PATTERN OF HEALTH EXPENDITURE IN TRIPURA

DISSERTATION

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This to certify that Mr. Ashamanja Roy, a candidate for the Master of Science Examination-2010 in Analytical and Applied Economics Semester-IV bearing Roll EC/IV/M NO.06/08 Registration no. 005435 of 2004-05 has prepared the Dissertation entitled "Pattern of Health Expenditure in Tripura" under my supervision and he has fulfilled all the requirements of the regulation related to the preparation of project Report for said examination.

Dated: Suryamaninagar

The 15th June, 2010 **(PARAMITA SAHA)**

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Dated: Suryamaninagar

The 15th June, 2010 **(ASHAMANJA ROY)**

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1.1 INTRODUCTION:

Health is basic to life and a foundation for productive activity in life. The constitution of an individual as determined by his genetic construct makes one individual's response to environmental stimuli in case of health and disease vastly different from the other. Resistance to diseases varies among individuals. Thus intervention in health needs to be personalized. Yet there are certain environmental factors affecting health which necessitates public interventions in health an important issue. Availability of medical care facilities plays a vital role in improving the health status of individuals and community by providing curative services. Proper living conditions, availability of pure drinking water, adequate food are some of the environmental factors which influence the health outcome of individuals and community as a whole. Ensuring these requires finances to be made available at the state level. The role of the State has been critical in ensuring universal availability of health care in countries around the world. In India, however, public health expenditure has been grossly inadequate right from the 1940s, when the Bhore Committee report stated that per capita private expenditure on health was RS. 2.50 compared to a state per capita health expenditure of just RS. 0.36 (Duggal, R. S. Nandraj, and A. Vadair). It is well known that health expenditure in India is dominated by private spending. To a large extent this is a reflection of the inadequate public spending, that has been a constant if unfortunate feature of Indian development in the past half century. This is particularly unfortunate because of the large positive externalities associated with health spending, which make health spending a clear merit good. The greater reliance on private delivery of health infrastructure and health services therefore means that overall these will be socially underprovided by private agents, and also deny adequate access to the poor. This in turn has adverse outcomes not only for the affected population but for society as a whole. It adversely affects current social welfare and labour productivity, and of course harms future growth and development prospects.

This is why the perceptions that government spending on health has been further undermined during the period of economic liberalization since the early 1990s create concern, and need to be investigated.

The present study seeks to examine how income affects expenditure on

health, i.e. if income rises spending on health is increased or decreased both at the macro and micro level.

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<u>1.2 DEFINITION OF HEALTH EXPENDITURE</u> :

1. ***Health spending consists of health and health-related expenditures. Expenditures are defined on the basis of their primary or predominant purpose of improving health, regardless of the primary function or activity of the entity providing or paying for the associated health services.***

2. ***Health includes both the health of individuals as well as of groups of individuals or population. Health expenditure consists of all expenditures or outlays for medical care, prevention, promotion, rehabilitation, community health activities, health administration and regulation and capital formation with the predominant objective of improving health.***

3. ***Health-related expenditures include expenditures on health-related functions such as medical education and training, and research and development.***

<u>Patterns of health expenditure in India</u> :

The first systematic analysis of the distribution of health spending in India by source of funds was published in the National Health Accounts of India, 2001-02. The results are shown in Chart 1, and confirm the widespread perception that private households account for the bulk of health expenditure. According to this estimate, households accounted for more than two-thirds of health spending in the country, and around three times the amount of all government expenditure taken together, by central, state and local governments. Employers (firms) account for only 5 per cent, but what is especially notable is the negligible role played by both external sources and others including NGOs. Despite the reported increase in foreign aid for dealing with HIV-AIDS and similar issues, all external sources taken together accounted for only 2 per cent of total health spending[1], while NGOs accounted for only 0.3 per cent.

More recent estimates suggest that the role of households has increased even more substantially in the most recent period. According to the Report of the National Commission on Macroeconomics and Health, 2005, households undertook nearly three-fourths of all the health spending in the country. Public spending was only 22 per cent, and all other sources accounted for less than 5 per cent. As Table 2 shows, both the per capita spending and the share of households in this varied widely across states. Per capita spending in the state with the highest rate (Goa) is nearly 7 times that of per capita spending in the state with the lowest per capita spending (Meghalaya). Interestingly, the share of household spending is lowest in Meghalaya, but was among the highest in Bihar which has relatively low per capita spending. There are many states where households undertake more than 80 per cent of all health spending, indicating an exceptionally high burden upon them.

1.3. Objectives of the study

Thus the primary objectives of the study are

- ***i) To examine the trend in state budgetary expenditure on health over a period of years from 2001-02 to 2008-09.***
- ***ii) To analyses the households' out of the pocket expenditure on health related matters.***

1.4Justification of the study:-

The present study has been designed to put some light on the spending of health expenditure both public private in two different income groups APL and BPL. So, far several studies have been carried out by different researcher regarding health expenditure to Tripura.

More over the present study will give a picture of spending on health expenditure both private and public in the content of Tripura.

1.5 Sources of data and methodology:-

Selection of study area:-

The justification of selecting the area for the study is to have a better comparative analysis, and also to have an easy accessibility of mine. Basically I select the Ishanchandranagar GP under Dukli R.D Block because there I find a good proportion of APL and BPL families which required for the present study. Another reason is that there is a medical college hospital very near to this area, that is why I want to study the health expenditure behavior of the BPL and APL families who having same kind of medical; accessibility because of the hospital and how their health expenditure varies in terms income having getting the same medical accessibility.

Selection of sample units:-

Two groups of households consisting of 70 BPL families and 30 APL families have been purposively selected for the study.BPL families are those whose income up to Rs.4000 per month and APL families are those whose income is above Rs. 4000 per month. Both the groups are belonging to same GP and having some kind of medical accessibility.

Methods of analysis:-

Secondary Data:- *Outlay on health in annual state budget of Tripura forms the basis of the macro perspective. The changes in per capita public expenditure on health are analyzed on the basis of secondary data.*

Primary data:- *For the household level analysis, data is collected through a sample survey using structured questionnaire (See Appendix).*

Data analysis has been done by tabular & cross-tabular method with the help of Simple statistical tools.

1.6 Limitation of the study :-

A better result would have been possible if the set of observation be a larger one and if proper secondary data be available. Time is also another factor which was very short one.

Chapter-2

2.1 Review of literature.

2.2 Centrally sponsored scheme (CSS).

2.3 Public health delivery system in Tripura.

2.4 Health insurance for the BPL families

2.1 Review of literature:-

Health care spending is considered to be a merit good because of the large positive externalities associated with it. Public spending in health care aconites importance in a country like India because of its positive impact on life expectancy and productivity and also because the poor population cannot afford private sources of health care delivery system. The greater reliance on private delivery of health infrastructure and health services therefore means that overall these will be socially under provided by private agents, and also deny adequate access to the poor.

Studies related to health expenditure can be broadly categorized as-

1. ***Studies regarding impact of public spending on health various human development indicators like life expectancy, Infant mortality Rate (IMR), productivity etc.***
2. ***Impact of change in income on health care spending.***
3. ***Equity of health.***
4. ***Out of pocket expenditure on health and its determinants.***

1. Studies regarding impact of public spending on health various human development indicators like life expectancy, Infant mortality Rate (IMR), productivity etc.

In an influential study,Filmer and Pritchett (1999) investigation the effect of Govt. Health in expenditure on infant and under-5 mortality using cross-sectional data on 98 developing countries in 1992/3,they find very small and statistically insignificant effect. They show that 95% of the variation in mortality between countries is explained by income precipitate ,income inequality, female education and ethnic fractionalization.

