Reviews/Analyses

Health care utilization patterns in developing countries: role of the technology environment in “deriving” the demand for health care

A.V. Wouters

Health care services, in combination with several intermediate (proximate) determinants of health such as environmental sanitation and nutrition, directly influence health status. In the economics literature, this is referred to as the health production technology. Although many studies recognize that demand for health care depends on the health production technology, otherwise known as a “derived” demand, this review indicates that few of them have so far been able to fully incorporate this technology in estimating significant determinants of health care use.

Understanding the technology environment could help explain why substantial portions of the population do not gain access to care even when financial factors do not appear to be a barrier. Also, low utilization of health services may simply reflect the low productivity of these services when other complementary factors such as nutrition or clean water and sanitation are lacking. Finally, since health-producing technology is often a multistep (multivisit) process, health care demand studies generally offer an incomplete picture of health care utilization patterns because they focus on a single event such as the first visit of an illness episode.

Researchers should obtain more complete information on the interaction between all health production inputs, their availability and access to them. Multidisciplinary methodologies are likely to be useful.

Introduction

In developing countries, poor economic trends and budget cuts in the health sector have forced policymakers to consider alternative sources of funding for health activities, e.g., the imposition of user fees. Several donor agencies such as the World Bank, Unicef, WHO, and USAID (United States Agency for International Development) have launched major initiatives to investigate the potential for cost recovery (by charging for services in public facilities) in the health sector (1-3).

In order to identify new strategies for health care financing, a great deal of research in health economics has attempted to estimate the importance of financial factors such as time price, cash price, travel price, and income in influencing patients’ utilization of various health care providers in the less developed countries (LDCs). Conceptually, many of these health care demand studies recognize that health care services are valued for their contribution to health rather than for something in themselves. These services, in combination with several intermediate (proximate) determinants of health such as environmental sanitation and nutrition, have a direct influence on health. In the economics literature, this is referred to as the health production function. The demand for health care depends on the available health production technology, otherwise known by economists as the “derived demand” for health care. In this review of health care demand studies, we find that a major aspect of the derived demand for health care has yet to be fully addressed by current studies, namely, how the health production technology affects the use of health care services. As will be shown, development of this aspect, both conceptually and empirically, could significantly improve our understanding of health care demand patterns in the less developed countries.

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This theme is developed in three major steps. First, key components of the household production of health and the derived demand for health care are reviewed. Second, selected empirical findings of a representative sample of health care demand studies are examined in the light of this theme. Additional evidence from anthropology is briefly introduced. Finally, methodological approaches to test these concepts are discussed.

Health care demand

The concept of household production of health

To understand the role of health care in health promotion, economists refer to Becker's framework which compares the household to a small firm which maximizes its welfare through the production of basic commodities such as health (4). The household combines its time and purchased market goods (such as medical care) to promote the health of its members, a process which depends on the health production technology environment which is available and known by the household. The technology environment specifies the array of inputs available to produce a commodity, in this case health, and how they are combined. The challenge to the household is to maximize the welfare of the household within the household budget constraint, using the available household health production technology. The demand for health care services is "derived" from a situation where welfare maximization occurs within certain constraints. Following this approach, one finds that the willingness to pay for health care from a particular provider or for another health input depends on its marginal productivity (i.e., incremental contribution) to health and on the available amounts and prices of other inputs to health. Becker does not focus his theory on health, but it has been widely applied to health.

One of the most complete and rigorous applications of economic production theory to health is Grossman's human capital model (5). Although Grossman's approach includes only medical care, he states that other inputs such as nutrition, water supply and sanitation could be important inputs in the health production function. His model, however, does not explain the relationship between investment in health and non-age-related illnesses.

