health care services, respectively. If public health care facilities are available within their locality, majority of the poor were willing to shift towards it from the private sector, where out of pocket expenses are unaffordable. Findings of the study indicate the need to strengthen the public health care system in order to maintain equilibrium in access to health care across different subgroups of the population.

Urban Poor and Unmet Need for Public Health Services in Mumbai, India

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Introduction

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The rural urban disparities in health outcomes in India are often attributed to urban bias in allocation of resources and location of health care services. Statistics clearly show that the per capita population ratio is higher in urban areas and that these regional inequalities have not seen any significant decline in these disparities over time (Duggal et al. 1995). This regional imbalance is there in both the public health sector and private health sector. Further, public spending on health care is also disproportionately higher in urban areas. However, while critiquing the regional bias it is to be examined whether the urban areas in India, where 22 percent of the population is residing in slums, has the required number of public health care facilities. Unlike other urban areas the matter requires special attention in an urban metropolis in India that is characterised by poor living conditions making the public more vulnerable to diseases, and where poverty levels are likely to be similar if not worse than that in rural areas. This could be understood by examining who utilizes these services and for what reasons.

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Recent all India surveys do not show any large scale rural-urban differentials in proportion utilising public health care services in India (NSSO 1998a). According to the survey those seeking outpatient care services from public sector was 19 percent and 20 percent in rural and urban areas, and for inpatient care services it was 44 percent and 43 percent, respectively. Out of pocket average expenditure incurred on inpatient care treatment was higher in urban areas as compared to rural areas for both public and private sectors and public-private differentials in out of pocket expenditure was also higher in urban areas.

Therefore despite better physical access to health care, the higher average cost for accessing health services makes the urban poor community as disadvantaged as their rural counterparts. This means that there is an emergent need for expansion of public health services even in urban areas so as to reduce the financial burden on the urban poor. What adds to the concern vis-à-vis use of public health services is the declining trend of utilisation of both ambulatory and inpatient care from the public health system. The 42nd (1986-87) and 52nd (1995-96) Rounds of NSSO surveys amply provide evidence for this – decline in out-patient care from about 27 percent to 19 percent and in inpatient care from 60 percent to 44 percent (NSSO 1998a). This large decline in use of public health care services is clearly a function of the decline in public health Investment during the same period (Duggal 1997; GOI 2002).

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-Table 1-

However there is a growing tendency in health policy to reduce public investment in health sector and focus it for selective care for targeted populations (World Bank, 1993). One reason cited against public investment on health care is that it is the rich who benefit from public spending more than the poor. Such arguments have gained strength through World Bank's benefit incidence analysis, which showed that it is the rich who benefit from hospital services (Mahal et al., 2001). Though the utilisation of resources is disproportionately higher among the rich, the intensity of utilisation of public health care services by poor is much higher when compared to the rich. As compared to the rich the poor have low levels of hospitalisation rates, completed immunization rates and institutional based delivery (NSSO 1998a, NSSO 1998b). Benefit incidence analysis does not factor the variance in utilisation rates across classes (Table 2). If they did that by standardizing rates across classes then results of the analysis would have been the other

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way around. One clear example of this is that the above analysis does not find any significant gender differentials in public health service use. This is due to the fact that data sets did not show any gender differentials in hospitalisation rates. If there had been significant gender differentials in hospitalisation rates, with the rates being higher among males than females, the benefits from public spending would have most likely benefited males as against females. Therefore in the present situation a decline in investment in the public hospital sector or a hike in user fees in public health care facilities on the basis of the above argument is both dangerous and anti-poor. The poor report lower prevalence and have lower utilisation rates because of lack of purchasing power in a health care market that is largely dominated by private care. If public services are strengthened and access for the poor to these services improves prevalence and utilisation rates for the poor will also go up and the class differentials we now see will also diminish if not disappear.