Guptaet.al. (2002) find some evidence that govt. health expenditure is negatively correlated with children morality, but they show that this relationship is not robust.

Anand and Ravallion (1993) find that health expenditure raises life expectancy and that, conditional upon this, income has no effect.

2. Impact of change in income on health care spending.

Newhouse (1977) found that 92% of the variance in health care expenditure between domestic products and that income elasticity was larger than one, since then, much research along this lines has been done, using cross-sectional data as well as time series and panel data Gerdtham and Jonsson (2000) present an overview of the extensive literature on international comparisons of health care expenditure. They find that the most important factor explaining variations in health care expenditures is aggregate income. The effect of gross domestic products positive and significant and close to unity or higher that unity. The effect of the population age structure is usually insignificant. The same holds for the less frequently used variables as unemployment rate and female labour participation. A number of institutional variables seem to be important too. For example, when the primary care sector acts a gatekeeper, the expenditures are lower. They also claim that many macro econometric analyses of health care expenditures lack a solid theoretical foundation.

Anil Deolalikar investigates the relationship for areduced sample of four years and fourteen states (N=56) for which information on female literacy is available. For this sample, an interaction term between health expenditure and state income is included and the results suggest a negative effect of health expenditure but only in the poor states. In a complementary analysis of micro data for the period 1994-1998,he finds the opposite that the effects of health expenditure are weaker in the poor states.

3. Equity of health

Wagstall(2002,1986) in his study "income inequality and health inequality observes that the relation between health and medical care is assumed to be concave, meaning that medical care is is subject to

diminishing returns in the production of health. It suggests that richer individuals are likely to end up with higher levels of health and that increases in income inequality result in higher levels of health inequality.

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Further it is inferred that it medical care is subsidized through public spending, it helps to lower the levels of health inequality it also suggest increases in health inequality if rising incomes are accompanied by technological improvements in health care.

4.Out of pocket expenditure on health and its determinants

Indrani Gupta (2009) identified three key preconditions for catastrophic payments as the availability of health services requiring payments, low capacity to pay and the lack of prepayment or health insurance. She concluded that individual particular in poor households, can be protected from catastrophic health expenditures by reducing a health systems reliance on out of pocket payments and proving more financial protection.

Another study from Burkina Faso (su et al 2006) identified the key determination of catastrophic health expenditure as economic status, household health care utilization especially for modern medical care, illness episodes in an adult household member and presence of a member with chronic illness.

Several studies of Indian villages to determine why households descent into poverty (Krishna 2004,Krishna et al 2005,Krishna 2006)find that in majority of cases of decline into poverty, three principle factors are at work, health expenses, high interest private debt and social and customary expenses, irrespective of distance to health care expenses figured prominently in more than half of all cases of decline in poverty.

2.2 Centrally sponsored scheme (CSS):-

Centrally-Sponsored Scheme(CSS) is a unique nomenclature. Normally as per the constitutional dispensation, all activities in Government are categorised as those falling in: Central List, State List and Concurrent List. While there is no ambiguity with regard to the Central List, activities which fall under the State and Concurrent List are often subject to over-lapping jurisdiction between the Government of India and the State Governments. Health and Education are two most important social sector programmes which figure in these two lists. While the State Governments have the primary responsibility to provide better quality of health and education to the people, it is the overall responsibility of the Government of India to achieve certain monitorable national goals in terms of health care and levels of education. This responsibility is not just to the people of the country but also to the international community represented through various UN and other multinational agencies. Some of these national goals are also articulated in international agreements and declarations to which India is a signatory.

The Centrally-Sponsored Schemes have figured in successive Five Year Plans of the Government as those which are normally identifiable responsibilities of the Central Government while the responsibility for implementation of these programmes is normally vested with the State Governments. A mechanism was, therefore, devised whereby schemes are formulated with monitorable targets at the central level with adequate provision of funds in the Union Budget under various Ministries.The objectives, strategy and methodology of implementation are prescribed and funds are released to the States based on their requirements. These schemes which were initially restricted to a few well defined activities, have later on started multiplying to include considerable areas of activity performed by the State Governments.

There are important reasons for the proliferation of CSS, identity of the State Governments to provide adequate resources for socially relevant programmes, lack of a clear strategy to implement social sector programme by the State Governments, inadequate commitment of resources on priority programmes because of lack of political will and bottlenecks in fund flow to the implementing agencies at the field level.

In the area of Health and Family Welfare, external assistance was restricted to bilateral assistance from some European and North American countries till the World Bank stepped into the arena in the early 1990s. The Bank which was the principal source of funding for economic and infrastructural

support till that time, has extended the soft lending through IDA to Health and Family Welfare programmes as well.

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The biggest beneficiaries of the external source of funding are the National Disease Control Programmes, Reproductive and Child Health Programme and the Integrated Child Development Programme of the Ministry of Women and Child Development. While in 1991 the percentage of external funding in the total planned budget was negligible, it grew upto 45-50 per cent by 1997 of the total planned budget in the Department of Health. About 20 per cent of the family welfare budget is financed by external funding for the RCH Programme. As the funding for the health programmes is in the form of soft loan with a very nominal rate of interest, the funding is determined through a Development Credit Agreement signed between the Government of India and IDA. Negotiating the loan is an important area of concern for the Government of India as well as the Bank for a smooth flow of funds to the implementing agencies, ensuring accountability and close monitoring and evaluation of the Programmes. Logically all these criteria have fitted into the pattern of Centrally-Sponsored Schemes. It is, therefore, no wonder that most of the external funding to Health and Family Welfare Programmes is channelised through CSS.

In the initial stages, the Government of India which is the recipient of external funding, routed the funds to the State Governments for implementation of the Programmes. However, many of the States facing intermittent fund flow problems during the first half of the financial year, started delaying the releases for implementation of the Programmes to the fag end of the year and mostly in the month of March. The negative impact of this lopsided and untimely release of funds had an adverse impact on the implementation of the Programmes. The establishment of alternative autonomous State society and district societies registered under the Societies Registration Act was, therefore, thought of as an alternative funding route for the Programmes. The society model is a convenient via media between the rigidity of fund flow mechanism through the Consolidated Fund of the States and flexibility of a registered society. Though autonomous, the societies have adequate representation from Government officials with the Health Secretary or sometimes the Chief Secretary heading the Societies' General Body.

The Society model facilitated representation of other related departments dealing with the social sector as members of the General Body and the Governing Board. In some of the programmes, representatives of NGOs have also been included to ensure effective participation of civil society. Registered societies are subject to commercial audit. The Comptroller and Auditor General of India also started auditing the societies on a regular basis. In 1995 a number of State- level societies were established to deal with the major health programmes like control of communicable diseases, e.g. T.B., leprosy, AIDS and malaria and Reproductive and Child Health Programme of the Department of

Family Welfare. There has been an immediate impact on performance as the bottlenecks of fund flow wherever existed, were effectively removed and the Programme expenditure has started picking up.

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As many of these programmes are Centrally-Sponsored Schemes where the Government of India is accountable not only to Parliament but also to the international donors, the society model has brought in a qualitative change in performance in many of the programmes.

The flip side of this arrangement was, however, the virtual proliferation of societies at the State and district levels. There are as many as 7 or 8 societies at the State and district levels which started implementing various health programmes. The Health Secretary of the State and the District Collectors/Magistrates at the district level are hard pressed round the year to conduct meetings of the societies to monitor their effective functioning. This virtually led to stratification of a number of activities like training which could have been optimized by pooling resources under various programmes. Slowly but surely, the idea of having a composite society for all the programmes instead of individual ones for various programmes, has started taking shape. Orissa was the first State to amalgamate all the State-level societies into a State Health Society at the State level and District Health Society at the district level. the Government of India has also encouraged all the States to take up this amalgamation of societies at the State and District levels for optimum utilisation of resources and to bring in the necessary synergy between various programmes.

