

INPATIENTS' SOCIOECONOMIC PROFILE OF PUBLIC HOSPITALS IN MIZORAM

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796004***ABSTRACT**Article DOI URL: <https://doi.org/10.36713/epra3185>

Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals own, which has inherent value (being healthy is an important source of well-being) as well as instrumental value. Researches in social sciences are of empirical in nature and based on the respondents perceptions of socio-economic conditions. Their perceptions are influenced by various socio-economic factors. It is necessary to understand the socio-economic condition of respondents in sociological studies. The study is based on primary data and is conducted between January and March, 2020. For the purpose of the study, 40 indoor patients are randomly selected and interview is done based on the interview schedule which is significant at 10 percent and 90 percent confidence level and hence reflects the entire indoor patients' population of Civil Hospital, Aizawl. This study shows that patients from the rural area have the highest number of inpatients as compared to urban and other town areas—with a total of 20. The annual expenditure on healthcare of indoor patients' family shows that a spending below 5,000 INR annually pertains only to BPL and AAY families with 50 percent each on both. People who are poor or living in relative poverty have the highest frequency with 21 (BPL category) which is 52.5 percent out of the total of 40. Those very poor or AAY have 5 families which is 12.5 percent of the total. Together, families who are in relative poverty and extreme poverty contributes 26 or 65 percent of the total indoor patients studied. Patients' family above the poverty line is 14 or 35 percent of the total. The study concludes that there is a significant relationship between poverty status and the use of public hospital services for inpatients.

KEYWORDS: *Health Economics, Socioeconomic profile, Healthcare, Public Hospitals***1. INTRODUCTION**

Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals own, which has inherent value (being healthy is an important source of well-being) as well as instrumental value. It reduces production losses due to illness, increases the productivity of adult as a result of better nutrition, and lowers absenteeism rates and improves learning among school children. Health also allows for the use of natural resources that used to be totally or partially inaccessible due to illnesses. Finally, it permits the different use of financial resources that might normally be destined for the treatment of ill health.

Health is one of those which most people find it difficult to define although they are confident of its meaning. According to (WHO) World health Organization (1948), Health is defined as "Health is a state of complete physical, mental and social

well-being and not merely an absence of diseases or infirmity". This definition is merely accepted a definition of Health universally. In recent years, this statement has been amplified to include the ability to lead a socially the ability to productive life.

Health care and Economics linkage

Economics as applied to the health field or health economics seeks, inter alias to quantity time, the resources used in health care, their organisation with which resources are allocated and used for health purposes, and the effects of preventive, curative and rehabilitative health services on individuals and on society, as such, health economics has become a distinctive field of study, emphasizing in particular the application of economic theory to the practical problems of improving the use of resources to achieve the supply of effective and health services.

An economic perception of health is in the nature of a merit good, characterized by idiosyncrasies of its own. They are basic only to defining health as a commodity, and in defining demand and supply of this commodity, understanding socio economic magnitudes of health, would be necessary from the operational point of view. Information about socio-economic and personal circumstances of the individuals classified according to health status and the place of residence, the sources of finance, sex and education are necessary to have an in-depth and scientific analysis. Circumstances of the individuals, regions and the nation so that suitable programmes of health can be visualized for improving the health status etc. should prove helpful for policy making in health.

An overview of Indian health care system

In India public healthcare is free and subsidized for those who are below the poverty line. The Indian public health sector encompasses 18 per cent of total outpatient care and 44 per cent of total inpatient care. (Thayyil & Jeeja, 2013) According to the World Bank, the total expenditure on health care as a proportion of GDP in 2015 was 3.89 per cent. Out of this, the government health expenditure as a proportion of GDP is just 1 per cent. Considering the goal of obtaining universal health care as a part of Sustainable Development Goals, scholars request policy makers to acknowledge the form of healthcare that many are using. Scholars state that the government has a responsibility to provide health services that are affordable, adequate, new and acceptable for its citizens. (Dey & Mishra, 2014)

Importance of socioeconomic profile

Researches in social sciences are of empirical in nature and based on the respondents perceptions of socio-economic conditions. Their perceptions are influenced by various socio-economic factors. It is necessary to understand the socio-economic condition of respondents in sociological studies. It is also necessary to understand these factors influencing the socioeconomic background of respondents for the study and Socio-economic background of the respondents.