The public health literature offers some clear guidelines on what the major input requirements for health are. Mosley & Chen (6) identify a set of proximate determinants that directly influence the risk of morbidity and mortality. Major categories include: maternal health care, environmental contamination, nutrition, and personal illness control (preventive and curative). DaVanzo & Gertler (7) suggest that the health production model is simply an economic analogue to Mosley and Chen's analytical framework of proximate determinants. Patients and households promote health through combinations of and substitutions between these proximate determinants or, in economic terms, factor inputs to health.

In developing countries, personal illness can be controlled through a variety of different providers (public, private, traditional) whose services can be substitutive or complementary. Environmental services include clean water and sanitation, vector control and so on. Nutrition covers access to calories, protein and micronutrients.

Implications of derived demand for health care

Following this conceptual framework, efficient demand for health care by a rational individual is determined by its marginal productivity and its price relative to other health input prices and marginal productivities. In other words, health care demand is a function of the total price (money and time) of the chosen health care provider service, the total price of other health care provider services, the total price of nutrition inputs, the total price of environmental inputs, full income, and the marginal productivity of each input. Inputs may be either substitutive or complementary. To understand health care demand one must be able to assess its marginal contribution to health; therefore, the health production technology—or in Becker's terms, the technology environment—must be specified. To date, the health production technology environment has been minimally explored in the economics literature on health care demand, either conceptually or empirically, and merits further research.

Health production technologies usually vary with the type of health problem. Mosley & Chen (6) show clearly that health status changes not only with age, but also with illnesses which may be independent of age. Some diagnoses require intensive medical care while others depend more on nutrition and/or sanitation. For example, Habicht et al. (8) found that mother's milk had its greatest effect in promoting child survival in areas where water and sewage facilities were poor.

Akin (9) notes that the conditions for health care demand in the less developed countries are substantially different from those in developing countries because many of the factors assumed to be homogeneous in the latter are quite heterogeneous in the former group of countries, factors such as housing, water, income, nutrition and so on. Health care
demand studies for the developing countries are unique because they usually try to explain the choice of provider, that is, choice of a factor input to health, rather than the amount of health care consumed. For these reasons, identifying the technology environment including the full specification of the variety of health-producing technologies are essential tasks for explaining health care demand in the developing world. In the next sections, representative health care demand studies for the less developed countries are examined in terms of how they address this aspect.

**Health care demand in the LDCs and health production technology**

Some health care demand studies depend on a model where satisfaction is obtained directly from the health service (10-13). Individuals are motivated to seek health care because it feels good to obtain the care. In this framework, patients do not consider how health care may complement or substitute with other inputs to health to improve their health status. These latter studies do not include a health production function. Other health care demand studies conceptualize health care demand using health production functions (14-18). Based on the previous review of production theory, these studies should be reviewed in the light of two major questions about health-producing technology: (1) Is the technology environment fully represented (e.g., all technology options)? (2) For each technology, is the technology fully specified (type and amount of inputs)? Approaches to the health production technology environment are discussed below by reviewing the literature in terms of the recognition of multiple technologies, multiple inputs, and multiple visits in an episode of illness.

**Multiple technologies**

Each treatment protocol consists of a combination of major inputs such as Western medical care, traditional medicine, self-treatment, nutrition, clean water and sanitation. Health production models must capture the relationship between the specific health need and the available health technologies to treat it and must identify how the inputs interact to influence health.

Tables 1 and 2 show that the relationship between specific health need and health production in health care demand studies is usually dealt with by restricting the empirical estimation to a subset of patients (e.g., adults versus children) and to a subset of illnesses (e.g., acute morbidity), and occasionally by using indicators of illness severity. The question is whether these subdivisions are homogeneous enough in terms of health problems to be characterized by the specified health technology.

