Chapter - 5

Health seeking behaviour and patterns of resort to private or public health care institutions

In this chapter, we review very briefly the concept of health seeking behaviour, factors affecting population patterns of resort to different HCIs. We argue that access character of HCIs may not show through pattern of resort data if availability of respective HCIs is a constraint. We then review available evidence on patterns of resort to different HCIs.

This study design did not include a population-based household survey of morbidities and health care consumption behaviour. So we turn to evidence about population patterns of resort to different health care institutions from other studies. There are mainly three regular sources of data on health care consumption behaviour for all India and major states. The National Sample Survey Organisation devotes some rounds of its National Sample Surveys (NSS) to morbidity and health care consumption. Leaving aside the pilots and preparatory work, the NSS-42nd round conducted in 1986-87 was the first of National Sample Survey to have collected and published comprehensive data on ailments and household consumption of health care. The NSS-52nd round conducted in 1995-96 is the most recent National sample data on health care consumption behaviour. The National Family Health Surveys (NFHS) focussing on women in reproductive age also collects information on health care consumption pattern by the respective households. So far two NFHS have been conducted. The NFHS-1 was conducted in 1992 and the second (NFHS-2) was conducted in 1998. We review data from these two sources on people's patterns of resort to different types of health care institutions in times of need. The National Council of Applied Economic Research (NCAER) regularly conducts Market Information Survey of Households (MISH). NCAER appears to have decided to include a component of health care utilisation to the MISH at periodic intervals (Sundar, 1995).

There are important differences in health seeking behaviour for ambulatory care and hospitalisation services. We first present evidence on pattern of report for ambulatory care, and then for hospital services. We then turn to some evidence of differences in pattern of resort by socioeconomic status. Finally we summarise available evidence on health seeking behaviour.

I. Factors affecting pattern of resort to different HCIs

Health seeking behaviour refers to what people do individually and collectively, in order to maintain and / or return to health (Scrimshaw and Hurtado, 1987). The specific steps taken by people to seek health care in times of need is referred to as patterns of resort. For example, people may first resort to self care followed by consultation with a doctor, etc. There is close relationship between patient composition of different types of HCI and patterns of resort to them. Access characteristics of HCIs can be viewed as evidence of patient seeking behaviour of HCIs. Patient seeking characteristic of different types of HCI provide the signal which may be processed by people according to their own perceptions, needs and beliefs. These perceptions about different types of HCIs, along with other circumstantial factor would influence their health seeking behaviour. Accordingly, patterns of resort data is sometimes viewed to directly represent accessibility characteristic of health care institutions. However, there is a subtle difference between people's patterns of resort to different HCIs and accessibility characteristics of the same HCIs. The actual pattern of resort decision is based on many factors in addition to the accessibility characteristics of different types of HCIs. Sundar (1995) observed that the utilisation of health care services depends on many factors including (a) the availability of quality health care services at reasonable distance and (b) on the ability of people to utilise the health service. Provision of appropriate health infrastructure, according to Sundar (1995) is a necessary condition for health care utilisation. For example charitable health care institutions operated by religious and philanthropic organisations are generally very accessible to poor, and may provide good quality care. People may be aware of this feature of charitable health care institutions, but may not be able to resort to such a HCI in times of need, simply because no such HCI is available within a reasonable distance. Suppose we study the health care consumption behaviour in a region with few charitable HCIs and a large number of private HCIs. If we look at the patient composition of charitable HCIs, we will see a larger proportion of socioeconomically poorer people being served by each such charitable HCI. If, however, we look at actual patterns of resort decisions of people to treat ailments, we would see a large number of patients resorting to private HCIs, simply because they are more ubiquitously available.

II. Pattern of resort to private and public HCIs for ambulatory care

Table- 5.1 shows estimates of the probability of resort to private or public HCIs for ambulatory care reported by different nationwide studies on health seeking behaviour. For some reason, the estimates of resort to public HCIs for ambulatory care from the two NSS studies is significantly lower than similar