-Table 2-

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In the present paper an analysis of utilisation patterns of public health care services in Mumbai is undertaken from the perspective of inadequate availability of such services in the city. Mumbai, the commercial capital of India is the largest city in the country carrying a population of 11.9 million (DCO 2001). The high density of population (21,190 persons per sq km) has put tremendous pressure on its infrastructure and amenities. About 49 percent of the population are residing in slums, characterised by shortage of living space, water supply and sanitation facilities. Slums in Mumbai are unique in the sense that only 4 percent are *Kacha*¹ hutments, while 45 percent and 51 percent of houses in slums are *Semipucca*¹ and *Pucca*¹, respectively (IIPS and ORC Macro 2001b).

Public Health Care Services in Mumbai

Brihan Mumbai Municipal Corporation (BMC), the largest Municipal Corporation in India, is the major provider of public health care services in Mumbai. It has got a network of 3 Teaching Hospitals, 14 Municipal General Hospitals, 26 Maternity Homes across Mumbai (BMC 2000). Apart from this there are 185 Municipal Dispensaries and 176 Health Posts² to provide outpatient care services and promote public health activities in the city. The state government in addition has one medical college hospital and 3 general hospitals and 2 health units have a bed capacity of 2871 beds (GOM 2001a). Though there is an urban bias in location of public health care infrastructure, delivery of these services especially in metropolitan cities like Mumbai is again plagued by uneven public preference for health care services. For example people living close to hospitals use them for minor illnesses, which should actually be treated in dispensaries. This is because there is a lack of an organised referral system and the result is overcrowding of public hospitals with minor ailments and under-utilisation of dispensaries where the latter should actually be treated. (Yesudian, 1988).

In spite of having better health care services there are studies that show people residing in Mumbai are not having proper access to health care services as 32 percent of the reported ailments remained untreated (Nandraj *et al* 2001). Surveys find that 7 to 8 percent of deliveries in Mumbai are still home deliveries (CORT 2000, IIPS and ORC Macro 2000a). All these three surveys showed that the public sector is providing health care to less than 20 percent of the population. Inconvenient location and timing is suggested as main reasons (CORT 2000; Nandraj *et al.* 2001) for not utilising services of public sector in Mumbai. But majority of ailments recorded in these surveys were minor (non-hospitalised) ones that could be treated in dispensaries. The role of public sector in

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providing inpatient care services is quite high, since hospitalisation is relatively a rare event and where the cost involved is high enough to push the ailing person's family into debt (Peters et al. 2002). As far as utilisation of inpatient care services are concerned majority of the patients use public hospitals, and the lower income groups mainly utilise public health care services in Mumbai (Yesudian 1988; Garg 1994). Moreover, service statistics clearly show that public hospitals are overloaded with patients (GOM 2001b). These public hospitals are not only major caregivers for a large section of the population in the city but also used by persons from rural areas of nearby districts. BMC is also a major health care provider for women and children in Mumbai. The Reproductive and Child Health Survey (CORT 2000) has shown that the public sector is a major provider of immunization and family planning services plus a sizeable proportion of the population in this district were depending on public sector for antenatal care services (40 percent) and child birth (48 percent). An analysis of BMC dispensaries in two wards in Mumbai showed that an average of 85 patients are treated every day (Duggal 2000), clearly indicating high level of utilisation of dispensaries also. The other alternative source is private health care which is relatively inaccessible to the poor but also characterized by poor quality infrastructure and manpower and was found to be indulging in profit motivated medical malpractices (Yesudian 1994).

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The Study and Methods

The data analysed here was collected for a demand assessment survey conducted in December 2001, in relation with the BMC's plan to set up a municipal general hospital in one of its wards. This ward is unique in the sense that it is the most populous ward as per the 2001 census (DCO 2001) in Mumbai with a population of 8,06,360 (32,938 persons per sq km.) and yet it does not have a single public hospital within its limits. The only

public health care facilities available within this ward are the 3 municipal maternity homes, 11 municipal dispensaries and 11 health posts. At the same time there were 114 private hospitals and nursing homes functioning in the area (Nandraj et al. 1998). Utility/need of a public health facility (here public hospital) can best be understood if we imagine a situation where what would happen if that particular facility were not available in the locality. Thus a unique advantage of these data sets is that it helps us in understanding this hypothetical situation to a certain extent. In the study ward the population living has two options for meeting their inpatient care needs; one to seek care from public hospitals outside their locality or to seek care from private health care services within or outside the ward.