For example, in the Nigeria study (10), all symptoms included in the survey (cough, fever, stomach pain, diarrhoea, weakness, headache,

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Table 1: Aspects of selected health care demand studies in the less developed countries

<table>
<thead>
<tr>
<th>Study authors</th>
<th>Country</th>
<th>Type of health care</th>
<th>Age group</th>
<th>% of ill persons not reporting care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dor et al. (16)</td>
<td>Côte d'Ivoire</td>
<td>Outpatient</td>
<td>15+</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Gertler et al. (17)</td>
<td>Peru</td>
<td>Inpatient, outpatient</td>
<td>16+</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Gertler &amp; Alderman</td>
<td>Pakistan</td>
<td>Outpatient</td>
<td>&lt;5 years</td>
<td>26% (self-care)</td>
</tr>
<tr>
<td>Heller (18)</td>
<td>Malaysia</td>
<td>Outpatient, inpatient</td>
<td>All</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Mwabu²</td>
<td>Kenya</td>
<td>Inpatient, outpatient</td>
<td>All</td>
<td>38% (self-care)</td>
</tr>
<tr>
<td>Akin et al. (11)</td>
<td>Philippines</td>
<td>Outpatient</td>
<td>&lt;5 years</td>
<td>38%</td>
</tr>
<tr>
<td>Akin et al. (12)</td>
<td>Philippines</td>
<td>Outpatient</td>
<td>Adult</td>
<td>36%</td>
</tr>
<tr>
<td>Akin et al. (13)</td>
<td>Philippines</td>
<td>Outpatient, deliveries</td>
<td>Children and adult</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Akin et al. (10)</td>
<td>Nigeria</td>
<td>Outpatient</td>
<td>16+</td>
<td>29%</td>
</tr>
<tr>
<td>Bitran (14)</td>
<td>Dominican Republic</td>
<td>Outpatient</td>
<td>All</td>
<td>62%</td>
</tr>
<tr>
<td>Bitran (15)</td>
<td>Zaire</td>
<td>Outpatient</td>
<td>All</td>
<td>20%</td>
</tr>
</tbody>
</table>

* See footnote b above.

* See footnote a above.
Table 2: Further aspects of selected health care demand studies in the less developed countries

<table>
<thead>
<tr>
<th>Study authors</th>
<th>Period of care</th>
<th>Illness category</th>
<th>Production of health framework</th>
<th>Other inputs to the production of health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dor et al. (16)</td>
<td>1 visit</td>
<td>Primary health care</td>
<td>Yes</td>
<td>Unobserved quality of care measures: age, patient education, gender, healthy days, number of adults, number of children, amount of land</td>
</tr>
<tr>
<td>Gertler et al. (17)</td>
<td>1 visit</td>
<td>Accident, acute illness</td>
<td>Yes</td>
<td>Unobserved quality of care measures: age, type of illness, location of provider, education, family income</td>
</tr>
<tr>
<td>Gertler &amp; Alderman*</td>
<td>1 visit</td>
<td>Acute morbidity</td>
<td>Yes</td>
<td>Unobserved quality of care measures: age, diagnosis, illness duration, height-for-age, mother's education, household size</td>
</tr>
<tr>
<td>Heller (18)</td>
<td>Outpatient, with inpatient referral</td>
<td>Acute morbidity</td>
<td>Yes</td>
<td>Preventive care, age, index of water supply, index of sewage disposal, infant mortality rate in community</td>
</tr>
<tr>
<td>Mwabu b</td>
<td>4 visits per episode</td>
<td>General morbidity</td>
<td>No</td>
<td>Indirectly via possibility of 4 visits</td>
</tr>
<tr>
<td>Akin et al. (11)</td>
<td>1 visit</td>
<td>Acute morbidity</td>
<td>No</td>
<td>Efficiency of production: mother's education</td>
</tr>
<tr>
<td>Akin et al. (12)</td>
<td>1 visit</td>
<td>Acute morbidity</td>
<td>No</td>
<td>Indirectly via asset measures: quality of water, quality of toilets</td>
</tr>
<tr>
<td>Akin et al. (13)</td>
<td>1 visit</td>
<td>Primary health care</td>
<td>No</td>
<td>Efficiency of production: education</td>
</tr>
<tr>
<td>Akin et al. (10)</td>
<td>2 visits</td>
<td>Acute morbidity</td>
<td>No</td>
<td>Indirectly via asset measures: toilet in home, piped water in home</td>
</tr>
<tr>
<td>Bitran (14)</td>
<td>1 visit</td>
<td>Acute morbidity</td>
<td>Yes</td>
<td>Unobserved quality of care measures: age, gender, education, accident, type of illness</td>
</tr>
<tr>
<td>Bitran (15)</td>
<td>1 visit</td>
<td>Acute morbidity</td>
<td>Yes</td>
<td>Unobserved quality of care measures: age, gender, education, bed confinement, fever, inactivity, perceived severity, other diagnoses</td>
</tr>
</tbody>
</table>