estimates from the NCAER and the NFHS-2 studies. It is difficult to say which of these estimates are more accurate. Hence we view the range of values reported by various studies as plausible. We see from Table-59 that between 60 to 80% people resort to private sector for ambulatory care. Many people (35 to 55%) resort to private doctor's i.e. solo clinics for ambulatory care. In rural areas, a significant number (8 to 25%) of people resort to the PHCs, ANMs or multipurpose health workers (MPHW) for ambulatory care. Hospitals, both private and public, are also important sources of ambulatory care. In rural areas, between 11% & 18% people turn to public hospitals, and another between 6% to 27% turn to private hospitals or nursing homes, for ambulatory care. In urban areas yet more people resort to hospitals for ambulatory care. In the public sector there is a substantial difference between rural and urban areas. If we look at the rural urban estimates by each of the four studies, we see that for all four studies the percentage of resort to public hospitals was higher by about 5 percentage points. Since the urban areas do not have PHCs there is a corresponding decrease in probability of resort to PHCs. Usage of dispensaries in urban areas is at the same level as usage of multipurpose health workers in rural areas. Later in this report, we have presented evidence suggesting that people from socioeconomically poor households are more likely to resort to the public sector. It would then appear that, in urban areas public hospitals compensate the lack of PHCs and sub centres to some extent.

Table-5.1: Patterns of resort for ambulatory care needs in rural and urban areas in India at different time points, 1986-87 (NSS 42nd), 1993 (NCAER), 1995-96 (NSS 52nd), and 1998-99 (NFHS-2).

	Hospital ownership and type	Rural				Urban			
		1986-87	1993	1995-96	1998-99	1986-87	1993	1995-96	1998-99
Public	Public hospital	18%	17%	11%	11%	23%	26%	15%	17%
	PHC / CHC	5%	20%	6%	15%	1%	0%	1%	3%
	Disp. / MPHW	3%	4%	2%	3%	2%	9%	2%	1%
	All govt. sources	26%	42%	19%	31%	28%	34%	20%	24%
Private	Hospital	15%	6%	12%	27%	16%	10%	16%	34%
	Nursing home	1%		3%			1%		2%
	Charitable HCI	0%	1%	0%	1%	1%	1%	1%	2%
	Private doctor	53%	46%	55%	35%	52%	49%	55%	38%
	All pvt. sources	74%	58%	81%	66%	72%	60%	80%	75%

Source: Estimates for 1986-87 and 1995-96 are from NSS 42nd and 52nd round respectively (NSSO, 1998 Table-4.10, p22). Estimate for 1993 is from the NCAER-MISH on health care utilisation (Sundar, 1995). Estimates for 1998-99 from India NFHS-2 Table-9.1, IIPS & ORC Macro, 2000.

It is difficult to say with great deal of certainty if the probability of resorting to private HCIs for ambulatory care has changed over time. Only two of the four point estimates are from studies with exactly similar methodology. These two are the NSS 42nd and 52 nd rounds. The NCAER study in 1993 followed a methodology pretty much similar to that of the NSS 42nd round. Estimates from this study gives a lower probability (58%) of resort to private HCIs for ambulatory care in 1993 compared to the estimate for 1987-88 obtained from NSS 42nd round (74%). If we compare the two rounds of NSS (42nd and 52nd) we see an increase, between 1987-88 and 1995-96, in the probability of resorting to private HCI for ambulatory care. Overall it appears that the probability of resorting to private HCIs for ambulatory care has either remained constant over the last two decades or has increased marginally.

Table-5.2: Changes between NSS 42nd (1986-87) and 52nd (1995-96) rounds in the pattern of resort to public sector for ambulatory care in India.

Rural		State	Urban	
1986-87	1995-96		1986-87	1995-96
12%	22%	Andhra Pradesh	16%	19%
40%	29%	Assam	26%	22%
14%	13%	Bihar	17%	33%
28%	25%	Gujarat	18%	22%
15%	13%	Haryana	19%	11%
32%	26%	Karnataka	30%	17%
32%	28%	Kerala	33%	28%
24%	23%	Madhya Pradesh	28%	19%
21%	16%	Maharashtra	15%	17%
37%	38%	Orissa	43%	34%
12%	7%	Punjab	11%	6%
46%	36%	Rajasthan	52%	41%
28%	25%	Tamil Nadu	31%	28%
*	8%	Uttar Pradesh	14%	9%
16%	15%	West Bengal	20%	19%
21%	19%	India	24%	20%

Source: NSS 52nd round report, Table-4.11, NSSO, 1998.