Meanwhile at the state level, resistance started building up against this funding mechanism as an alternative to the State Governments. The argument held out by some of the States was that the State Legislative Assemblies which normally approve allotment of funds for Government programmes, do not get the opportunity to approve the funds routed through the societies. The fact of the matter is that the large flow of funds directly going to the programmes is not in any way influencing the 'ways and means' position of the State Governments. The matter was taken up by Chief Ministers of several States with the Government of India and finally the latter had to revert back to the old system of routing funds through the Consolidated Funds of the State Governments instead of the autonomous state societies.

The Finance Ministry issued an order on 13th January 2003 that the Ministry dealing with Centrally-Sponsored Schemes should revert back to the old system even in case of external funding. This may amount to amendment/violation of the Credit Agreement signed between the funding agencies and the Government of India. The Committee of Secretaries to whom the matter was referred has decided that in case there are binding agreements

for credit from the World Bank and other funding agencies, the implementing Ministries may continue routing the funds through State societies.

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This clearly shows that the mechanism of CSS has now come openly into question as an effective instrument of service delivery for socially relevant programmes. There are arguments and counter arguments in favour of and against continuing CSS. The extreme view is of course total scraping of the CSS schemes and handing them over to the State Governments. Some functionaries in the Government of India are also openly advocating this line of approach.

What is, however, needed is a judicious and pragmatic approach to the whole issue of Centrally-Sponsored Schemes. The Government of India is responsible for achieving certain national objectives which are enunciated in the National Policy documents like National Health Policy-2002, National Population Policy–2000, and the National AIDS Control Policy-2002. The Central Government is not only responsible to Parliament and public but also to the UN and its various organs for achieving some of these milestones. Some of the examples are eradication of polio, control of communicable diseases like malaria, TB and leprosy. This can be achieved only if there is a Central initiative and direction with a strong element of decentralisation and ownership built in at the State level as the implementation strategy. While a number of States are proactive and do not need micro management of programme by the Central Government, there are States where the required political will to conduct an effective implementation of the programmes is woefully lacking. In such cases a strong monitoring of the programmes is essential at the Central Government level. The growing disparity in social indicators among the States is a case of serious concern at the national level. The responsibility of the Government of India is to ensure that these disparities are minimized if not eliminated all together. The mechanism of CSS to a large extent can help in this effort. What is, therefore, needed is a dialogue between the State Governments and the implementing Ministries in the social sector regarding the scope of CSS and the mechanics of their implementation. In the Tenth Plan, there has been a substantial pruning of CSS and those which are left are extremely relevant to achieving clearly identified national objectives in the area of Health and Family Welfare. Bringing in a national consensus and greater involvement and ownership of the State Governments in implementing these programmes is the need of the hour.

2.3 Public health delivery system in Tripura:-

- ***The particulars of organization, functions and duties of the Health & Family Welfare Department.***

A. Organization.

1. Health & Family Welfare Department is a State Level Organization.

2. There are two Directorates under this Department namely :

B. Functions :

Administrative Functions :

1) Implementation of medical & Public health Acts& Rules

2) Deployment of Tripura Health Service Cadre personnel except appointment of Director of Health Services and officers of equivalent rank

3) Implementation Medical Attendance Rules

4) Implementation of Public Health ,Sanitation & vital Statistics

5) Implementation of Family Welfare, Maternity and Child Welfare all references relating to.

6) Implementation of Drug Act and Rules there under

7) Control of Epidemics, Leprosy ,T.B, V.D., Malaria, Small Pox and other such diseases

8) Vaccination

9) Registration of births &deaths

10) Assistance from UNICEF and other international agencies for Medical & Public

Health programmes.

11) *Admission of mental patients in Mental hospitals*

12) *Procurement & supply of Medical stores for institutions under various Departments*

13) *Implementation of BCG scheme*

14) *Admission of cancer patients in Cancer Hospitals*

15) *Medical Training & Stipends*

16) *Establishment , budget and accounts matters*

17) *Medical Education.*

18) *Implementation of Citizen Charter.*

<u>Financial Functions :-</u>

1) *Sanction of advance or withdrawal from General Provident Fund Accounts of Officers belonging to Tripura Health Services, Tripura Dental Services, Medical Officer, Homeopath, Medical Officer(Ayurved) and other Gazetted Officer.*

2) *Sanction of House Building Advance, Leave Travel Concession Advance of Officers belonging to Tripura Health Services, Tripura Dental Services, Medical Officer, Homeopath, Medical Officer(Ayurved) and other Gazetted Officer.*

3) *Exercise of financial power as per Delegation of Financial Rule.*

C. Duties :

- *Secretary – As the Administrative head of the Department he assists the Minister-in-charge of the Department in all policy related and administrative matters.*
- *Addl. / Joint Secretary – To assists the Secretary and in discharging his functions.*
- *Deputy/Under Secretary – Responsible for authenticating different orders of the*

government.

- *Director of Health Services – Administrative head of State Hospital, District Hospitals and Sub-Divisional Hospitals and Ayurvedic & Homoeopathic Hospitals. He is assisted by the Jt. Director, Deputy Director, Assistant Directors & other Officers.*

- *Director of FW & PM – He is the Administrative head of all National Programmes implemented through Societies, Community Health Centers, Primary Health Centers and Sub-Centers meant for primary health care services and O/o the Chief Medical Officers. He is assisted by the Deputy Director, Assistant Directors, Member Secretary / Project Director of various Societies and other Officers.*

2.4 <u>Health insurance for the BPL families:</u>

<u>Objective:-</u> The main objective of this scheme is to provide health security to five members of unorganized BPL family and opportunity of free medical treatment up to Rs.30000/- in an indene of a fixed hospital.

<u>How it works:</u>- All the 5 members of unorganized BPL family will help to prepare smart card being present in a fixed place under panchayat area

and receive this smart card in schedule time for a Rs 30.After receiving the smart card membership will get opportunity of medical treatment in an indoor of the fixed hospital under this scheme. It is to be remembered that at the time of preparing this card all enlisted members have to be present otherwise, no opportunity will be available.

<u>Medical service:-</u> Any members of the enlisted family can take medical advice with this smart card, when we suffers from any disease. After medical test when he admitted in a fixed hospital we will have to report on the RSBY counter. Expenses in connection with medicine and diet will be provided by the hospital authority free of cost. Under this scheme a sum of Rs 30000/- will

may be given for a year Rs. 100/- will given for communication to the hospital which

may extend up to 1000/- may for a period of one year.

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Public expenditure on health has been measured from budget data cover years. Dept. of Health and Dept. of Family welfare and Preventive medicine is jointly prepared the budget for health. In this chapter the total spending on health as public expenditure has been given. What percentage of budget outlay spend on health and how much comes from centrally sponsored schemes (CSS) is shown by Table-1 and how much money Govt. spend on health per person i.e. per capita public expenditure on health is shown by the Table-2. In the Table-1 data is available from 2001-02 to 2008-09 and in Table-2 data is available from 2004-05 to 2008-09.

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Chapter-3

3.1 Public expenditure on health in Tripura (2001-2009)

3.2 secondary information of the study area

3.1 Public expenditure on health in Tripura (2001-2009):-

Public expenditure on health has been measured from budget data cover years. Dept. of Health and Dept. of Family welfare and Preventive medicine is jointly prepared the budget for health. In this chapter the total spending on health as public expenditure has been given. What percentage of budget outlay spend on health and how much comes from centrally sponsored schemes (CSS) is shown by Table-1 and how much money Govt. spend on health per person i.e. per capita public expenditure on health is shown by the Table-2. In the Table-1 data is available from 2001-02 to 2008-09 and in Table-2 data is available from 2004-05 to 2008-09.