* See footnote b on page 383.  
*b See footnote a on page 383.
guinea worm, burns, bites and stings, poisoning and falls) were tested both individually and in various combinations, while controlling for severity (number of days the patients were unable to carry on with normal activities because of health problems). Only stomach pain and diarrhoea were found to be statistically significant predictors of the health care choices which included various public and private Western-type providers, but not traditional care. This may be because the choices of health providers included in the empirical estimation were not appropriate for the other symptoms. In reviewing these findings, Nigerian policy-makers stated the importance of the informal health sector (various traditional providers) in treating these illnesses. Data on these providers are difficult to collect.

A remarkable finding of health care demand studies is that 26–62% of those who are ill do not gain access to any health care. These results are summarized in Table 2. Authors of the studies often interpret these findings in terms of patients having access to alternative technologies that are not included in their health care demand model.

In the case of Santo Domingo, Bitran (14) finds that as much as two-thirds of those who perceive themselves to be ill do not seek care, at least as captured by the survey instrument. In many cases it is expected that they use unreported sources of traditional care or self-treatment.

Although there is some evidence that absence from the Western health care market is related to the direct measures of household income, financial factors appear not to be the binding constraint on the decision to use the modern health care system. Most health care demand studies find low price sensitivity in the choice of whether or not to seek any medical care regardless of income (10–16, 18).d

According to the study in Ogun State, Nigeria (10), if the prices of public health care drop to zero from an average of 1.20 naira, the probability of nonconsultation would decrease slightly (from 53% to 50%). Doubling the price of health care would increase self-care from 52% to 55%, again only a small change. The study in the Bicol region of the Philippines gave similar results (12). In the choice of adult outpatient care, case price does not have a significant effect on the decision to use modern health care; however, waiting-time price is significant. In an analogous study of child health services in the Bicol region (11), it was shown that money price is not significant in the decision to use modern health care.

Heller (18) obtained similar results for Malaysia using a different methodology. He concluded that total medical demand, as measured by the absolute volume of outpatient and inpatient consumption, appeared highly inelastic to cash price, income or time.

A study in Côte d'Ivoire (16) calculated net travel time elasticities for those moving in and out of the professional market and found that they were lower than cross-price elasticities among provider choices. Gertler et al. (17) reported that, for a selected population in Peru, price elasticities for those moving in and out of the professional market was modest, yet larger for lower income groups. Using the same conceptual and empirical techniques, Bitran (14, 15) found price insensitivity for seeking medical care in the Dominican Republic and Zaire. In the case of Zaire, this effect was greatest at higher price levels.

The implications of these findings are perhaps best expressed by Akin (13), who concluded that a service supply system designed to overcome the low-income barrier may be focused on an assumed constraining factor that is not overwhelmingly important, while missing others that are. Here we draw attention to the role of the technology environment.