Considering India's size and diversity it is quite natural that National level estimates may not apply to all states. Take for example the data on changes in patterns of resort to public sector for ambulatory care (Table-5.2). Comparison

of all India estimates from NSS 42nd (1986-87) and 52nd rounds shows that the probability of resorting to a public sector HCI for ambulatory care reduced in rural areas from 21% in 1986-87 to 19% in 1995-96 and in urban areas from 24 to 20%. However, the estimates for Andhra Pradesh show that probability of resorting to a public HCI increased between the two surveys both in urban as well as in rural areas. Around 1986-87 in rural areas of AP the probability of resorting to public HCI for ambulatory care was 12%. This increased to 22% in 1995-96. Similarly in case of urban areas, the probability of resorting to a public HCI increased from 16% in 1986-87 to 19% in 1995-96. In rural areas of Orissa, the probability of resort to public HCIs for ambulatory care increased marginally from 37% to 38%. Thus it will not be correct to assume that the National pattern holds for all states. Moreover, study of statewise variation in pattern of resort may give some insights about the factors affecting health seeking behaviour of people. This is what we attempt in the following paragraph.

Statewise estimates of resort to private or public HCIs for ambulatory care is available from the two NSS surveys (42nd and 52nd rounds) and the NCAER survey in 1993. Table-5.3 shows the pattern of resort for ambulatory care by people in different states. The per capita public sector expenditure on health in respective states as well as the percentage of hospital beds in government sector are also given. Two sets of Pearson correlation coefficients are computed and shown in the bottom two rows. These are simple correlation, without controlling for any other variable. The first set of coefficients estimate the correlation between the probability of resorting to different type of HCIs and the per capita government expenditure on health. The second set of coefficients are the correlation between the probability of resort to respective type of HCIs and the percentage of hospital beds in the government sector. Review of these correlation shows that probability of resorting to a public health care institution in times of need for ambulatory care varies widely between states. There appears no relationship between the people's inclination to seek care from public sector HCIs and the level of government expenditure on health. The correlation with the percentage of total hospital beds in the government sector is low but the signs are consistent. There is a weak inverse relationship between the relative size of government health sector expressed in share of hospital beds and the probability of resort to government institutions for ambulatory care. There is some negative correlation between the level of government expenditure on health and the proportion of people deciding not to seek any ambulatory care in time of need. In other words people living in states where the government is spending more on a per capita basis on health care, are more likely to seek ambulatory care when they need.

Table-5.3: Pattern of resort for ambulatory treatment and per capita public expenditure on health in major states. NCAER-1993, and NSS 52nd round, 1995-96

PEH	Rural					State	Urban				
/ cap	NCAER-93		NSS52nd 1995-96				NCAER-93		NSS52nd 1995-96		
	Pvt.	Pub.	Pvt.	Pub.	None		Pvt.	Pub.	Pvt.	Pub.	None
99	58	42	92	7	1.0	Punjab	74	24	91	6	3.0
97	56	39	84	13	3.0	Haryana	56	38	87	11	2.0
96	30	66	54	36	9.0	Rajasthan	37	52	50	41	8.0
78	53	44	73	16	11.0	Maharashtra	65	33	77	17	6.0
77	44	50	54	25	21.0	Tamil Nadu	56	37	65	28	7.0
71	66	32	61	28	11.0	Kerala	52	42	62	28	10.0
65	36	62	27	29	43.0	Assam	49	50	41	22	38.0
58	62	34	62	23	15.0	Madhya Pr.	61	34	75	19	6.0
55	77	20	65	15	20.0	West Bengal	66	31	72	19	9.0
54	61	36	67	25	7.0	Gujarat	60	35	75	22	3.0
54	40	60	51	26	23.0	Karnataka	47	46	74	17	9.0
47	13	70	31	38	31.0	Orissa	45	42	53	34	13.0
43	65	31	83	8	9.0	Uttar Pr.	77	18	85	9	6.0
40	59	37	53	22	25.0	Andhra Pr.	57	34	68	19	13.0
36	48	37	65	13	22.0	Bihar	62	26	53	33	14.0
70	**58**	**42**	**64**	**19**	**17.0**	**All India**	**60**	**34**	**72**	**20**	**8.0**
1.00	-6%	20%	34%	-3%	-51%	*r(.,PEH/cap)*	-13%	27%	23%	-12%	-27%
	-38%	36%	-16%	15%	13%	*r(.,BedsinGov)*	-16%	17%	-19%	20%	9%

Source:NSS 52nd round report, Table-4.11, NSSO, 1998. Data on public expenditure on health is also taken from Table-4.11, NSSO, 1998. *r(.,x)* = Correlation between data in respective columns and per capita public expenditure on health (PEH/Cap) or hospital beds in govt. sector, as the case may be. NCAER data from Sundar (1995) Tables-14 & 15.