TABLE 1 :PERCENTAGE OF BUDGET OUTLAY SPEND ON HEALTH						
YEAR	*EXPENDITURE ON HEALTH*				*TOTAL BUDGET OUTLAY (RS. IN LAKHS)*	*PERCENTAGE (%) SPEND ON HEALTH*
	HEALTH (RS. IN LAKHS)	*FW & PM (RS. IN LAKHS)*	*TOTAL (RS. IN LAKHS)*	*CSS (RS. IN LAKHS)*		
2001-02	*3987.87*	*5347.65*	*9335.52*	*2210.53*	*272543.39*	*3.43*
2002-03	*4320.32*	*5394.70*	*9715.02*	*2723.98*	*274006.99*	*3.55*
2003-04	*3782.39*	*5518.42*	*9300.81*	*1411.00*	*282641.35*	*3.29*
2004-05	*4642.15*	*5518.42*	*10160.57*	*1403.78*	*311202.64*	*3.26*
2005-06	*9895.89*	*5697.76*	*15593.76*	*1342.52*	*330141.71*	*4.72*
2006-07	*10643.11*	*6356.35*	*16999.46*	*1350.85*	*330146.64*	*5.15*
2007-08	*11423.42*	*6356.35*	*17779.77*	*1321.97*	*383511.24*	*4.64*
2008-09	*13921.06*	*7678.21*	*21599.27*	*2924.52*	*451104.05*	*4.79*

TABLE 2 : PER CAPITA PUBLIC EXPENDITURE ON HEALTH				
YEAR	*TOTAL HEALTH EXPENDITURE (RS. IN LAKHS)*	*TOTAL POPULATION*	*PER CAPITA PUBLIC EXPENDITURE ON HEALTH (RS. IN LAKHS)*	*PER CAPITA PUBLIC EXPENDITURE ON HEALTH (IN RS.)*
2004-05	*10160.57*	*3390000*	*0.002997218*	*299.7218289*
2005-06	*15593.76*	*3432000*	*0.004543636*	*454.3636364*
2006-07	*16999.46*	*3474000*	*0.004893339*	*489.333909*
2007-08	*17779.77*	*3515000*	*0.005058256*	*505.8256046*
2008-09	*21599.27*	*3557000*	*0.006072328*	*607.2327804*

Source: Department of Finance & Budget

3.2 Secondary information of the study area:-

Secondary information of the study area collected from Gram Panchayet office of Ishanchandranagar. Here given some important data for the purpose of the current study.

TABLE 1 : GENERAL INFORMATION					
TOTAL NO. OF HOUSEHOLD	*TOTAL POPULATION*	*MALE*	*FEMALE*	*% OF MALE*	*% OF FEMALE*
1551	*5619*	*2870*	*2749*	*51.08*	*48.92*

TABLE 2 : COMMUNITY WISE HOUSEHOLD STATUS					
COMMUNITY	*BPL*	*APL*	*TOTAL*	*% OF BPL*	*% OF APL*
GEN	*146 (11.92%)*	*67 (20.55%)*	*213 (13.73%)*	*68.54*	*31.46*
SC	*267 (21.80%)*	*55 (16.87%)*	*322 (20.76%)*	*82.92*	*17.08*
OBC	*812 (66.29%)*	*204 (62.58%)*	*1016 (65.51%)*	*79.92*	*20.08*
TOTAL	*1225 (100%)*	*326 (100%)*	*1551 (100%)*	*78.98*	*21.02*

TABLE 3 : PROPORTION OF WORKER AND NON-WORKER			
OCCUPATION	*MALE*	*FEMALE*	*TOTAL*
WORKER	*1942 (90.83%)*	*196 (9.17%)*	*2138 (38.05%)*
NON-WORKER	*928 (26.66%)*	*2553 (73.34%)*	*3481 (61.95%)*
TOTAL	*2870*	*2749*	*5619 (100%)*

Source: Ishanchandrabagar Gram Panchayat

Chapter-4

4.1 State profile.

4.2 Study area profile.

4.3 Sample profile.

4.4 Findings of the study.

4.1 State Profile:-

Tripura is one of the seven states in the north eastern part in India. It is bounded on the north, west, south, and south-east by Bangladesh whereas in the east it has a common boundary with Assam and Mizoram. The former princely state of Tripura was ruled by Maharajas of Manikya dynasty. It was an independent administrative unit under the Maharaja even during the British rule in India though this independence was qualified, being subject to the recognition of the British, as paramount power, of each successive ruler. After independence of India, an agreement of merger of Tripura with the India union was signed by the Regent Maharani on September 9, 1947 and the administration of the state was actually taken over by the Govt. of India on October 15, 1949.Tripura become a union territory without legislature with effect from November 1, 1963.on January 21, 1972 Tripura attained statehood. All information about Tripura is summarized below.

Area :

Location	**Remotest in the North-East**
Land	***Total area 10.492 sp Km, 84% international border with Bangladesh (839 km), 60% Hilly Terrain, 60% forest, 52.76% Forest cover, 39% Reserve Forest, 25% Net Shown Area , 30% operational Holding, Average Holding 1.02 Hect., Irrigation 13% of Cropped area.***
Climate	***Temperature varies between 10 and 35 degree Celsius, Average Annual rain Fall 2100mm, Highest Rain fall 2855mm (Kamalpur), Lowest Rain fall 1811 mm (sonamura).***

Demographic profile of Tripura :

Population	***31,99202 (census 2001)***
Density per sq KM	***305 (Census 2001)***
Gender ratio	***948 (Census 2001)***
BPL Families	***66.81% (Census 2001)***
APL Families	***33.19 % (Census 2001)***
Literacy rate	***73.2% (Census 2001)***
Major language	***Bengali and Kokborak***

Source: Tripura at glance -2004, Director of economics and Statistics, Government of Tripura, Agartala.

The economy of Tripura is primarily agriculture based. The primary sector (Agriculture) contributes about 64% of total employment in the state and 48% of the state Domestic Product (SDP).

The State's economy is characterized by,

i. High rate poverty

ii. Low per capita income

iii. Low capita formation

iv. In-adequate infrastructure facilities

v. Geographical isolation and communication barriers.

vii. In-adequate exploitation and use of forest and mineral resources.

viii. Low progress in industrial field

ix. High unemployment problem

A variety of horticulture/plantation Crops are produced in Tripura like Pineapple, oranges, cashew nut, jackfruit, coconut, tea, and rubber etc. There is sample scope for increasing the area under such plantations as well as the productivity and in turns this will help in reducing high incident of poverty of the State.

Administratively Tripura is divided into four districts, 15 subdivision 38 rural development blocks, 31 revenue circles 183 Tashisl, 874 revenue moujas, 962 gram panchayets , 3 jilla parishad,18 notified area, 1municipal council. National highway no.44 is the life line of the state. The state is connected with the rest of the country though Assam by 44 km railway line. The capital Agartala has an airport (Agartala airport) which is connected with Kolkata, Chennai, Guwahati and Shilchar.

Agartala is the capital of Tripura .It is situated at the western corner of the state. It connected by the national highway no 44 with the rest of the country via the state of Assam.

