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Entitlements to health care: Why is there a preference for private facilities among poorer residents of Chennai, India?

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This paper examines access to health care by poorer residents in Chennai, India. It reveals constraining and enabling conditions for impoverished users seeking treatment. We explore patterns of health-seeking behaviour through the reasoning of residents themselves as well as stakeholders involved in providing care for these users. Particular attention is paid to the needy residents' preference for private health care providers despite the costs involved and that free public facilities are available. We address this issue by combining Sen's entitlement approach with Penchansky and Thomas' work on access to health care. Based on data gathered in a qualitative field-based research design including interviews with 14 residents and 58 stakeholders involved in caring for poor people, we argue that the availability of health care facilities within walking distance is a necessary but not sufficient precondition for satisfactory access. Rather, we demonstrate the influence of 'entitlements to health care' which allow poor households that are endowed with resources such as income, knowledge and social networks to realise access. The narratives we present reveal not only experiences of health care, but also feelings about its utilisation. The latter, we contend, are crucial in determining choice of health care facilities. This finding suggests that analyses of affordability and physical access to health care in less developed countries should include a focus on emotional dimensions of utilisation. In other words, there is a need to consider not only *effective* access to health care, but also *affective* dimensions of treatment for poorer citizens.

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Introduction

Most of India's population still lives under marginal conditions (Planning Commission, 2008), and continues to suffer from infectious health threats, but is increasingly prone to lifestyle diseases such as diabetes or cancer (e.g. Nanda & Ali, 2006; Sakdapolrak, 2007). Costs in the health care system, therefore, rise not only due to the double burden of diseases and infrastructure costs, but also because of the increasing need for health care personnel (MoHFW, 2002). Health care resources tend to be concentrated in urban areas and predominantly in the private sector (e.g. Akhtar, 2004; De Costa, Al-Muniri, Diwan, & Eriksson, 2009; Peters et al., 2002). The literature on developing countries in the 1980s and 1990s concluded that urban residents are generally healthier than their rural counterparts as they have better access to health-related resources and services such as basic infrastructure and health care (e.g. Harpham, 2009; Phillips, 1990). Nonetheless, this "urban advantage" has been challenged by various studies (e.g. McGranahan, Songsore, & Kjellén, 1999; Montgomery, Stern, Cohen, & Reed, 2004; Stephens & Satterthewaite, 2008).

A more recent consensus is that living in cities in the developing world tends to be associated with an "urban penalty" as the process of rapid urbanisation and resulting overburdened infrastructure exposes residents to various social and environmental risks (e.g. Akhtar, 2002; Krafft, Worf, & Aggrawal, 2003). However, it is more accurate to speak of a "health penalty for the urban poor" (Harpham & Molyneux, 2001), as they are the ones who suffer most from the numerous environmental, economic and social risks that shape health status in a changing urban environment. This is the case, for example, in India where the *National Family Health Survey* (2005–06) revealed the worsening of an intra-urban health inequality, which had already loomed in previous surveys (Singh et al., 2004).

Although health care facilities are concentrated in cities, the geographical availability and physical proximity of facilities do not necessarily imply better access for poorer residents as other factors

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also play a role (i.e. Acharya & Cleland, 2000; Andersen, 1995; Butsch, 2008; Dilip, 2005; Obrist et al., 2007; Penchansky & Thomas, 1981). For example, a study from Delhi reveals that impoverished residents mainly attend private sector facilities which involve out of pocket payments despite the provision of care at subsidised government facilities which are meant for those with fewer resources (Gupta & Dasgupta, 2003). Given this context, we focus on the case of Chennai, India and examine the ability of poorer urban residents to access health care, and why they express this 'private preference'. We argue that the mere availability of health services does not guarantee access and thus a good health status for poor urban dwellers.

We draw on the health care accessibility literature (e.g. Penchansky & Thomas, 1981) and combine it with insights from Amartya Sen's (1981) entitlement approach, to address the question of *why poor residents prefer to utilise private facilities despite the availability of free public services*. We employ a qualitative research design informed by a holistic health-geographical approach and present data from semi-structured interviews with slum residents as well as stakeholders in the health care system. This engagement with users, planners and providers complements mapping of the facilities around two slums in order to gain a critical understanding of the health care landscape in Chennai. Our approach to understanding the local expression of a local health concern (i.e. the links between poverty, health and access to health care) allows us to explore the complex nature of entitlements to health care in this emerging mega city. In the following sections we introduce the theoretical framework of the study, describe the research design in more detail, and present and discuss the fieldwork results. We conclude by reflecting on access to health care and suggest the importance of considering affective dimensions of utilisation in cities like Chennai.