Researchers such as Richard G. Wilkinson, J. Lynch, and G.A. Kaplan have found that socioeconomic status strongly affects health even when controlling for economic resources and access to health care. (Wilkinson & Pickett, 2009) The most famous for linking social status with health care are the Whitehall studies—a series of studies conducted on civil servants in London. (Marmot, Rose, Shipley, & Hamilton, 1978)

The study of socio-economic background is very important to understand its perceptions regarding subject under study, goals, opportunities, achievements and contributions to society as a social being. These factors include age, residential address, marital status, education, and control on economic activities, economic status and occupation. Social role of a person and his contribution to the society is based on his socio-economic background.

2. LITERATURE REVIEW

In examining the potential impact of socioeconomic differences on rates of hospitalization, based on patterns of hospital use in New York City in 1988, Billings et. al. (1993) suggests that lack of timely and effective outpatient care may lead to higher hospitalization rates in low income areas. The study concludes that further study is needed to determine the relative impact of various economic, structural, and cultural

factors that affect access to care. (Billings, Zeitel, Lukomnik, Carey, Blank, & Newman, 1993)

Kangovi et. al. (2013) states that patients with low socioeconomic status (SES), use more acute hospital care and less primary care than patients with high socioeconomic status. This low-value pattern of care use is harmful to these patients' health and costly to the health care system. Their study concludes that many current policy initiatives, such as creation of accountable care organisations, aim to provide both health outcomes and the cost-effectiveness of health services. Achieving those goals requires understanding what drives low-value health care use. (Kangovi, Barg, Carter, Shannon, & Grande, 2013)

Alter et. al. (2006) argues that gradients that link socioeconomic status and cardiovascular mortality have been observed in many populations, including those of countries that provide publicly funded comprehensive medical coverage. Their study concludes by suggesting that the "Wealth-health gradient" in cardiovascular mortality may be partially ameliorated by more rigorous management of known risk factors among less affluent persons. (Alter, et al., 2006)

In their study of the impact of socioeconomic status on operative mortality which is relatively unexplored, Birkmeyer et. al. (2008) finds that patients with lower socioeconomic status have higher rates of adjusted operative mortality than patients with higher socioeconomic status across a wide range of surgical procedures. Their study concludes by stating that these disparities in surgical outcomes are largely attributable to differences between the hospitals where patients of higher and lower socioeconomic status tend to receive surgical treatment. (Birkmeyer, Gu, Morris, & JD, 2008)

3. OBJECTIVES

- To highlight the socioeconomic profile of indoor patients of Civil Hospital, Aizawl
- To determine the relationship between poverty status and the use of Public Hospitals
- To highlight the nature of relationship between income and the use of Public Hospital

4. METHODOLOGY

The study is based on primary data and is conducted between January and March, 2020. For the purpose of the study, 40 indoor patients are randomly selected and interview is done based on the interview schedule. The questions asked on the interview schedule are both open-ended and closed-ended. The maximum number of indoor patients' census in any particular month during the base period is 263. With this data, 40 indoor patients across various wards are randomly selected which reflect 15 percent of the entire population—as calculated by the maximum number of indoor patients' census in a particular month during the base period, which is significant at 10 percent and 90 percent confidence level and hence reflects the entire indoor patients' population of Civil Hospital, Aizawl. The collected data are analyzed using relevant statistical techniques. Civil Hospital Aizawl has been selected as a representative of all other public hospitals in Mizoram since it has the best facilities as well as the most number of indoor and outdoor patients in Mizoram.

5. FINDINGS AND DISCUSSIONS

Table-1 shows that the age structure of the respondents is broadly classified into six categories. It can be seen that 30-40 and 50-60 have the highest frequency with a total of 8 each and amounts to 20 percent out of the total respondents. The

age distribution below 20 years, 40-50 and above 60 has the second highest frequency, i.e., 7 or 17.5 percent. Patients who are between 20-30 years have the lowest frequency with

only 3 respondents and merely 7.5 percent of the total respondents.

Table-1: Age Distribution of Respondents

Class interval	Frequency	Percent	Valid Percent	Cumulative
Below 20	7	17.5	17.5	17.5
20-30	3	7.5	7.5	25
30-40	8	20	20	45
40-50	7	17.5	17.5	62.5
50-60	8	20	20	82.5
Above 60	7	17.5	17.5	100
Total	40	100	100	

Source: Author's Field Survey, 2020

Table-2 shows the gender distribution of indoor patients of the respondents. There are a total of 40 patients out of which 21 are males and 19 female. It can be seen from the above table that the age distribution of patients is quite

symmetrical, i.e., there is no significant difference between male and female in terms of procuring admission to Civil Hospital Aizawl.