4.2 Stydy area profile:-

Ishanchandranagar gram panchayat (GP) under Dukli R.D Block has been selected as the study area .Total area of the Ishanchandranagar gram panchayat (GP) is 17sq/km the boundaries are,in the last there is Hapania and khas Madhupur GP,in the west it surround by Bangladesh,in the north there is Charipara GP and in the South partition surround by Pandab Pur. Ishanchandranagar gram panchayat (GP) is under Amtali Police Station and under the Tahasil of Suryamaninagar .It is situated in the west Tripura District, and is 12km far from the capital

Ishanchandranagar gram panchayat (GP) has 7wards which are as follows

Bidyasagar Palli 'D' colony (ward no:-1)

Bidyasagar Palli 'B' and 'C' colony (ward no:-2)

Bidyasagar Palli 'A' colony (ward no:-3)

Madhupur (ward no :-4)

Nishchinta pur (ward no:-5)

Mouchkuri kismatpur (ward no:-6)

Haripur (ward no:- 7)

This GP having total population of 5619 and in this and in this total no.of male and female is 2870 and 2749 respectively.Total families lived in this GP are 1551,

in this 1225(78.98%) families are BPL (Below Poverty Line) and 326 (2.02%) families are APL (Above Poverty Line).In the BPL family there is OBC-812,SC-267 and GEN-146.In the APL families there is OBC-204,SC-55 and GEN- 67.In total no of GEN families are 213,SC-322 and OBC-1016,In this GP percentage of male and female are 51.08% and 48.92% respectively.

BPL families are those which are the income less than or equal to Rs. 4000 and APL families are those which are the income above Rs.4000. all the BPL families having health insurance (which is described alter on in this paper).

But the APL families doesn't have health insurance in this GP is around 40%, of them daily labourers are 65%.In this GP 70% house is kutcha,25% is semi pucca and 5% is pucca. Sanitation type is 98% of them using pit. In this GP all the families are using tubewell for drinking water,of them 90% of families filtered the water before drinking.

The most common type of disease suffered by the people in this area is infectious disease. After that enteric diseases and there after muscular skeleton disease by the people of this area. All the families are consulting Allopathy also using Homeopathy and Ayurvedic , but the no is very few.

4.3 Sample Profile:-

100 household has been taken from the Ishanchandranagar GP for the purpose of the current study. The 100 household consisting of 432 members,in which 234 are male and 198 are female.The percentage of male and female are 54.17% and 45.83% respectively. In the 100 households there are 70 (70%) BPL families and 30 (30%) APL families.In the BPL families there is OBC-41,SC-16 and GEN-13.In APL families there is OBC-19,SC-4 and GEN-7.In total no.of GEN-20,SC-20 and OBC-60.

There is 70 BPL families having health insurance and 30 APL famililies who doesn`t have health insurance. Working population in this sample is 34.26%, of them daily labourers are 58.11% .In this sample 66% house is kutcha,32% is semi pucca and 2% is pucca. Sanitation type is 97% of them using pit, 2% using sanitary and 1% using kutcha.In this sample of 100 households all the families/household are using tube well for drinking water, of them 90% families fitter the water before drinking and 10% doesn`t.

The most common type of dies are suffered by the people in this sample in infectious disease, which is suffered by 155 people, after that enteric disease (86), muscular skeleton disease(74),cardiac disease (37), nervous system(32), respiratory disease (19),skin(11),teeth(10),eye(10) and others(38).All the families in the sample are consulting Allopathy for the treatment purpose, 4 families are also consulting Homeopathy and 2 families are also consulting Ayurvedic.

In the sample there is 70 families who are BPL monthly earns up to 4000 and 30 families who are APL earns above 4000 per month. The occupational pattern of the sample is cultivation (20 people), daily labour(86),business(12),service(30) and the total is 148.Non-worker population is quite high i.e. 284 peoples are under this ,of them student(119), aged people(11),children below 6 years (13),house wife(141).

In this sample population under age group 0 to 5 are 13 (M=6, F=7), 6 to 14 are 61 (M=31, F=30), 15 to 59 are 331 (M=185, F=146), 60 above are 27 (M=12, F=15).

Percentage of income spend on health expenditure monthly in the BPL and APL families are as follow-0 to 10% expenditure of health spend by BPL-14 and APL- 6, 10 to 15% spend by BPL-31, APL-17, 15 to 20 %spend by BPL 6 families 25-30% spend by 1 BPL family and above 30% spend by BPL- 4 and APL- 1 families. Per capital expenditure on health spend by BPL families is Rs.142.05/month, APL families Rs.199.33/month. In the overall sample overage is Rs.161.81/month.

4.4 Findings :-

In these sections the data which are collect from filled survey has been given and their interpretation is given in the next chapter.

TABLE 1 : PROFILE OF THE SAMPLE					
TOTAL NO. OF SELECTED HOUSEHOLDs	*POPULATION IN SELECTED HOUSEHOLDs*	*MALE*	*FEMALE*	*% OF MALE*	*% OF FEMALE*
100	*432*	*234*	*198*	*54.17*	*45.83*

TABLE 2: POPULATION OF THE SAMPLE			
Households	*Male*	*Female*	*Total*
APL	*83 (55.70%)*	*66 (44.30%)*	*149 (100%)*
BPL	*151 (53.36%)*	*132 (46.64)*	*283 (100%)*
TOTAL	*234(54.17%)*	*198(45.83%)*	*432(100%)*

TABLE 3 : COMMUNITY WISE HOUSEHOLD STATUS					
COMMUNITY	*BPL*	*APL*	*TOTAL*	*% OF BPL*	*% OF APL*
GEN	*13 (18.57%)*	*7 (23.33%)*	*20 (20%)*	*65.00*	*35.00*
SC	*16 (22.86%)*	*4 (13.33%)*	*20 (20%)*	*80.00*	*20.00*
OBC	*41 (58.57%)*	*19 (63.33%)*	*60 (60%)*	*68.33*	*31.67*
TOTAL	*70 (100%)*	*30 (100%)*	*100 (100%)*	*70.00*	*30.00*

TABLE 4 : HOUSE STRUCTURE			
COMMUNITY	*KUTCHA*	*SEMI PUCCA*	*PUCCA*
GEN	*12 (60%)*	*7 (35%)*	*1 (5%)*
SC	*16 (80%)*	*4 (20%)*	*0 (0%)*
OBC	*38 (63.33%)*	*21 (35%)*	*1 (1.67%)*
TOTAL	*66 (66%)*	*32 (32%)*	*2 (2%)*

TABLE 5 : SANITATION TYPE				
COMMUNITY	*HOUSEHOLD TYPE*	*PIT*	*KUTCHA*	*SANITARY*
GENERAL	*APL*	*6*	*0*	*1*
	BPL	*13*	*0*	*0*
	Total	*19*	*0*	*1*
SC	*APL*	*4*	*0*	*0*
	BPL	*16*	*0*	*0*
	Total	*20*	*0*	*0*
OBC	*APL*	*18*	*0*	*1*
	BPL	*40*	*1*	*0*
	Total	*58*	*1*	*1*
TOTAL	*100*	*97*	*1*	*2*

TABLE 6 : DRINKING WATER FACILITY			
CATEGORY	*TUBE WELL*	*FILTERED*	*NOT FILTERED*
BPL	*70*	*62*	*8*
APL	*30*	*28*	*2*
TOTAL	*100*	*90*	*10*

TABLE 7 :OCCUPATIONAL PATTERN		
	TYPE	*NO. OF PEOPLE*
Worker (%)	*Cultivation*	*20*
34.26	*Daily worker*	*86*
	Business	*12*
	Service	*30*
	TOTAL	*148*
Non-worker (%)	*Student*	*119*
65.74	*Aged*	*11*
	Children	*13*
	Housewife	*141*
	TOTAL	*284*
	TOTAL	*432*