Anthropologists (19) have looked more closely at local perceptions of health and illness, including patterns of distress to explain the use of various health care providers, and have investigated beliefs about the causation of illness. The anthropological literature provides evidence that even slight differences in patterns of illness distress motivate patients to alter their choice of health-producing technology. For example, families in Tamil Nadu, India, attend the outpatient clinic of the medical college for simple diarrhoea. For the more serious disorder called "dosham", they consult traditional healers skilled in Ayurveda and Siddha medicine. They also consult a manthramkaran healer with special knowledge of sacred verses. Because they consider "dosham" a matter of ritual pollution, these people believe allopaths cannot help. The anthropologic literature is replete with such examples. Such ethnographic findings should enable researchers of health care utilization to formulate useful hypotheses about the range of technologies patients choose from, depending on the type of illness.

Technology specification: multiple inputs

Ideally, data should be collected on as many "inputs" to health as possible. Table 2 lists the inputs to the production of health used in each study. Heller (18)

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d See footnote b, page 383.
includes preventive services, the hygienic quality of the environment (index of water supply, index of sewage disposal), health status (age), and virulence of disease agents in the community (e.g., regional infant mortality rates). He also attempts to link inpatient and outpatient behaviour which most other studies are unable to do. He recognizes, however, that with the available data, he is not able to capture the technological and physiological complementarity between alternative types of providers.

Many of the health care demand studies which include a health production function \((14-18)\) propose that improvement in health is a function of the quality of care rendered by a specific provider, where quality of care is referred to as the marginal productivity of health care. Since data on the quality of care are rarely available, quality is proxied with a parametric function of individual characteristics such as age, sex, education, and income as well as health care provider attributes such as time and cash prices and other facility features. Although these factors may influence the effectiveness of health care, we have seen conceptually that the effectiveness of health care may also depend on the availability of other proximate determinants to health, such as nutrition and environmental sanitation. These health care demand studies to date have not yet fully addressed the significance or importance of the full range of health inputs beyond medical care.

Those health care demand studies which do not include a health production function in the conceptual framework interpret the nonmedical care inputs to health as measures of assets. For example, Akin \((12)\) uses household quality of water and quality of toilets as indicators of wealth; they are significant in choosing public and private providers over traditional care, and public and private providers over no care. It is reasonable to suspect that these variables also operate as inputs to health, affecting the marginal productivity of certain types of health care. Future research should attempt to clarify the role of such variables.

In a relevant study, Sirageldin & Diop \((20)\) carefully examine the implications of differences in availability of multiple inputs to health (nutrition, environmental contamination, medical care) on equity of health care utilization and on health status. They note that selected inputs to health are publicly subsidized nonuniformly across communities. They conclude that when complementary inputs to health care have lower subsidies, the health benefit (the marginal value product) of the use of health services should be lower. Accordingly, a low household utilization of health services may simply imply a rational decision reflecting the low productivity of these inputs.

### Technology specification: multiple visits

Although medical treatment often involves several visits, data constraints often limit health demand models to the analysis of a single visit, as shown in Table 2. For acute morbidity, the single visit assumption is more reasonable. In Nigeria it was reported that only 11% of patients return for a second visit \((10)\).

Mwabu \((21)\) does the most extensive examination of the multiple-visit phenomenon. He shows that, in general, 67% of patients return for a second visit, 40% for a third visit, and 24% for a fourth visit. Mwabu allows for the interdependence of visits in his empirical estimations by including a variable for repeat visits. He interprets this variable to mean that patients are learning about their illnesses as they visit different providers and it is because of this learning that their probabilities of returning to some clinics rise while others fall in subsequent periods. Mwabu observes that in their visits to several clinics in the modern health care sector, patients may come to learn that the causes of their illnesses cannot be removed by the types of treatment received from modern clinics. This would be the case especially if the patient comes to believe that his or her health problem could be due to a curse or a spell and not to what modern providers call “disease”. In this case, the patient or his/her family would choose to move from modern clinics to traditional clinics. It should, of course, be noted that patients with illnesses that are due to the causes mentioned above may first visit the modern clinic with the aim of going to a traditional healer later. Mwabu finds that, in Kenya, as the number of visits in an illness period increases, the probability that the patient would visit a traditional healer rises while that of a visit to any other provider falls. This also reinforces the perspective that the health promoting technology is need-specific.