The survey was conducted in three health post areas, which are in the vicinity of the plot for the proposed municipal general hospital. Health posts which are established to render health services to the poor population in urban areas have got administrative boundaries and this facilitates defining the sample frame. Each of these health post areas are divided into sections, each of which is served by 2 - 3 health workers. Sections formed the primary sampling units for the study and three sections were selected from each of the health posts that were selected for the study. A total of 120 households were targeted for survey from each section. Thus the present data is on the basis of a rapid household survey which covered 1035 households in the study area using a stratified systematic sampling procedure (Dilip and Duggal 2002). Respondents were head of the household or adult members in the household in their absence. Here an analysis of households' preference for health care services and choice of health care of both public and private health care services is undertaken to understand the utility value of public health care services in the metropolitan cities.

Characteristics of Sample Households

A brief description of households surveyed is as follows (Dilip and Duggal 2002). Majority of the households were having 4-6 members and the average family size was 5.4 members per household. The mother tongue spoken was Marathi in 48 percent of the sample households, while Hindi and Urdu were also spoken in a sizeable proportion of households. Households mainly belonged to the Hindu (73 percent) and Muslim (24 percent) community.

Median monthly income of households was reported to be 3000 rupees³, with 52 percent households in 2000-4000 monthly income group. The type of residence was mostly *chawls*⁴ (92 percent). Only 4.5 percent were residing in apartments, while remaining 2.6 percent were residents of slum/*kacha* structures. It was found that 75 percent of dwellings were occupied by owners themselves while the remaining were occupied by tenants. Information on years of stay in the dwelling showed that the majority (about 75 percent) were staying in them for more than 10 years, with average number of years of stay in the dwelling being as high as 23 years.

In brief the study area is mix of lower class and a lower middle class community depicting a typical poor settlement in a metropolitan city. Type of housing and years of stay hints that they were essentially a slum which got transformed into *chawls*⁴ with extended years of stay, a phenomenon which is common in cities like Mumbai. Moreover housing characteristics show that we are talking about a settled community, and this is important from the access perspective because such communities have a stake in the city.

General source of health care for the household

Health seeking preferences of the household is studied by asking the respondents about the major source of health care for the household for treating ailments requiring inpatient and outpatient care services. About 54 percent (Table 3) reported that they generally take inpatient care (if required) treatment from private sector. Another 40 percent reported that they preferred services provided by BMC for treatment of ailments involving hospitalisation. This in fact is quite high considering the fact that the study area or the nearby locality does not have a BMC owned public hospital. 'Other public facility' are the state government owned and ESI/Insurance related facilities which account for only 4.5 percent of preference for such hospitals.

-Table 3-

Public preference for outpatient care services from a BMC facility was very low (14 percent) when compared to that for inpatient care services. Here majority of households reported to seek treatment from private sector (82 percent). As mentioned earlier there are only 11 public dispensaries in the area, which is grossly inadequate to meet the demand for OPD care services of over 800,000 people residing in this area.. We will discuss this in a later section. Given the larger and physically more accessible presence of private doctors people are likely to prefer services from private providers rather than seeking care from public health care services outside the locality, where 'time' and 'travel' costs are higher. Here the main worry is about the identity of private providers in this low-income locality as many of the practicing doctors in the locality are likely to be non-qualified practitioners and /or doing cross practice⁵.

Reasons for preferring public/private sources of treatment

The respondents who reported about health seeking preferences as public/private sector were further queried about the major reasons for seeking care from that corresponding source (public or private) of treatment. Results (table 4) show that ‘Cost is affordable’ as the major reason (65 percent), which makes them prefer services in public sector for inpatient care services. The main reason reported for choosing private hospital was it being the ‘Nearest facility’ (45 percent). It should be noted that another 30 percent reported ‘no other option’ as a reason for preferring treatment from private hospitals; this indicating that if a convenient public option were available preference for it would increase for about one-third of the people who currently use private hospitals. Interestingly in terms of quality of service the public hospitals seem to be scoring over private ones in people’s preference ratings.

