



CONSUMPTION EXPENDITURE PATTERN OF HOUSEHOLDS WITH OLDER ADULTS IN KARNATAKA; EVIDENCES FROM LONGITUDINAL AGEING STUDY IN INDIA (LASI)

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Abstract: Consumption expenditure pattern showing type of goods and services households buy and expenditure share on such goods, important to understand materialistic satisfaction. Proposed study interested to analyse consumption expenditure pattern of households with individuals aged 45 and above (older adults) in Karnataka. Study based on data gathered by LASI wave 1 and useful for appropriate fiscal policies and measures, ensuring households wellbeing with older adults. For Karnataka, LASI had covered 1488 households with individuals aged 45 and above, three stage rural sampling design and four stage urban sampling design, interviewed eligible respondent and their spouse irrespective of age. It is found that, more than half of household expenditure incurred towards non-food expenditure and little less than half incurred towards food. Monthly Per capita Consumption Expenditure (MPCE) decreased as the household size increases. When household is poor expenditure share on food is more. This pattern of household expenditure behaviour has important policy implication in terms of pro-poor pricing through fiscal measures to ensure equity. Out of pocket spending (OOPS) on health has positive relationship with level of economic status of households. About 9.5% of MPCE spent on medical expenses by households with older adults indicating the burden of medical expenditure, very close to catastrophic expenditure defined by LASI. Nearly half of OPD spending is for medicines. Therefore generic medicine consumption is critical for better health care. Because OOPS and catastrophic expenditure effect poor the most there is likely to increase autonomous consumption expenditure, calls for appropriate insurance package to protect the such households from economic impoverishment.

Keywords: older-adults, expenditure pattern, catastrophic-expenditure, health-insurance, equity.

JEL Classifications: D1, D31, D63, I13

THE BACKGROUND

Consumption pattern of a household/individual refers to the type/category on which consumer spends. It not only refers to the type of goods and services that a consumers buy, but also the share of his expenditure on various goods and services. Based on the category of goods/services, consumers' expenditure on goods or services, can be broadly categorised as food- expenditure and non-food expenditure. Food is the basic expenditure that every individual has to incur some expenditure irrespective of his of income at one point of time. The quality and quantity may vary depending on households/individual income level. However, expenditure pattern on food and non-food item depends on changes in the level of income of individual/household and also on **utility**¹ of a good. Since expectation and economic need of different age group changes by age Ann (2015), understanding the pattern of expenditure of persons aged 45 and above (older adults) would throw some light on their social and health needs. In the Indian context, financial security in older ages affects social prestige and impacts the elderly's decision-making capabilities. With poor social security measures and a weak pension system providing meagre pension Kulkarni *et al.* (2017), therefore a major proportion of elderly live in poverty. Such poverty-driven financial insecurities limit the healthcare utilisation capacities for the elderly, leaving a gap in health service provision. The average household size in India has been decreasing over the past few decades owing to varying factors like disintegrating joint family system. Niranjana and Sarita (2005). Such transitions have major economic implications for India's adults and elderly population in terms of HH consumption pattern. A major proportion of elderly persons are not covered under old-age pension schemes Rajan *et al.* (2020). This creates a major gap in universal coverage and the utilization of social security measures in India. There is a lack of scientific literature on socio-economic status of adults in India.

Therefore, LASI made an attempt to fill this gap by producing evidence-based data on 'pattern of consumption expenditure of adults across different socio-economic, demographic units are very critical to chalk out policy formulations on social security measures, health care coverage and assured pension schemes to elderly.

Based on LASI data the current study has intended to see what is the consumption expenditure pattern of older adults including their expenditure on health.

METHODOLOGY

The Study Design

The target population for the Longitudinal Ageing Study in India (LASI) Wave 1 included all Indian adults and elderly men and women age 45 and above and their spouses who reside in the same household, irrespective of age. In accordance with the conventional practice for other population-based surveys, the LASI sampling frame included only household population. The LASI is designed to provide reliable estimates of all health outcomes and social and economic wellbeing indicators for older adults age 45 and above,

including spouses less than age 45 representative to India's population and also for all of its 30 states and 6 union territories according to 2011 census. The main objective of the LASI is to study the health status and the social and economic well-being of older adults in India. Within each state, LASI Wave 1 adopted a three-stage sampling design in rural areas and a four-stage sampling design in urban areas. In each state/UT, the first stage involved the selection of Primary Sampling Units (PSUs), that is, sub-districts (Tehsils/Talukas) and the second stage involved the selection of villages in rural areas and wards in urban areas in the selected PSUs. In rural areas, households were selected from selected villages in the third stage. However, sampling in urban areas involved an additional stage. Specifically, in the third stage, one Census Enumeration Block (CEB) was randomly selected in each urban area. In the fourth stage, households were selected from this CEB. As the states and union territories differ greatly in size, the sample was allocated proportionate to the size of the states and union territories