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\* See footnote b on page 383.

\footnote{As shown in equations \((1)\) and \((2)\), improved health depends on the quality of care (sometimes referred to as the marginal productivity of health care) rendered by a single provider. Quality is unobservable and proxied by a parametric function of patient and provider attributes:}

\[ H_j = f(Q_j, H_j) \]

\[ Q_j = g(Z_j, X_j) \]

\[ \text{where } H_j \text{ = health status after care from provider } j; H_j = \text{expected health status without care}; Q_j = \text{quality of provider } j; Z_j = \text{health care provider attributes}; \text{and } X_j = \text{individual characteristics}. \]

\footnote{See footnote a on page 383.}
Enhanced health care demand studies: methodologies

For both conceptual and empirical reasons, health care demand studies should be enhanced to more fully incorporate the role of health technology in the demand for health care. The implications for data collection and methodology are significant.

Economists have made important advances in developing and analysing household surveys which link sociodemographic and economic information with health care utilization data. Statistically rigorous empirical techniques for examining the determinants of discrete choices between multiple providers have been developed. However, although many health care demand studies recognize health care as one among many factors which constitute the health promoting technology, they are still missing important information about these technologies.

Data collection efforts should include much more complete information on the availability and prices of all inputs to health. Public subsidy patterns may vary across individuals, households and communities and it will be important to know them in calculating real income and relative prices of inputs. The public health literature should be consulted to correctly identify interactions, if any, between health inputs in promoting health.

In addition, ethnographic and anthropological surveys may usefully complement these household surveys. Since household and ethnographic surveys are each a sizeable effort in itself, it is not likely that undertaking both a household and an ethnographic survey would be feasible for research on health care utilization. Another approach would be for economists to complement household data sets with rapid assessment techniques to collect background information on the sociocultural environment. This would enable researchers to formulate culturally-relevant hypotheses and develop additional questions which might be incorporated in the household survey to identify the various health technologies. Substantial support already exists for a mixed-methods approach to assist in development planning (22, 23). On the one hand, incorporation of qualitative anthropological research methods within a large household survey would improve data validity (24). On the other hand, such surveys would provide additional information about the processes of seeking health care which cannot be obtained from traditional household survey methods.

Further consideration of public health literature, public policies on the distribution and access to the various health inputs, and rapid assessment techniques to complement household surveys on health care utilization should not only improve future data collection efforts, but also open the possibility that existing data sets can be re-examined. For example, some refinement may be possible to distinguish health-promoting technologies (categorization of illnesses, identification of perceived causes, interaction of inputs) and more fully specify each technology (multiple inputs, multiple visits).

Conclusions

Empirical findings from health care demand studies support the importance of giving further attention to issues of health technology. Understanding the technology environment could help explain why substantial portions of the population do not have access to care when financial factors do not appear to be the barrier to access. Also, low utilization of health services may simply reflect the low productivity of these services when other complementary factors are missing. Also, this approach recognizes that patients often require a sequence of visits to resolve a health problem.

Data collection efforts should include much more complete information on the availability and prices of all inputs to health. Close examination of the public health literature and review of public policies on subsidies and access to health inputs should be useful here.

Multidisciplinary methodologies are likely to be necessary to enhance conceptual and empirical research on health care demand. Anthropological literature may provide useful insights for developing hypotheses relevant to health care demand. A possible approach might be for economists to complement their traditional household surveys with rapid assessment techniques to collect relevant background information on the sociocultural environment. This would enable researchers to formulate culturally-relevant hypotheses and develop additional questions which might be incorporated in the household survey to identify the various health technologies. These methodologies should not only improve future data collection efforts, but also open the possibility that existing data sets can be re-examined.