-Table4-

For outpatient care services about 82 percent (table 2) preferred services in private sector, and among them 78 percent reported ‘nearest facility’ as a reason for doing so. Among those utilizing services in public hospital it can be seen that, ‘nearest facility’ (55 percent) ‘cost is affordable’ and ‘good quality service’ as reasons for seeking care from a public sector. All these indicate outpatient care services in public sector are mostly utilised by population residing near the public facility and those with limitations in paying for health care. This also means that if physical access to OPD facility improves, then more users will shift to public sector.

Choice of health care

As mentioned earlier proximity/distance is the major reason for choosing services (table 4). Therefore the respondents were asked about the choice of health care if both public and private health care facilities are made available to them. In such a situation, 83 percent and 88 percent reported that they would prefer to utilise services in public sector for outpatient and inpatient care services, respectively (table 5).

-Table 5 & Table 6-

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The reasons for such a reversal in choice of health care is presented in table 5. Here also affordability is coming out as a major reason for choosing public sector if it is available to them. The reason that 'Cost is affordable' has been reported by 58 percent and 72 percent as their choice for public sector for inpatient and outpatient care services, respectively. It hints that non-availability of public facility in the locality is a major factor that drives the community to seek care from the private health sector. Also there exists a sizeable section of population in this locality who are not interested in seeking care from public sector but are forced to seek care from the private sector due to lack of public health care services in the locality. This is a clear pointer towards the need to strengthen public health care services. Further, enhancing user charges could prove fatal for the public health system since people reported 'low cost to user' as a major advantage of the public health care system.

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Unmet need for public health facilities

In the previous section we have seen that a large section of population are seeking health care services from private sector even if they are not interested in doing so. Here an

attempt has been made to find out the intensity of this problem in the study population. The need for a public/private facility is considered to have been met, if the current source of health care for the household matches with the choice of treatment when both public and private facilities are made available to the household. If both these responses don't match then it is unmet need for a public/private healthcare facility in the population.

-Table 7-

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The above table indicates that the unmet need for inpatient care services from public facility is 44 percent in the population, that is 44 percent of the population are forced to seek inpatient care services from the private sector. For outpatient care services, the unmet need for public facility is even higher at 67 percent. At the same time the unmet need for inpatient care services and outpatient care services from private sector was negligible (only about 1 percent) showing that the area does not need any more private health care facilities. This has policy implications for regulating the private health care sector and at the same time for considerable expansion of public health care facilities. Also there exists a segment of a population who solely depend on public health care services, which comes under the "met need" category, that is 44 percent for the expensive inpatient care and 16 percent for outpatient care which is relatively cheaper.

Utilisation of public health care services and unmet need for public facility by Income level

As in the case of any other population in India, a higher proportion of poorer sections were reported to be preferring to seek treatment from public health care services. More than 50 percent of the population belonging to 'less than 2000 rupees' income category reported to

seek inpatient care treatment from public sector. The household preference for outpatient care services also showed a similar picture.

Unmet need for public health care services by income classes shows that given a choice even the relatively higher income groups would prefer public services. Another thing that emerges is that the level of unmet need for public health care services depends on household's potential to seek treatment from alternate sources of care. Poverty is driving households belonging to lower economic groups to public health facilities located at far of places to meet their health care needs, since they don't have the necessary purchasing power to seek treatment from the private sector.

Discussion:

The study brings out how a largely poor urban community in the biggest metropolitan city in India is lacking access to public health care services. Non-availability of a public hospital within or in close proximity to their locality and an inadequate number of public dispensaries makes life difficult, especially of the poor who too are forced to seek care from the private sector. The findings of the study very clearly indicate that the potential demand for public health services is very high provided they are conveniently located and are affordable. Infact, given the choice, a large proportion of users of private health services too would prefer public health services.