Entitlements to health care: A research framework

In "*Poverty and Famines*" (Sen, 1981) and elsewhere Sen and colleagues (Drèze & Sen, 1989, 1997; Sen, 1990) emphasize the connection between the availability of food and entitlements to this resource. They argue that availability does not guarantee the prevention of famines. Inequalities in distribution and accessibility may generate famines even if overall food supplies are sufficient. Consequently, they shift their focus to access and entitlements instead of supply. This approach has been successfully used to explain access issues in different contexts (e.g. Fünfgeld, 2007; Leach, Mearns, & Scoones, 1999; Pryer, Rogers, & Rahman, 2005).

By analogy, just as the mere availability of food cannot prevent famine, we argue that the presence of health care services cannot guarantee good health status for slum inhabitants. Rather, it is their entitlements to health care that shape their access to facilities and affect their well-being. According to Sen (1984, p. 479) entitlements are

> "*the set of alternative commodity bundles that a person can command in a society using the totality of rights and opportunities that he or she faces.*"

Sen's approach is legalistic, economic and descriptive, but not normative. Therefore, entitlements refer not to what people *should* have, but to the range of possibilities they *can* have (Leach et al., 1999). Entitlements originate in the transformation of endowments (e.g. land or labour) into a set of opportunities. Accessing these entitlement relations is based, for example, on production, trade or inheritance (Sen, 1981). Consequently, Sen is interested in the extent to which people in different contexts are able to transform their endowments into entitlements in order to improve their well-being and capabilities.

People are more vulnerable to disease if their entitlement set does not include a commodity bundle with adequate access to health care facilities, or if their endowment or exchange entitlements decline such that they become unable to acquire a commodity bundle with the necessary access to health care or to be able to cope with diseases (Watts & Bohle, 1993). It is important to note that the poor in India are, in principle, entitled to free access to public facilities and pharmaceuticals. However, command over health-related goods and services depends upon more than just legal or formal rights.

Leach et al. (1999, p. 233) refine and extend Sen's approach to include "*the whole range of socially sanctioned, as well as formal institutional mechanisms for resource access and control*". Hence, they respond to the often-levelled critique that Sen's approach focuses solely on property and legal rights (e.g. Devereux, 2001; Fünfgeld, 2007; Gore, 1993) by including an institutional dimension in their framework. Institutions are not stable entities; rather they are (re)negotiated on a regular basis and may entail formal and informal relationships. Consequently, we see cultural and historical settings as well as social interactions (e.g. patterns of obligation and duty within and among communities, households and state systems) as central to the context of entitlements to health care.

Following Watts and Bohle (2003) we regard entitlements to health care as being socially constructed and unstable. As Watts (2002, p. 12) explains, both "*social networks and positionality determine whether and what sorts of entitlements are available*". Our approach, therefore, covers both social and cultural dimensions and the subjective, emotional and psychological perspectives of the urban poor and stakeholders in the health care system. In brief, following Leach et al. (1999), entitlements to health care refer to all alternative sets of utilities derived from social goods and services over which social actors have legitimate effective command and which are instrumental in achieving well-being (see Fig. 1). Therefore, we see the entitlement approach as a potential tool for improved understanding of the opportunities and constraints poor people face in transforming their endowments into entitlements to health care.

In order to address accessibility, we integrate ideas from Penchansky and Thomas (1981) into our entitlement framework (see Fig. 1). These authors identified five factors that influence the realisation of health care: *Availability* refers to the adequate supply of health care infrastructure, whereas *accessibility* depends on the spatial and geographical location of health care providers and their users, whereby travel cost and time are taken in account. The term *accommodation* describes the organisational structures of health care services (e.g. waiting time or opening hours, and the patient's ability to cope with these structures). The need for patients to have the financial means to use the available health care is termed *affordability*. Lastly, the relationship between users' attitudes towards the providers and vice versa is summarized under the umbrella of *acceptability*.

We consider these five factors influencing access to health care as potential entitlement barriers. But given our focus on their endowments (Sen, 1981) we are interested in how poor people can surmount these access barriers in order to gain health care entitlements. Rather than framing an inadequate health status as simply caused by access problems, a more disaggregated entitlement approach considers the role of a range of institutions in mediating the relationship between different actors and components of the health care system. Therefore, it is important, as Andersen (1995) notes, not only to know the characteristics of the population utilising the health care system, but also the characteristics of the system itself.

Applying the entitlement approach in this way stretches it further than Sen's original concept, by seeking insights into not only

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