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Résumé

Conditions d’utilisation des services de santé dans les pays en développement: rôle de la technologie dans la formation de la demande de soins de santé

Dans les pays en développement, la précarité de la conjoncture économique et les compressions budgétaires effectuées dans le secteur de la santé ont obligé les dirigeants à envisager d’autres sources de financement des activités sanitaires, en faisant par exemple supporter une partie des coûts aux usagers. Face à cette conjoncture, de nombreux travaux de recherche en économie sanitaire ont consisté à savoir dans quelle mesure les facteurs financiers influaient sur le choix des prestataires de soins de santé dans les pays moins avancés. Dans bon nombre de ces études relatives à la demande de soins de santé, il est proposé que les services de santé soient évalués en fonction de leur contribution à la santé et non de leur valeur intrinsèque. Ces services, combinés à plusieurs déterminants intermédiaires de la santé comme l’hygiène du milieu et la nutrition, ont des répercussions directes sur l’état de santé. Dans les études économiques, cette fonction est qualifiée de fonction de production sanitaire. La demande de soins de santé procède d’un comportement en vertu duquel le ménage cherche à retirer un maximum de bien-être des prestations sanitaires dans les limites d’un budget donné et des techniques de production sanitaire existantes. Ce tour d’horizon des études relatives à la demande de soins de santé nous a permis de constater que rares sont les travaux qui étudient réellement le rôle que jouent les techniques de production sanitaire dans l’estimation des déterminants importants de l’utilisation des soins de santé.

Ce thème est développé selon trois grands axes. Les éléments constitutifs de la production sanitaire au niveau des ménages et la demande qui en découle sont tout d’abord passés en revue. Un certain nombre de données empiriques provenant d’un échantillon représentatif d’études sur la demande de soins de santé sont ensuite examinées à la lumière de ce thème. Des indications anthropologiques supplémentaires sont brièvement données. Enfin, des approches méthodologiques visant à vérifier les notions présentées sont envisagées.

Théoriquement, le prix que les particuliers sont prêts à payer pour une prestation de santé donnée dépend des productivités marginales relatives (c’est-à-dire de l’efficacité additionnelle) et des prix relatifs des soins de santé et des autres éléments. Il faut, si l’on veut estimer la demande de soins de santé, examiner la gamme complète des technologies sanitaires pour chaque besoin de santé en tenant compte des consultations et des apports multiples.

Il ressort de conclusions empiriques d’études portant sur la demande de soins de santé qu’il importe de prêter une plus grande attention aux questions relatives à la technologie sanitaire. On pourrait sans doute, si l’on connaissait les technologies existantes, expliquer pourquoi une partie importante de la population n’a pas accès aux soins lorsque l’obstacle ne semble pas être de nature financière. La faible utilisation des services de santé peut aussi simplement refléter la faiblesse de la productivité de ces services lorsque d’autres facteurs complémentaires font défaut. Cette approche montre également que les malades ont souvent besoin de plusieurs consultations pour résoudre un problème de santé donné.

Il serait donc utile d’avoir des informations plus complètes sur la disponibilité, les prix relatifs et l’interaction de tous les éléments de la production sanitaire. Il faudra sans doute utiliser des méthodologies pluridisciplinaires pour faire progresser les recherches théoriques et empiriques sur la demande de soins de santé. Les études anthropologiques peuvent être utiles pour élaborer des hypothèses applicables à la demande de soins de santé. Les économistes pourraient par exemple compléter leurs enquêtes traditionnelles sur les ménages par des techniques d’évaluation rapides permettant de recueillir les informations de base utiles sur l’environnement socioculturel. Les chercheurs pourraient ainsi formuler des hypothèses tenant compte des différentes cultures et mettre au point des questions supplémentaires qui pourraient être intégrées dans l’enquête sur les ménages afin de recenser les diverses technologies sanitaires, ce qui permettrait non seulement d’améliorer la collecte de données, mais aussi de réexaminer les données existantes.

References