The NCAER-MISH survey on health care utilisation (Sundar, 1995) also corroborates the findings from other studies that as socioeconomic status improves, people tend to resort to private health care institutions more often. Estimates of resort to private and public health care institutions for ambulatory care are shown in Table-5.4. These estimates are from the survey in 1993 applicable for all India. Clearly the proportion of patients resorting to public HCIs tend to decrease as the annual household income increases, or the literacy level of the household increase. Another study (Chirmule and Gupte, 1997) on health seeking behaviour in certain districts of Maharashtra, Gujarat, Karnataka,

Uttar Pradesh and Rajasthan, certain districts in India also reported that utilisation of health services was linked with the ability to pay for the cost of service. This study found that people with higher incomes preferred seeking private treatment. People with low income, few or no assets either did not seek treatment or resorted to the public health care institutions.

Table-5.4: Patterns of resort for ambulatory care to different HCIs by household income and literacy. All India estimates from NCAER survey 1993.

	Rural		Urban	
	Private	Public	Private	Public
Annual household income (rupees)				
≤ 18000	50.9%	43.4%	52.3%	41.7%
18001-54,000	54.5%	39.8%	62.8%	30.5%
> 54,000	69.3%	27.6%	74.6%	20.7%
Highest level of education in the household				
No formal education	40.2%	48.5%	50.3%	44.5%
Primary	50.8%	48.5%	48.9%	44.2%
Higher secondary	57.6%	37.8%	59.2%	35.3%
Graduate and above	52.0%	42.6%	67.6%	24.9%

Source: Household survey of health care utilisation, Sundar (1995) Table-17.

III. Patterns of resort to private and public HCIs for hospital care

We now turn to available evidence on pattern of resort for hospital care. In Table-5.5, we show data on patterns of resort to public and private hospitals estimated by the National Sample Survey for the years 1986-87 and 1995-96 and by the Market Information Survey of Households (MISH) about health care utilisation conducted by the NCAER, in 1993. Around the year 1986-87, in rural areas of India, 60% people who needed hospitalisation resorted to a public hospital. This pattern of resort appears to have continued at least till 1993 when the NCAER survey on health care utilisation was conducted. Thereafter, by 1995-96, the proportion of people resorting to public hospitals had reduced to 44%. At the first sight, one may be lead to believe that accessibility and / or quality of service in public sector hospitals must have reduced between the two surveys. However, we can neither confirm nor deny such hypotheses based on data about patterns of resort alone. As discussed earlier, other factors may have contributed to changes in patterns of resort to different types of HCIs. For example, if enough public hospital facilities are not available or the growth in private hospital capacity has outpaced public hospital construction activity, then

the pattern of resort data will show lower share of hospitalisation in public hospitals compared to private hospitals. Although the probability of resorting to PHC/CHC for hospitalisation was low, there was no change in this figure between the two surveys both in rural and urban areas. So the reduced level of resort to public hospitals would be applicable to the bigger hospitals which are located in urban areas. The growth of private sector over the last decade has been quite high in these areas. We saw in Figure-3.1, based on data from this study, that the private health sector has experienced rapid growth during the 1980s and 1990s. The relative reduction in share of public hospital beds might have, to some extent, contributed to reduction in the probability of resort to public hospitals.

Table-5.5: Patterns of resort for hospitalisation needs in rural and urban areas in India at different time points, 1986-87 (NSS 42nd)), 1993 (NCAER), and 1995-96 (NSS 52nd).

	Hospital ownership and type	Rural			Urban		
		1986-87	1993	1995-96	1986-87	1993	1995-96
Public	Public hospital	55.4%		39.9%	59.5%		41.8%
Public	PHC / CHC	4.3%		4.8%	0.8%		0.9%
Public	Public dispensary	-		0.5%	-		0.4%
Public	All Govt. Sources	59.7%	62%	43.8%	60.3%	60.1%	43.1%
	Hospital	32.0%		41.9%	29.6%		41.0%
	Nursing home	4.9%		8.0%	7.0%		11.1%
	Charitable institution	1.7%		4.0%	1.9%		4.2%
	Others	1.7%		0.8%	1.2%		0.6%
	All non-govt. sources	40.3%	38%	56.2%	39.7%	39.9%	56.9%

Source: Estimates for 1986-87 and 1995-96 are from NSS 42nd and 52nd round respectively (NSSO, 1998 Table-4.16, p28). Estimate for 1993 is from the NCAER-MISH on health care utilisation (Sundar, 1995).