The Sample Size

The Karnataka state is purposively selected considering the fact that proportion of household members less than 60 years of age is comparatively higher in Karnataka (58%) (LASI 1). For Karnataka state the Number of PSUs are 16 with total 80 SSUs (ie 5 SSU from each PSU). The targeted HH from each SSU are 25 to form 2000 HHs, with targeted age eligible respondent are 2000. Ultimately 2420 age eligible interviews were completed covering 1488 HH

Reference Period

Expenditure heads of households may be broadly divided in to two groups. One is Food expenditure and other one is non-food expenditure (Annexure-1). All the food expenditure has reference period of 7 days. Non food expenditure has mainly two components; one is household expenditure on non durable goods and other one is household medical expenditure. The reference period varies based on the type of goods that consumer purchases/ services received. Accordingly for all the expenditure related to recurring non food expenditure has reference period of 30 days. Other non durable expenditure that rarely recurs has reference period of 365 days. Similarly under medical expenditure inpatient expenditure has reference period of 365 days, while out-patient expenditure has reference period of 30 days. Since MPCE gives average expenditure for 30 days, all the expenditure head which has not having reference period of 30 days were converted in to 30 days as per LASI Methodology.

ANALYSIS

The data is analyzed using SPSS package. The results are given in tabular form and through figures wherever necessary. Extensive reviews are made to support the evidences quoted in the report.

Assumption of the Study

- i) The price level is constant throughout the survey ie price of goods and services under consideration in the survey remained constant during survey period.
- ii) There is no change in real income of respondents throughout the survey period.
- iii) The taste, preferences and **speculations**² of the consumers of any household surveyed would remain constant in short-run

Consumption expenditure pattern of households with older adults

Understanding the share of different consumption expenditure heads in the MPCE is very relevant from macroeconomic policies related to social securities and economic welfare of older adults. **Fig 1** shows percentage distribution MPCE on food and non-food expenditure³ in households with members aged 45 and above. It is witnessed from the figure that, more than half of the expenditure in households with older adults is incurred towards consumption of non-food expenditure and little less than half of the expenditure is incurred towards food. Non-food expenditure broadly includes expenditure for housing, education, health, travelling and other durable goods. Out of total consumption expenditure, around 9.5 percent of expenditure reported to be incurred for medical purposes indicating the burden of medical expenses and also extent of **out-of-pocket expenditure (Fig 2)**. The overall share of medical expenditure (9.5%) out of MPCE which is very close to the predefined threshold limit for catastrophic expenditure (10%) under LASI. The share of expenditure out of MPCE shows wide variations across the different socio-economic and demographic groups were explained in the subsequent discussions.

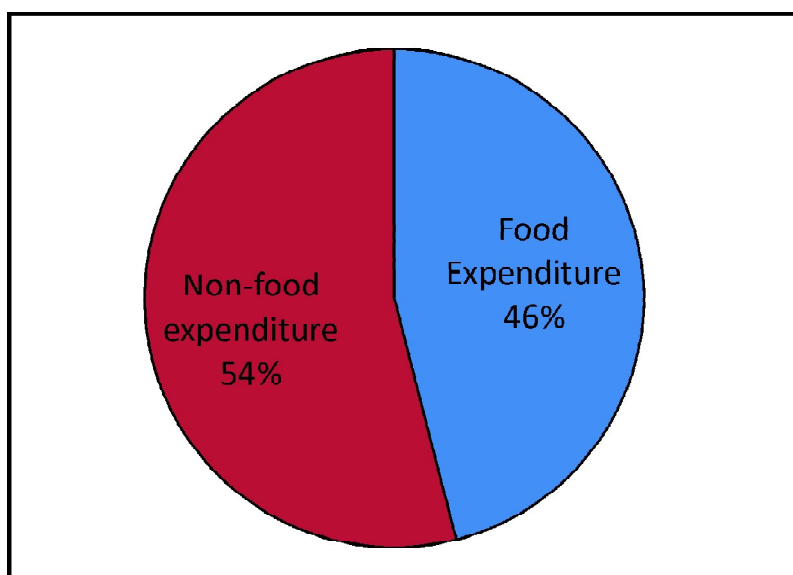


Figure 1: Distribution (%) of food and non food expenditure in MPCE Karnataka Wave 1