TABLE 8 : PROPORTION OF WORKER AND NON-WORKER			
OCCUPATION	*MALE*	*FEMALE*	*TOTAL*
WORKER	*136(91.89%)*	*12 (8.11%)*	*148 (34.26%)*
NON-WORKER	*98 (34.51%)*	*186 (65.49%)*	*284 (65.74%)*
TOTAL	*234*	*198*	*432 (100%)*

TABLE 9 : INCOME PATTERN

INCOME GROUP	*TOTAL NO. OF HOUSEHOLD*	*APL*	*BPL*
UPTO 2000	*2*	*0*	*2*
2001-4000	*68*	*0*	*68*
4001-6000	*9*	*9*	*0*
6001-8000	*15*	*15*	*0*
8001-10000	*5*	*5*	*0*
ABOVE 10000	*1*	*1*	*0*
TOTAL	*100*	*30*	*70*

TABLE 10 : TYPES OF DISEASE SUFFERED

DISEASE TYPE	*NO. OF PEOPLE*	*BPL*	*APL*
INFECTIOUS DISEASE	*155*	*94*	*61*
MUSCULO SKELETON DISEASE	*74*	*48*	*26*
ENTERIC DISEASE	*86*	*66*	*20*
CARDIAC DISEASE	*37*	*15*	*22*
RESPIRATORY DISEASE	*19*	*12*	*7*
NERVOUS SYSTEM	*32*	*27*	*5*
SKIN DISEASE	*11*	*4*	*7*
TEETH	*10*	*6*	*4*
EYE	*10*	*3*	*7*
OTHER	*38*	*26*	*12*
TOTAL	*472*	*301*	*171*

TABLE 11 : DOCTOR CONSULTED	
TYPE	*NO. OF HOUSEHOLD*
ALLOPATHY	*100*
HOMEOPATHY	*4*
AYURVEDIC	*2*

TABLE 12 : HEALTH INSURANCE	
HEALTH INSURANCE	*NO. OF HOUSEHOLD*
YES	*70*
NO	*30*
TOTAL	*100*

TABLE 13 : AGE STRUCTURE			
AGE GROUP	*MALE*	*FEMALE*	*TOTAL*
0 TO 5	*6*	*7*	*13*
6 TO 14	*31*	*30*	*61*
15 TO 59	*185*	*146*	*331*
60 ABOVE	*12*	*15*	*27*
TOTAL	*234*	*198*	*432*

TABLE 14 : PERCENTAGE OF HEALTH EXPENDITURE			
% OF HEALTH EXPENDITURE ON INCOME	*NO. OF HOUSEHOLD*	*BPL*	*APL*
0 TO 10%	*20*	*14*	*6*
10 TO 15%	*48*	*31*	*17*
15 TO 20%	*20*	*14*	*6*
20 TO 25 %	*6*	*6*	*0*
25 TO 30%	*1*	*1*	*0*
ABOVE 30%	*5*	*4*	*1*
TOTAL	*100*	*70*	*30*

TABLE 15 : PER CAPITA HEALTH EXPENDITURE			
HOUSEHOLD	*TOTAL MEMBERS*	*TOTAL HEALTH EXPENDITURE*	*PER CAPITA HEALTH EXPENDITURE*
APL	*149*	*29700*	*199.33*
BPL	*283*	*40200*	*142.05*
TOTAL	*432*	*69900*	*161.81*

TABLE 16 : WORK DAYS LOST DUE TO ILLNESS			
TYPE OF HOUSEHOLD	*TOTAL HOUSEHOLD*	*TOTAL NO. OF DAYS*	*PER HOUSEHOLD LOST*
BPL	*70*	*323*	*4.61*
APL	*30*	*168*	*5.60*
TOTAL	*100*	*491*	*4.91*

Source : Field Survey 2010.

Chapter-5

5.1 SUMMARY

5.2 CONCLUSION

5.1 Summary:-

The public health expenditure spending is changing every year. The total of spending on health is increasing every year, but it dose not mean that percentage of spending on health increasing. If we see then will find, in 2001-02 percentage spend on health is 3.43% in 2002-03 it increases to 3.55% but then it falls in the next two years i.e. 2003-04 and 2004-05 it falls by 3.29% and 3.26% respectively. Then in 2005-06 it again rises to 4.72%, after that spending on health goes to the highest level of 5.15% in 2006-07. After this it again decline in 2007-08 and it was 4.64% that year. But in 2008-09 slightly increase and stood at 4.79%, the data is available from 2001-02 to 2008-09. It is seen from the above discussion the percentage spend health is quite inconsistent in nature. If it is increase in one year then next year it falls. If we consider the total volume of money spend on health then it will be better because the volume increasing every year. In 2001-02 it was 9335.52 (Rs. in lakhs) And it stood at 21599.27 (Rs. In lakhs) in 2008-09. Every year it is rising except 2003-04.

Centrally Sponsored Schemes (CSS) which is discussed before is played a vital role in the spending on health expenditure. CSS in 2001-02 was 2210.53 (Rs. In lakhs) and it increase in 2002-03. After that it was declining till 2007-08. But in 2008-09 it again in creased and at last it stood at 2924.52(Rs. In lakhs).

Let us discuss percapita public expenditure on health. The population data of Tripura is available from 2004-05 to 2008-09. In this section I find that percapita public spending on health is increasing every year. In 2004-05 it was Rs.299.72 per person which is in 2008-09 was Rs. 607.23 per person. From this it an be seen that Govt. spending on health for per person is increasing and that's a very good sign.

In the methodology part it has been stated that the data analysis is based on tabular and cross tabular method. On the basis of study area and sample data it has been seen that Ishanchandranagar GP having total population of 5619, in that male and female is 2870 and 2749 respectively i.e. 58.08% male and 48.92% female. In the case sample data I find that in the total 100 households total population is 432,in that male and female is 234 and 198 respectively i.e. 54.17% male and 45.83% female ,which is quite similar to the study area data. In the case of total no. of households the study area has 1551 total house holds, in that 1225 household (families) are BPL and 326 are APL i.e. 78.98% BPL and 21.02% APL. In my sample there is 100 families, in that 70 BPL and 30 APL i.e. 70% BPL and 30% PL which is also not very different from the study area data. In the Ishanchandranagar GP there are 812 OBC, 267 SC and 146 GEN families under 1225 BPL families i.e. 66.29% OBC, 21.80% SC and 11.92 GEN. In the sample 41 OBC, 16 SC, 13 GEN under 70 BPL families i.e. 58.57% OBC 22.86% SC and 18.57% GEN which is also very much similar although GEN is little bit low in the sample. In the study area under 326 APL families 204 (62.58%) OBC, 55 (16.87%) SC and 67 (20.55%) GEN and in the sample under 30 APL families 19 (63.33%) OBC, 04 (13.33%) SC and 07 (23.33%) GEN which is also not very different from the study area data. In 1551 families in the study area there is 1016 (65.51%) OBC, 322 (20.76%) SC, 213 (13.73%) GEN and in the sample of 100 families there is 60 (60%) OBC, 20 (20%) SC and 20 (20%) GEN, which is also almost same. In the study area among the 1016 OBC families there is 79.92% BPL and 20.08% APL, among the 322 SC families there is 82.92% BPL, 67.08% APL and among the 213 GEN families 68.54% BPL and 31.46% APL .In the case of sample data among 60 OBC families there is 68.33% BPL and 31.67% APL, among the 20 SC families 80% BPL and 20% APL and among 20 GEN families 65% BPL and 35% APL, which is also quite similar to the study area only percentage of OBC in the study area is little bit high.In the sample house structure is designed as Kutcha, Semi Pucca and Pucca. In the sample I find total 66 house are Kutcha, 32 are Semi pucca and 02 are Pucca. In the 60 Kutcha houses 38 OBC, 16 SC and 12 GEN families are there.