Table-2: Gender of Respondents

Gender	Frequency	Percent	Valid Percent	Cumulative
Male	21	52.5	52.5	52.5
Female	19	47.5	47.5	100
Total	40	100	100	

Source: Author's Field Survey, 2020

Table-3 shows the residential area of the respondents which is broadly classified into three categories, viz., Aizawl, Village and Other Towns area. It can be seen from the above table that patients from the rural area have the highest frequency with a total of 20. There are a total of 17 indoor

patients residing in Aizawl and 3 from other towns, i.e., from the semi-urban areas which are mainly district capitals in Mizoram. It can be said from this table that Civil Hospital Aizawl serves the need of patients from the rural areas more than urban or cities.

Table-3: Residential Area of Respondents

Residential Area	Frequency	Percent	Valid Percent	Cumulative
Aizawl	17	42.5	42.5	42.5
Village	20	50	50	92.5
Other towns	3	7.5	7.5	100
Total	40	100	100	

Source: Author's Field Survey, 2020

Table-4 shows that the types of disease of indoor patients are broadly classified into three broad categories—Chronic, natural and accidental. Chronic disease has the highest frequency with a total of 18 indoor patients, followed by natural causes and accidental with 11 each.

Table-4: Types of Disease of Respondents

Types of Disease	Frequency	Percent	Valid Percent	Cumulative
Chronic Disease	18	45	45	45
Natural Causes	11	27.5	27.5	72.5
Accidental	11	27.5	27.5	100
Total	40	100	100	

Source: Author's Field Survey, 2020

Table-5 shows the residential area and disease type of respondents. It can be seen that natural causes are highest in Aizawl area with 63.60 percent out of 40 indoor patients. Meanwhile, accidental is highest in Village area with 63.60 percent out of 40 indoor patients. Other towns only pertain

to chronic disease with 16.7 percent while Aizawl and Village have 33.30 percent and 50 percent respectively. It can be said from the table that Aizawl area is prone to natural causes and accidental in village area.

Table-5: Residential Area and Disease Types of Respondents

Residential Area	Chronic Disease	Natural Causes	Accidental	Total
Aizawl	33.30%	63.60%	36.40%	42.50%
Village	50.00%	36.40%	63.60%	50.00%
Other towns	16.70%			7.50%
Total	100.00%	100.00%	100.00%	100.00%

Source: Author's Field Survey, 2020

Table-6 shows the occupational structure of the respondents is broadly classified into 8 categories as seen from the above table. It shows that dependents such as students, children, housewives and unemployed have the highest in terms of occupational structure as seen in the figures given in the table. The dependent indoor patients have a

frequency of 20 which is 50 percent of the total indoor patients studied. Among these, housewives have the highest frequency with 9 or 22.25 percent of the total, i.e., 40 or 100 percent. Government employee and agricultural workers have the same frequency with 6 each which amounts to 15 percent of the total. Private employee has the lowest frequency with 3 which amounts to merely 7.5 percent of the total.

Table-6: Occupational Structure of Respondents

Types of occupation	Frequency	Percent	Valid Percent	Cumulative
Govt. Employees	6	15	15	15
Private Employees	3	7.5	7.5	22.5
Daily Wage Earners	5	12.5	12.5	35
Agricultural Workers	6	15	15	50
Students	7	17.5	17.5	67.5
Children	3	7.5	7.5	75
Housewives	9	22.5	22.5	97.5
Unemployed	1	2.5	2.5	100
Total	40	100	100	

Source: Author's Field Survey, 2020

Table-7 shows the poverty status of the respondents' family. In India, poverty status is broadly classified into three categories—Antyodaya Anna Yojana (AAY), Below Poverty Line (BPL) and Above Poverty Line (APL). It is broadly classified into three categories as per Government's classification of poverty status in India. People who are poor or living in relative poverty have the highest frequency with 21 as seen in the BPL category of the table which is 52.5

percent out of the total of 40. Those very poor or AAY have 5 families which is 12.5 percent of the total. Together, families who are in relative poverty and extreme poverty contributes 26 or 65 percent of the total indoor patients studied. Patients' family above the poverty line is 14 or 35 percent of the total. It can be said that most of the indoor patients of Civil Hospital Aizawl are people from below the poverty line.