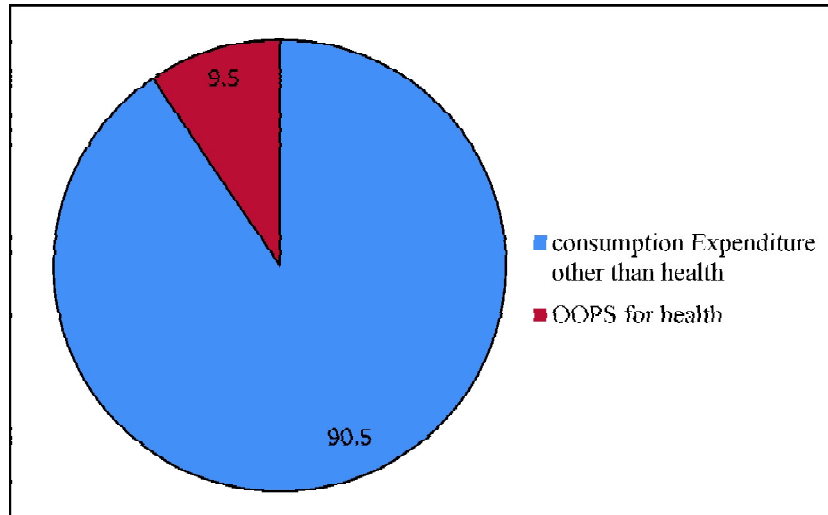


Figure 2: Share (%) of OOPS in MPCE of HH with older adults in Karnataka LASI Wave I

Consumption expenditure and Share of Non-food consumption expenditure in household of older adults

Estimation of consumption expenditure of a household is very necessary in order to understand standard of living of that household. Though annual income is the best and direct method of assessing standard of living of any household, obtaining the reliable data on source of income of any household is very difficult in Indian context. Therefore, consumption expenditure is a proxy measure of standard of living of a household.

Table 1, shows MPCE of households having at least one member aged 45 and above by background characteristics. The table also shows what is the proportion of non-food expenditure as a share of MPCE. While MPCE is a proxy measure of standard of living of households, the share of non-food expenditure shows the willingness of a household to purchase goods and services over and above its expenditure on food. Because food and shelter are the basic necessity of mankind and therefore typically only after meeting the basic needs, consumer spends on non-food goods. It is witnessed from the table that, the mean MPCE is Rs 3915 and share of non-food expenditure out of total MPCE is 55.1%. MPCE is found to be decreased as the household size increases. The MPCE is Rs 5406 when HH size is 1-3, Rs 4115 when HH size is 4-6 and is Rs 2917, when HH size is 7 or more. Though it is generally believed that higher the number of members in a household, higher the expenditure, but in reality, it is not so. Indeed, MPCE is likely to decrease whenever HH size increase due to sharing of most of the non-food items by household members, so that average per capita expenditure decreases. Therefore, usually MPCE declines as the size of the HH increases. Across the place of residence MPEC is much higher in urban than the rural areas, due to higher cost of living in urban areas, more

Table 1: Monthly per capita consumption expenditure (MPCE) and Household non-food expenditure as a share of MPCE by background characteristics, Karnataka LASI, wave I 2017-18

<i>Background Characteristics</i>	<i>Monthly per capita expenditure (MPCE) Mean</i>	<i>Non-food expenditure as a share of MPCE (%)</i>	<i>Number</i>
Household Size			
1-3	5406	52.1	462
4-6	4115	58.0	771
7 or more	2917	54.7	225
Residence			
Rural	3600	53.1	1012
Urban	4656	56.0	476
Religion			
Hindu	3874	56.4	1273
Muslim	4128	53.5	200
Others	4281	57.4	15
Caste			
SC/ST	3348	50.0	266
OBC	4031	56.9	1052
None	4129	58.1	170
MPCE quintile			
Poorest	1557	47.2	139
Poorer	2406	50.0	235
Middle	3097	50.2	351
Richer	4447	57.2	392
Richest	7426	61.6	371
Total	3915	55.1	1488

consumption expenditure in urban set-up due to wide choice for consumer goods and demonstration effect⁴ (Ritu 2018)

Among the religion higher MPCE reported among the 'Others' followed by Muslims and Hindus. Further in caste category the category 'None' found to be having higher MPCE than OBC and SC/STs. The categorisation of households based on MPCE quintile shows that households belonging to poorest class has least average monthly consumption expenditure compared to households belonging to richer MPCE quintile.