Table-5.6 shows share of all hospitalisations for which people resorted to public hospitals in different states reported by the NCAER-1993 survey and the NSS 52nd round, 1995-96. In addition, public-private composition of hospital bed capacity in the respective states has been shown as the percentage of total hospital beds in government hospitals. These figures are from the Central Bureau of Health Intelligence (CBHI) annual compilation of hospital data, reproduced by the NSS 52nd round report. The CBHI data on hospital bed capacity relies on reports sent up from state public health departments, which do not

have any regulatory mechanism to keep an account of the private sector hospitals. Thus, the CBHI figures on share of hospital beds in government sector should be viewed as overestimates. See for example the figures for Madhya Pradesh and Rajasthan. According to the CBHI data, cent percent of hospital beds in these two states was in government sector. This is implausible. There are definitely quite a few private hospitals and nursing homes in these two states, as well. However, we can use these figures to give us a rough idea about the relative size of public sector.

The states, in Table 5.6 have been arranged in descending order of the percentage of total hospital beds in government sector. This shows that states like Orissa, Rajasthan, MP, West Bengal, and Assam are yet to develop a sizeable number of private sector hospitals. Clearly, states where the relative size of public sector hospital beds is higher tend to have a greater share of people resorting to public hospitals for treatment. According to the NCAER survey in 1993, the probability of resort to public hospitals was about 60% and more in states like Assam, West Bengal, Orissa, Punjab, Rajasthan, Haryana, Madhya Pradesh, Uttar Pradesh, Kerala, Karnataka, and Bihar. According to the NSS 52nd round, the probability of resort to public hospitals was about 60% or higher in states like Orissa, West Bengal, Assam, and Rajasthan. These same four states showed high reliance on public hospitals according to the NCAER study results. The correlation coefficient between percentage of hospitalisations in government hospitals and percentage share of hospital beds in government is about 0.6 for the two surveys, both in rural and urban areas. Another pattern is that the probability of resort to public hospitals is generally lower than the proportion of hospital beds in the public sector. We have pointed out earlier that the CBHI estimate of hospital numbers and beds would under-report private hospitals. Thus the true proportion of hospital beds in government sector will be less than the proportion reported by CBHI. Our conjecture is that, the pattern of resort to private or public hospitals may be similar to the relative share of hospital beds in the two sector. There is evidence from this study, that the bed occupancy in private sector hospitals is not higher than that in public hospitals. The turnover rates are also pretty much similar between the two sectors. If there is no difference in capacity utilisation between the two sectors, the proportion of patients handled by each sector would be similar to the proportion of beds in each sector. Consequently, the probability of resort to hospitals in the two sectors will be more or less proportional to their share of total hospital bed capacity.

Table-5.6: Pattern of resort to government hospitals in various states, 1993 (NCAER) and 1995-96 (NSS).

State	NCAER-MISH, 1993		NSS 52nd round, 1995-96		Hospl. beds in
	Rural	Urban	Rural	Urban	Govt.
Orissa	98.1%	68.7%	90.6%	81.0%	91%
West Bengal	100.0%	76.8%	82.0%	72.1%	87%
Assam	100.0%	100.0%	73.8%	65.2%	84%
Tamil Nadu	14.6%	49.6%	41.1%	35.7%	79%
Uttar Pradesh	64.9%	59.7%	47.1%	39.8%	75%
Karnataka	61.1%	57.8%	45.8%	29.8%	74%
Punjab	95.3%	67.2%	39.4%	27.6%	74%
Bihar	59.3%	63.1%	24.7%	34.6%	71%
Haryana	73.5%	65.9%	30.5%	37.3%	68%
Maharashtra	30.5%	58.8%	31.2%	31.8%	52%
Gujarat	32.2%	27.2%	32.1%	36.9%	43%
Kerala	64.7%	64.2%	40.1%	38.4%	36%
Madhya Pradesh	72.2%	72.7%	53.3%	56.0%	100%
Rajasthan	78.1%	88.8%	64.9%	73.1%	100%
Andhra Pradesh	30.6%	56.1%	22.5%	36.2%	10%
All India	**62.0%**	**60.1%**	**45.3%**	**43.1%**	**65%**
Corr. with % beds in govt. →	**58%**	**55%**	**67%**	**58%**	**1.00**

Source: NSS 52nd round report, Table-4.17, p28, NSSO, 1998. NCAER: Sundar (1995)