Mumbai has one of the best networks of public healthcare facilities in the country. But if one looks at numbers there are very few public health facilities within easy access of people, especially for ambulatory care. In contrast the private healthcare facilities have better physical access and often this becomes a critical deciding factor in the choice of

health facility to use. In the study area, there is no public general hospital and only 11 public dispensaries for a population over 800,000. Estimates (Dilip and Duggal 2002) indicate that we should find 2 percent (in our study it was 2.3 persons ill on the day of the survey) daily morbidity (1.5 being incidence), 80 percent of which is general OPD care, and a hospitalisation rate of 30 per 1000 population per annum. Given this, the daily load in this population would be over 16,000 cases to be handled in OPD clinics. Data from Mumbai's dispensaries shows that each dispensary handles on an average 80 cases every day (Duggal 2000) and assuming that each should be handling at least twice the number at the optimal level, even then 11 dispensaries can deal with only 1760 cases, about 10 percent of the expected morbidity load in that population. And there being no general hospital the expected 24,000 hospitalisation cases (in a year) have to go elsewhere. This is clear evidence of the gross inadequacy of public facilities in this area.

The study area population is lower and lower middle class, and their disposable incomes being very limited, it is natural that they have overwhelmingly indicated that given a choice they would prefer public health services. This is so, because clearly that is the least cost option as well as it does not exploit in terms of unnecessary medication, diagnostics and procedures. This would be true at the larger level across the country given the overall context of poverty. Thus the role of the state in such a context becomes very crucial and hence the public health services have to be geared towards meeting the demands being made on them. In today's scenario with declining public investments and expenditure in healthcare on the one hand and the introduction of user charges on the other the expectations of the people, especially the poor, are being belied. The people have great faith in the public system and expect social support from the state for services like health, education and housing - the three critical elements of social security.

Given the responses on the unmet need expressed by respondents it is clearly evident that if public health services were in easy access range and well provided then 88 percent and 83 percent of the population would use public health services for hospitalisation and ambulatory care, respectively. This is in sharp contrast to the actual utilisation pattern within the same community. This gap reflects the inadequacies within the public healthcare system, both with respect to numbers or physical access as well as in terms of adequacy of resources and quality care. In contrast the private health sector fulfils these expectations but at a tremendous cost to the patient.

Therefore the state must assume a more proactive role in strengthening access and quality of care of its health services for its citizens. This would mean not only more resources to be allocated for healthcare in its budgets but also increased efforts into improving allocative efficiencies so that resources are better and more effectively utilised. For instance, even from the existing budgets if more resources are allocated to dispensaries, if dispensaries and health-posts are integrated, if a referral system for hospitals is put in place and graduates passing out of public medical schools compulsorily put in 3-5 years of public service as a return for the virtually free medical education they have received, and other similar measures, then the effectiveness of the public healthcare system will improve tremendously and it will regain the esteem and respect it enjoyed until recently.

Acknowledgement:

We take this opportunity to thank Brihan Mumbai Municipal Corporation (BMC) for entrusting our organisation to under take this study.

End Notes

¹ The classifications Kachha, Semi pucca and Pucca are on the basis of type of house construction. *Kachha* are the ones made from mud thatch or other low quality materials; *Semipucca* are made from partly high and partly low quality materials; and *Pucca* are made with high quality materials.

² 'Health Posts' are set up in the community to deliver preventive and promotive health care services and is expected to cover a population group that has 40 percent of it's constituents living in slum/slum like localities. Each Health Post covers an average of 50,000 population.

