The Importance of Quality and Price in Choice of Health Care

A Study of West Bengal

Abstract

It is often argued that an increase in the price of health care will not have any adverse impact on its utilisation if quality of health care is also improved. This argument has an important place in the recent discussions on health sector reform. The reform proposals include introduction of user fees and other cost recovery mechanisms with the objective of generating resources for quality improvement. A substantial number of studies, which have found quality as an important determinant of demand for health care, seem to support this argument. Most of the studies, however, ignore the fact that different individuals have different degrees of sensitivity to various dimensions of quality and price. The way quality is defined in these studies and the way the theoretical models incorporate the notion of quality and price need further scrutiny. We develop an approach based on an in-depth conceptual analysis of the quality of health care, which is more appropriate in understanding individuals' choice of health care. We then operationalise our approach to understand the choice of health care by individuals in the concrete context of the state of West Bengal by using the National Sample Survey 52nd round (NSS52) and National Family Health Survey 2 (NFHS2) data.

Two broad ways of approaching the quality of health care – the economists' approach and the public health approach – are observed in the existing literature. While the economist looks at quality from an individual's choice perspective, which may not exactly coincide with how a medical expert would view quality, the public health perspective tends to define quality of care exclusively in terms of objectively verifiable health outcome. The latter is clearly inadequate in understanding individuals' choice. Drawing on these two types of approaches and on Amartya Sen's contributions to the standard of living literature, we develop our alternative approach. We make a distinction between technical and functional quality and a distinction between direct price and access cost. While technical quality is strictly related to the health outcome, functional quality is concerned with an individual's non-health outcome related satisfaction. The direct price is the sum of all expenditures that an individual incurs at the health care facility/provider for doctor's service, medicines, diagnostic tests etc, and access cost is the sum of monetary and non-

monetary cost of accessing care, excluding the direct price. This approach helps clarify many conceptual ambiguities associated with quality and price and illustrate what kind of data one needs to collect on quality to understand individuals' health care seeking behaviour. Further, our approach is amenable to the econometric framework that is commonly used in the context of choice of health care providers.

An analysis of NSS 52 data on outpatient care shows that there is a steady increase in the percentage of treated illness with increase in economic status. This clearly points to the negative role of monetary price of care in the demand for health care. However, data on reasons for 'not going for health care' does not support the negative role of price in reducing utilisation of health care except for the rural poor. Although on an average the direct price of outpatient care from non-government providers is significantly higher than that from government facility, individuals mostly depend on non-government providers implying that quality and/or access cost is more important than direct price in the choice of outpatient care. Further evidence shows that it is the higher access cost and not lack of quality, which is the main reason for the an individual not utilising government health care providers. Higher access cost as a reason for non-utilisation of government providers is significantly more important for individuals belonging to households with higher opportunity cost of time. However, the relative importance of quality with respect to access cost is higher for the rich compared to the poor. Our multinomial logit analysis also supports these evidences. Analysis of NFHS 2 data shows that as far as quality indicators like 'time spent by the doctor/health staff' and 'respected the need for privacy' are concerned, the 'ever-married' women (of age group 15 – 49) are more satisfied with the non-government providers than the government providers. When we focus on the indicators like 'time spent by the doctor/health staff', 'behaviour of the doctor/health staff, 'doctor/health staff respected the woman's need for privacy', there is some evidence of discrimination against poor women at the government facilities, while such discrimination does not seem to be present at the non-government facilities, except the 'privacy' indicator.

The huge rural-urban and poor-rich difference in the rate of utilisation of inpatient care as evident from NSS 52 data clearly indicates the positive role of economic status (or alternatively negative role of price) and negative role of access cost in determining the utilisation of inpatient care. The higher access cost faced by individuals in rural areas, which seems to be the major reason for

lower utilisation by them, is probably due to the fact that a rural household need to spend much higher time to utilise an inpatient care compared to urban households. Unlike outpatient care, individuals mostly depend on government facilities for inpatient care and the degree of substitutability between government and non-government inpatient care is very low because of the high price differentials. The degree of substitutability is even much lower for the rural individuals since they face higher access cost of inpatient care from non-government sources compared to the urban individuals. Since there is no evidence that access cost of non-government inpatient care is lower than that of government care, individuals seeking inpatient care from non-government sources must be doing so on the ground of better quality. A macro analysis at the district level clearly shows that the spatial inequality in utilisation is primarily rooted in the spatial inequality in access to inpatient care.

Our conceptual discussion and empirical findings throw light on some widely discussed policy measures aiming at improving quality and reducing price of health care. Measures to improve quality should have a clear understanding about the perspective from which the issue of quality improvement is to be addressed, which in turn require detailed data on individuals, health care providers, and individual-provider interaction. While designing the price and quality, one needs to distinguish between outpatient care and inpatient care since individuals' sensitivity to quality and price are different for the two kind of care. Except the rich, it is clear from the empirical analysis that individuals are highly responsive to price than quality. However, quality related discrimination towards specific groups at government facilities must be paid serious attention. Since the households with higher opportunity cost of time are very responsive to access cost of health care, there is a need to take steps to reduce the access cost of health care. In this direction, area targeting and exemption based on household occupational categories may prove to be more effective than other conventional measures of exempting the poor. However, not all factors affecting individuals' perception of quality and access can be influenced by the health sector policies alone.