IV. Socioeconomic status and pattern of resort to health care:

The NFHS-2 (IIPS & ORC Macro, 2000) household questionnaire included a question "When members of your household get sick, where do they generally go for treatment?". The NFHS computed a standard of living index (SLI) based on ownership of durable goods by the households. The SLI is a reasonable proxy of economic status. Three SLI categories, namely low, medium, and high were constituted by the NFHS for tabulation of data by socioeconomic status. Table-5.7 shows the patterns of resort to different HCIs reported by women from households classified by SLI and rural - urban residence of the respondent households. Both in AP and all India, the probability of resorting to a private

sector HCI increases as economic status increases. The opposite is the case for public sector HCIs. The probability of resorting to public HCIs decreases as socioeconomic status increases. For example, in all India, probability that a household with low SLI will resort to a public HCI for medical care was 34% compared to 19% for high SLI households. There's hardly any difference between the rural and urban areas of AP about people's inclination to resort to a public or private HCI for medical care. But for all India, probability of resorting to a public HCI is higher in rural areas (31%) compared to urban areas (24%). The absolute level of the probability of resort to a public HCI is however, low. It was 30.6% for rural India compared to 66.2% for the private sector. For urban India, the probability of resorting to a public HCI was 23.5% compared to 74.8% for private sector HCIs. In Andhra Pradesh, the difference is still more. In rural AP, the probability of resorting to public HCIs was 14.6% compared to 81.9% for private HCIs. In urban areas of AP, the probability of resorting to public HCIs was 15.3% compared to 81.2% in urban areas.

Table-5.7: Patterns of resort to different HCIs by household standard of living index, and rural - urban areas. All India and AP, 1998-99.

		Private			Public		
		Doctor	Hospital / Clinic	All private	PHC/Rural Hospital	Urban Hospital	All public
Standard of living index (SLI)							
AP	Low	23.6%	49.2%	76.7%	7.9%	8.3%	19.4%
	Medium	24.3%	56.5%	83.8%	4.2%	6.1%	13.2%
	High	16.5%	68.7%	89.8%	0.9%	3.5%	6.4%
India	Low	33.7%	24.0%	62.5%	16.7%	13.5%	34.0%
	Medium	36.3%	30.0%	69.3%	11.0%	13.2%	28.3%
	High	38.7%	37.8%	78.8%	4.5%	10.9%	19.0%
Rural - Urban Residence							
AP	Rural	24.5%	53.1%	81.9%	6.3%	5.9%	14.6%
	Urban	18.4%	61.5%	81.2%	2.1%	8.9%	15.3%
India	Rural	35.0%	27.3%	66.2%	15.4%	11.3%	30.6%
	Urban	38.4%	34.1%	74.8%	2.6%	17.0%	23.5%

Source: India NFHS-2 Table-9.1, IIPS & ORC Macro, 2000, and Andhra Pradesh NFHS-2, Table-9.1, IIPS & ORC Macro, 2000 AP

V. Summary of evidence about health seeking behaviour

Let us summarise the available evidence on patterns of resort to private and public HCIs. All the four nationwide surveys conducted during the 1980s and 1990s show that majority of people (60% to 80%) resort to the private HCIs for ambulatory care. In rural areas, however, significant number of people (10% to 20%) turn to the Primary Health Centres or Sub centres for ambulatory care. The level of resort to private HCIs for ambulatory care, has remained constant or marginally increased between the 1980s and 1990s. However, there are notable regional exceptions to this trend. For example, in Andhra Pradesh, the level of resort, for ambulatory care, to public HCIs increased during this period. In rural areas of AP the number of people resorting to public HCIs increased from 12% in 1986-87 to 22% in 1995-96. In urban areas of AP, the increase was comparatively less, from 16% in 1986-87 to 19% in 1995-96. There is some evidence to suggest that the proportion of people who do not seek any ambulatory care in times of need is higher in states spending comparatively less money on public health services. For inpatient care, traditionally more people have been resorting to the public hospitals. Till 1993, about 60% of people needing inpatient services resorted to the public sector. The situation appears to be changing. By 1995-96 the proportion of people resorting to public hospitals for inpatient services reduced to about 43% with a corresponding increase for the private sector. We have found in this study that private hospitals and nursing homes have grown at a much faster rate in numbers and bed capacity during the 1980s and 1990s. This would appear to be the most plausible explanation for the increase in resort to private hospitals during the 1990s. Estimates of pattern of resort to private and public HCIs by socioeconomic status reveal that people from poorer households tend to rely more on public HCIs. As socioeconomic status increases more and more people resort to the private HCIs. At the all India level, people in rural areas tend to rely more on the public sector. In AP, however, the rural-urban difference is not so much.