³ One US Dollor (\$) was equivalent to 48 Indian rupees

⁴ *Chawls* are *pucca* and *semipucca* a set of houses with common walls and shared toilets and bathrooms

⁵ Cross practice refers to ayurvedic, unani and homeopathic practitioners who also prescribe allopathic medicines

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Tables

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Table 1: Utilisation of public health care services in India
(figures are percent users of public services from total users)

	Rural	Urban
Inpatient Care Services ¹	44	43
Outpatient care services ¹	19	20
Delivery care services (Institutional) ²	50.8	44.7
Family Planning Services ²	60.1	83.2
General source of health care for household ²	23.5	30.6

Source: ¹NSSO (1998a); ²IIPS ad ORC Macro (2000a)

Table 2: Per 1000 distribution of hospitalisation cases during last 365 days by fractile -group of monthly per capita consumer expenditure, India 1995-96

Place of residence	sex	Monthly percapita consumer expenditure fractile group							Total
		0 - 10	10 - 20	20 - 40	40 - 60	60 - 80	80 - 90	90 - 100	
Urban	male	22	39	106	140	232	154	307	1000
	female	28	39	122	143	233	160	276	1000
	person	25	39	113	141	233	157	293	1000
Rural	male	54	62	160	189	197	134	205	1000
	female	66	69	150	189	211	134	181	1000
	person	59	65	155	189	203	134	194	1000

Source NSSO 1998a

Table 3: Percentage distribution of reported source of healthcare for the households

Type of health facility	Inpatient care	Outpatient care
BMC facility	40.3	14.4
Other Public facility	2.3	2.0
ESI/Insurance related	2.2	0.5
Private sector	53.8	82.4
Charitable institutions	1.4	0.6
Others	--	0.1
Total	100	100
N	1029	1033

Table 4: Percentage distribution of reasons reported for preferring to take treatment from a particular source

Reason reported	Inpatient care treatment		Outpatient care treatment	
	Public sector	Private sector	Public sector	Private sector
Nearest Facility	8.4	44.6	55.0	78.6
Convenient Timing	5.1	17.4	14.9	11.0
Offers good quality service	32.6	23.3	24.6	13.6
Cost is affordable	64.5	10.8	31.5	1.4
Availability of medicines	1.4	1.8	1.2	1.6
No other option	6.8	29.6	6.3	15.6
Others/Missing	1.5	3.2	2.9	2.4
Total#	100.0	100.0	100.0	100.0
N	463	569	175	858

percentages will not add up to hundred because of multiple response in some cases

Table 5: Type of facility preferred by the household if both public and private health facilities are available to them

	Percentage preferring		Total (N)
	Public facility	Private facility	
Outpatient care services	83.4	16.6	100 (1001)
Inpatient care services	88.1	11.9	100 (1008)

Table 6: Percentage distribution of reasons reported for preferring to take treatment from public/private if both services are available to them

Reason reported	Inpatient care treatment		Outpatient care treatment	
	Public Facility	Private Facility	Public Facility	Private Facility
Nearest Facility	29.3	59.9	11.9	30.9
Convenient Timing	6.5	11.4	5.1	19.2
Offers good quality service	20.0	25.2	20.3	44.4
Cost is affordable	57.5	6.6	72.0	4.1
Availability of medicines	1.5	3.6	4.7	7.5
No other option	4.1	2.4	6.6	5.8
Others/Missing	5.1	3.6	5.2	8.4
Total	100	100	100	100
N	841	167	882	119

Table 7: Unmet need for public/private facility for inpatient and outpatient care services in the population
(Figures are in percentages)

	Inpatient care services	Outpatient care services
Current preference public and choice also public (met need for public health facility)	43.7	16.0
Current preference public but choice is private (unmet need for a private health facility)	1.2	1.0
Current preference private but choice is public (unmet need for a public health facility)	44.4	67.4
Current preference private and choice also private (met need for private health facility)	10.7	15.6
Total	100.0	100.0
N	999	1006

Table 8: Percent of households preferring treatment from public health care sector and percent of households having unmet need for public health care facility by level of household income.

Monthly income of household (in Rupees ³)	Percent preferring public sector for		Percent having unmet need for public facility for	
	Outpatient care services	Inpatient care services	Outpatient care services	Inpatient care services
Less than 2000	22.8	56.5	63.2	37.1
2000-4000	18.3	46.3	66.1	42.7
4000 and above	10.0	32.5	72.0	53.3
Total	16.9	44.8	44.4	67.4