In 32 Semi Pucca houses 210 OBC, 04 SC and 07 GEN and in 02 Pucca houses 01 OBC and 01 GEN. In total GEN having 60% Kutcha, 35% Semi pucca and 05% Pucca houses, SC having 80% Kutcha and 20% Semi pucca houses and OBC having 63.33% Kutcha, 35% Semi pucca and 02% Pucca houses.

In the sample sanitation system is quite similar. In the 100 families 97 are using Pit, 01 Kutcha and 02 Sanitary. In that 20 GEN families 19 using Pit and 01 is Sanitary, in 20 SC families all using Pit and 60 OBC families 58 using Pit, 01 Kutcha and 01 Sanitary.Drinking water facility in this sample is quite same, all are using tube-well for the drinking water purpose, in this 90 families (BPL-62 and APL-28) filter the water before drinking and 10 families (BPL-08, APL-02) does not filtered the water.

In the sample upto Rs. 2000/month earned by 02 households, Rs. 2001-4000/month earned by 68 households, these two groups are BPL consisting of 70 families. Again Rs. 4001-6000/month earned by 09 families, Rs. 6001-8000/month earned by 15 families, Rs. 8001-10000/month earned by only 01 family, these 30 families are APL because their monthly income is above Rs. 4000.

The sample is tells about the age group also in 0 to 05 years there is total 13 people of them 06 male and 07 female, in 06 to 14 years there is 61 people of them 31 male and 30 female, in 15 to 59 years 185 male and 146 female with a total of 331, above 60 years there is 27 people of them 12 male and 15 female.

Occupational pattern in the study area is that in population 5619 there is 2138 (38.05%) are worker and 3481 (61.95%) are non-worker. In the sample the population is 432 of the 148 (34.26%) are worker and 284 (65.74%) are non-worker which is very much similar to the study area data. In the study area among 2138 workers 1942 (90.83%) are male and 196 (9.17%) are female and among the 3481 non-worker 928 (26.66%) are male and 2553 (73.34%) are female. In the sample among 148 worker 136 (91.89%) male and 12 (8.11%) female and among 284 non-worker 98 (34.51%) male and 186 (65.49%) female which is also quite similar to the study area data.

In the sample among the 148 workers cultivation is the main occupation of 20 peoples, daily lobours are 86, business is 12 and service is 30. Among the 284 non workers students are 119, aged people are 11, children 13, house wife are 41. In the previous discussion we find that aged people i.e. above 60 years people are 27 ,but here it is 13 because in that 2714 people are still working somewhat but 13 are totally non worker. Study area data is not available properly that is why not given.

Now after all these comes the main point i.e. spending on health expenditure pattern. In the sample of 100 households all the household consulting allopathy as for treatment purpose, but 4 families are also consulting homeopathy and 2 are consulting ayurvedic for treatment purpose.All the BPL families are having the facility of health insurance but an APL family doesn't. it was explain before in the chapter2.

The total no of disease suffered by the people in the sample of 432 peoples are 472.the no of disease is higher because one person may have more the one disease. The no of disease suffered by the BPL population is 301 and by the APL is 171.infectious disease i.e. fever etc. suffered by the 155 people, of them. 94 BPL peoples and 61 APL peoples musculo skeleton disease i.e. the disease like back pain arthritis, join pain etc suffered by 74, peoples of them 48 BPL and 26 APL, Enteric disease .i.e. the disease like gas , loose motion etc suffered by the86,of them 66 BPL and 20 APL cardiac disease i.e. disease like problem of heart, high blood pressure etc is suffered by 37, of them 15 BPL and 22 APL. Respiratory disease i.e. disease related to respiratory, asthma etc suffered by 19 of them 12 BPL and 7 APL. Nervous system problem i.e. mentally disorder etc suffered by 32, of them 27 BPL and 5 APL. Skin disease suffered by 11, of them 4 BPL and 7 APL. Teeth problem suffered by 10, of them 6 BPL and 4 APL, Eye problem suffered by 10, of them 3 BPL and 7 APL. Other diseases like energy, sugar, pregnancy, physically handicapped, accident, etc suffered by 38, of them 26 BPL and 12 APL. Note that pregnancy and accident is not disease but it needs medical attention that is why this two are taken under other diseases.

Percentage of health expenditure spend depending on income by the 100 household of the sample is that, 0 to 10%, of income spend by 20 household of them 14 BPL and 6 APL household, 10 to 15% of income spend by 48 families of them 31 BPL and 17 APL, 15 to 20% spend by 20 families of the 14 BPL and 6 APL, 20 to 25% spend by 6 BPL families, 25 to 30% spend by 1 family and above 30% of income spend on health by 5 families of the 4BPL and 1APL families.

In the sample the average percapita expenditure on health spends by the people is Rs.161.81/person.

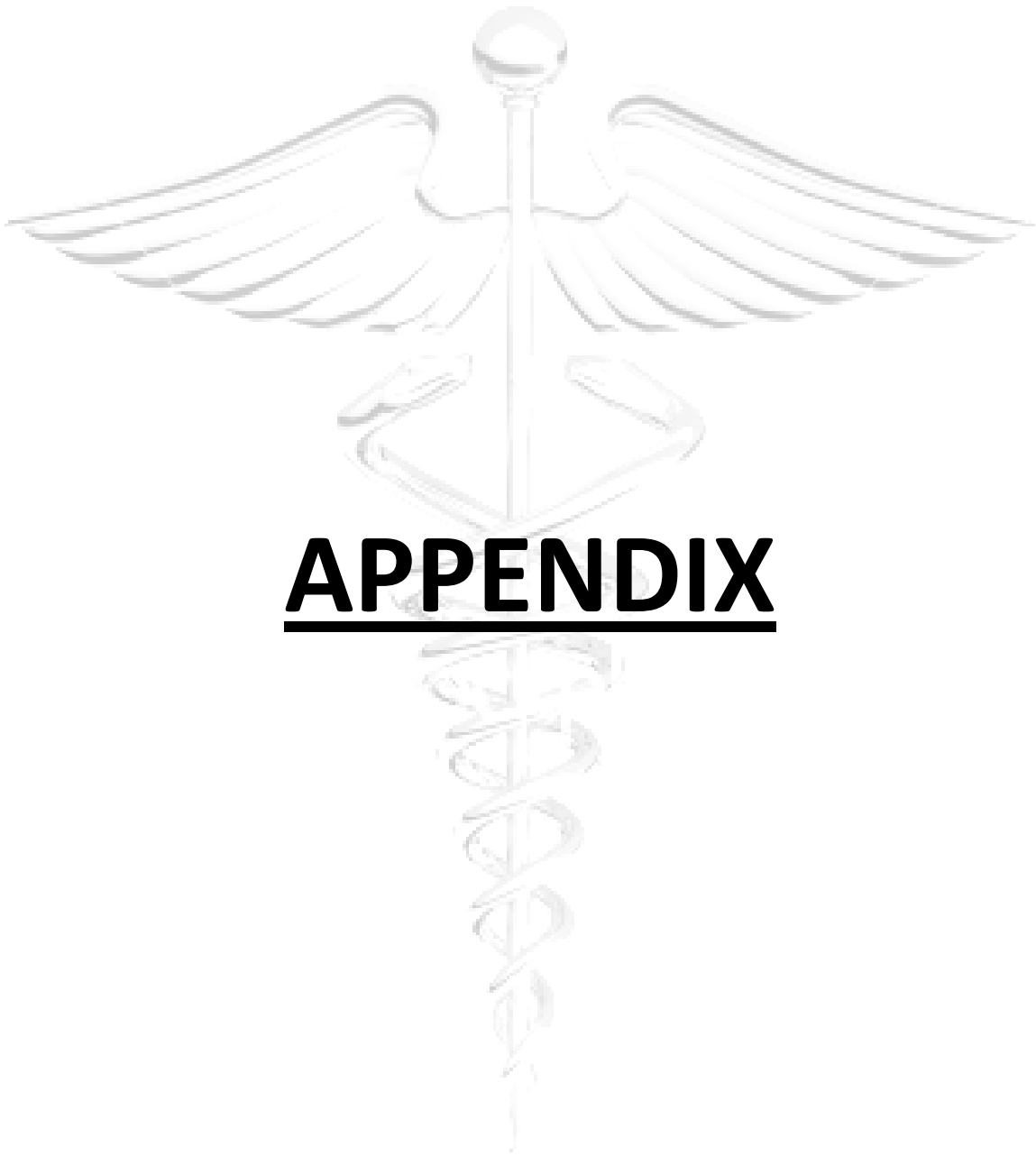
This expenditure is much higher in APL families. In the APL family it is Rs.199.33/ person and in the BPL families it is Rs.142.05/person. This means that APL families are spending more for each person in the family.