Table-7: Poverty Status of Respondents' Family

Family Status	Frequency	Percent	Valid Percent	Cumulative
AAY	5	12.5	12.5	12.5
BPL	21	52.5	52.5	65
APL	14	35	35	100
Total	40	100	100	

Source: Author's Field Survey, 2020

It can be seen from the following table, i.e., table 8 that respondents' family income below 50,000 INR is from AAY and BPL family. 83.30 percent are from AAY and 16.70 percent from BPL family. Further, only APL families have an income range of higher than 400,000 INR.

Table-8: Poverty Status and Annual Income Distribution of Respondents' Family

Poverty Status	Annual Income Distribution (INR)					Total
	Below 50000	50000-200000	200000-300000	400000-500000	Above 500000	
AAY	83.30%					12.50%
BPL	16.70%	100.00%	40.00%			52.50%
APL			60.00%	100.00%	100.00%	35.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Source: Author's Field Survey, 2020

Table-9 shows annual expenditure on healthcare of indoor patients' family. It can be seen that a spending of below 5,000 INR annually pertains only to BPL and AAY families with 50 percent each on both. The highest annual expenditure on healthcare is above 40,000 INR where there are 80 percent and 20 percent from APL and BPL respectively. It can be said that most of the respondents' family spends between 5,000 INR and 20,000 INR annually where all the poverty groups are included. In this range, i.e., 5,000-20,000 INR, 11.80 percent are from AAY families, 58.80 percent from BPL families and 29.40 percent from APL families respectively. None of the AAY families spend more than 20,000 INR for healthcare annually.

Table-9: Poverty Status and Annual Expenditure on Healthcare

Poverty Status	Annual Expenditure on Healthcare (INR)				Total
	Below 5,000	5,000-20,000	20,000-40,000	Above 40,000	
AAY	50.00%	11.80%			12.50%
BPL	50.00%	58.80%	85.70%	20.00%	52.50%
APL		29.40%	14.30%	80.00%	35.00%
	100.00%	100.00%	100.00%	100.00%	100.00%

Source: Author's Field Survey, 2020

6. CONCLUSION

The study shows that there is a significant relationship between poverty status and the use of public hospital services for inpatients. This shows that public hospitals in Mizoram are the forefront of health care provisions to the masses especially the economically challenged section of the society. Hence, it can be said that even though public healthcare providers are often maligned and criticized for incompetence, negligence and rampant discrimination, their importance and the role they played for realizing universal basic health care can not be neglected.

REFERENCES

- Alter, D., Chong, A., Austin, P., Mustard, C., Iron, K., Williams, J., et al. (2006). Socioeconomic Status and Mortality after Acute Myocardial Infarction . Annals of Internal Medicine, Vol. 144(2) , pp. 82-93.
- Billings, J., Zeitel, L., Lukomnik, J., Carey, T., Blank, A., & Newman, L. (1993). Impact of Socioeconomic Status on Hospital Use in New York City . Health Affairs, Vol. 12(1) , pp. 162-173.
- Birkmeyer, N., Gu, N. B., Morris, A., & JD, B. (2008). Socioeconomic Status and Surgical Mortality in the Elderly . Medical Care, Vol. 46(9) , pp. 893-899.
- Dey, D., & Mishra, V. (2014). Determinants of Choice of Healthcare Services Utilization: Empirical Evidence from India . Indian Journal of Community Health, Vol. 26(4) , pp. 357-364.
- Kangovi, S., Barg, F., Carter, T. L., Shannon, R., & Grande, D. (2013). Understanding Why Patients of Low Socioeconomic Status Prefer Hospitals Over Ambulatory Care . Health Affairs, Vol. 32(7) , pp. 1196-1203.
- Marmot, M., Rose, G., Shipley, M., & Hamilton, P. (1978). Employment Grade and Coronary Heart Disease in British Civil Servants . Journal of Epidemiology and Community Health, Vol. 32(4) , pp. 244-249.
- Thayyil, J., & Jeeja, M. (2013). Issues of Creating a New Cadre of Doctors for Rural India . International Journal of Medicine and Public Health, Vol. 3(8) , pp. 8-11.
- Wilkinson, R., & Pickett, K. (2009). The Spirit Level: Why More Equal Societies Almost Always Do Better . London : Allen Lane .