Due to illness the average no of days lost is about 5 days in a month. The BPL families lost 4.61days /month and the APL families lost 5.60 days/month. Monetary loss due to loss of working days is 100/day for each BPL and APL families

5.2 Conclusion:-

Having the same kind of medical facility because of Hapania medical college hospital still there is difference in the pattern of health expenditure in the two income group i.e. APL and BPL. APL families spending more for per person than BPL families, but the interesting thing is BPL families are spending their percentage of income more on health expenditure than APL families. This is because BPL families earning less than APL families that is why if APL and BPL both spending same amount of money on health, because of lesser income of BPL families their percentage on health expenditure goes higher than APL families. In this paper we can say that burden of disease is more on BPL families. In factious disease, musculo skeleton disease, enteric disease, Respiratory disease, Nervous system problem, Teeth problem and other diseases all suffered by the BPL families most. Only cardiac disease, skin disease and eye problem suffered by the APL families most. For that reason BPL families have to spend higher percentage of income on health expenditure. But they spend lesser per person amount on health because of low income. Is income is higher than person spending is also higher. In this whole discussion house structure, sanitation system and drinking water facility doesn`t influence the study much. Because the sample is not so large and study area also only one that is why they doesn`t influence much. But occupation structure and income influence the study. Because better occupational will lead to higher income and that will lead to higher health facility and vice-versa.

From the study I will recommend that BPL families should get better health facility by increasing their earning through various Govt. schemes and Govt. has to look at them to increase their earning opportunities. In this area non-workers are at a higher proportion so that Govt. had to implement new projects by this unemployed peoples get some earning option. Public spending on health must be increased for the betterment of health infrastructure in Tripura for each and every class of people in this state.



APPENDIX

Pattern of Expenditure on Health in Tripura

Questionnaire

SL Number

Date:

1. Area information:

District : **Block:** **Gram panchayat:**

Ward No. and Name:

2. Household information:

a) Name of the Respondent:

(Sl. No._____)

b) Pattern of family: Joint ☐ **Nuclear** ☐

c) Community: **GEN-1/SC-2/ST-3/OBC-4/RM-5**

d) APL/BPL.

e) House ownership: Rented ☐ **Owned** ☐

f) Structure of dwelling Unit :

Mud house ☐ **Pucca house** ☐ **Kutcha House** ☐

g) Sanitation

i) Latrine Type:

Sanitary ☐ **Pit** ☐ **Kutcha** ☐ **Open** ☐

ii) Drainage facility: Yes/No

iii) Garbage Disposal: whether collected Yes/No

if No in open space/in pit

Within Household/outside household

h) Drinking water facility: (encircle)

i) Source of drinking water: piped/ tube-well/well/ river/ponds/others (specify)

Within Household ☐ **Outside Household** ☐

ii) Whether drinking water purified: Yes/No

iii) If yes method used to purify: Filtered/ Boiled/ others (specify)

3. Household Members:

Sl. No.	Name	Sex	Age	Level of Education	Marital Status	Occupation	Monthy Income	Disease suffered *
1	HOH-							
2								
3								
4								
5								
6								
7								
8								
9								
10								

*** which needed medical attention in the last one year**

4. No. of earning members:

5 Household Income category -

a) Upto Rs. 2000 b) 2000 - 4000 c) 4001- 6000 d) 6001 - 8000 e) 8001 - 10000 f) above 10000

6. Total monthly expenditure on a) Food :

b) Cloths

c) Education

d) Transport

e) Health

7. Total expenditure on health

(in last 12 months)

8. Type of Doctor consulted :

a) Allopathy : Private / Public Why

b) Homeopathy : Private / Public

c) Ayurvedic : Private / Public

9. Expenditure incurred (For all members):

a) Doctor Visit :

b) Medicine :

c) Diagnostics:

d) Transportation Cost:

e) Others:

10. Do you face any difficulty in seeking treatment due to

lack of fund

distance

lack of time

unavailability of doctors

any other reasons

11. No. of work days lost due to illness:

(in past one week / one month)

12. Monetary loss due to loss of workdays:

13. Medical reimbursement: Yes ☐ **No** ☐

14. Health Insurance : Yes ☐ **No** ☐

If yes: Monthly Expenditure:

15. Do you receive any grant/help from government/other organisation

Investigators comment:

Name of the investigator: _____

The classification of the house type is given below.

House type	*Roof*	*Wall*	*Floor*
Kutcha house	*Tin* *Thutched*	*Mud* *Mud*	*Mud* *Mud*
Semi Pucca house	*Tin* *Tin*	*Brick* *Brick*	*Cement* *Mud*
Pucca house	*Cement*	*Brick*	*Cement*

Name of the 73 PHCs

Narsinghar PHC,Bamutia PHC ,Katlamara PHC ,Mandai PHC,Ranirbazar PHC,Borakha PHC ,Anandanagar PHC , Madhupur PHC ,Kanchanmala PHC,Chacubazar PHC, Kathalia PHC ,Boxanagar PHC, Matinagar PHC,Kamalnagar PHC,Taibandal PHC,Bishramganj PHC,Baijalbari PHC,Tulashikhar PHC,Mungibari PHC,Chebri PHC, Ampura PHC,Fatikroy PHC Kanchanbari PHC ,,Irani PHC,Kanika Memorial (Dhanbilas) PHC,Pecharthal PHC.Machmara PHC,Panisagar PHC,Jalabasa PHC,Uptakhali PHC,Tilthai PHC,Kadamtala PHC,Bungnang PHC, Brajendranagar PHC,Damcherra PHC,Khedachera PHC,Dasda PHC,Anandabazar PHC,Jampui PHC,Karbook PHC,Chelagang PHC,Tirthamukh PHC,Rajnagar PHC,Niharnagar PHC,Barpathari PHC,Hrishyamukh PHC,Nalua PHC,Santirbazar PHC,Jolaibari PHC , Muhuripur PHC, Kalacharra PHC,Srinagar PHC, Rupaichari PHC,Manubankul PHC,Silacharri PHC,Maharani PHC,Garjee PHC, Tulamura PHC Kakraban PHC, Killa PHC,Atharabhola PHC, Salema PHC, Maracharra PHC,Nakashipara PHC,Ambassa PHC, Kulai PHC,Ganganagar PHC,Jagabandhu para PHC,Raishyabari PHC,Manu PHC,82 Miles PHC,Chowmanu PHC,Manikpur PHC

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