Relationship among Food and non-food expenditure across MPCE

While analysing consumption expenditure, looking in to share of food and non-food consumption expenditure out of MPCE is very crucial for appropriate policies related to taxes and subsidies. The analysis is also helpful to guide how income at macro level may-

be redistributed through fiscal measures. **Fig 3** shows share of food and non- food consumption expenditure across MPCE quintile. From the figure it is evident that, when economic standard of a household shifts from poorest to richest, the share of non-food consumption found to be increased. On the contrary, the share of food consumption expenditure goes on decreasing when economic standard of households improves. The reason is that, when economic standard improves, there is always a limit for consumption of food by any household. However, unmet expenditure on non-food items like, expenditure on housing, purchase of TVs or any other durables slowly start picking demand as per basic consumer behaviour. As a result, share of expenditure shows a surge on non-food items. It should be noted however that, decrease in share of expenditure does not mean there is a less consumption of food by richer class, but it means that there is a decrease in share of their expenditure on food out of total expenditure. When a household is poor, relatively share of expenditure on food is more and therefore non-food curve below the food curve. At the middle level of economic standard more or less food expenditure and non-food expenditure are same therefore both the curves are coincided and as the standard of living improves non-food expenditure is greater than food expenditure therefore non-food curve lies above food curve.

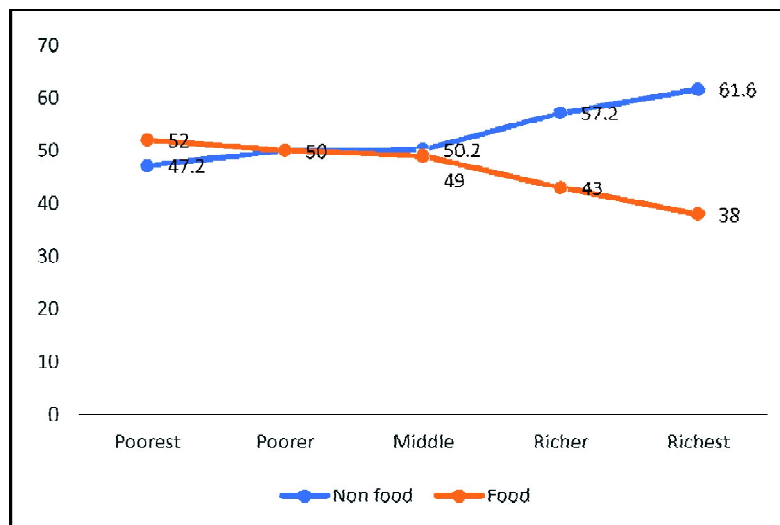


Figure 3: Share of food and non-food consumption expenditure across MPCE quintile

Out of Pocket Spending (OOPS) of Households with older adults

Health expenditure implies the out-of-pocket spending (OOPS) health payments made by households for the health services received by household member. Health payments includes doctor’s consultation fees, purchases of medication/traditional medication and hospital bills. And any reimbursement (from insurance/employer/government, etc.) is deducted to find out the net out-of-pocket payments. In India, like other developing country, characterized

by inadequate and inefficient public health provision, therefore, it is very relevant to know the share of health care spending out of total household spending. The analysis would be helpful for the design of appropriate insurance coverage across socio-economic groups and fiscal health protection as well.

Table 2 presents monthly per capita out of pocket (OOPS) spending on inpatient and outpatient care by background characteristics. Both inpatient and outpatient care standardised based on the 30 day reference period. The total OOPS found to be Rs 374 in the household having at least one person age 45 and above. The per capita inpatient expenditure (Mean) stood at Rs 122 and outpatient expenditure stood at Rs 252, but wide variations can be observed across the different socio-economic categories. It is witnessed from the table that, inpatient and outpatient mean expenditure found to be decreased as and when the size of the household increases. This may be due to the fact that, invariably not all the members

Table 2: Monthly per capita out of pocket expenditure for Inpatient and outpatient care in Rs according to background characteristics

<i>Background Characteristics</i>	<i>In-patient health expenditure (30 days) Mean</i>	<i>Out-patient health expenditure (30 days) Mean</i>	<i>Total health expenditure (In-patient & Out-patient) (30 days) Mean</i>	<i>Number</i>
Household Size				
1-3	138	344	483	462
4-6	123	225	348	771
7 or more	89	166	256	225
Residence				
Rural	121	232	354	1012
Urban	122	295	419	476
Religion				
Hindu	123	244	368	1273
Muslim	104	269	374	200
Others	218	734	952	15
Caste				
SC/ST	105	207	312	266
OBC	121	268	390	1052
None	151	225	377	170
MPCE quintile				
Poorest	13	53	67	139
Poorer	30	89	119	235
Middle	59	141	200	351
Richer	107	246	353	392
Richest	295	536	831	371
Total	122	252	374	1488

of any household likely to be sick and encounter expenditure on health. This would naturally pull down the average expenditure on health when size of the household increases, be it inpatient or outpatient expenditure. As expected, higher OOPS both inpatient and outpatient expenditure reported from urban residence due to relatively higher cost of living in urban set-up, better accessibility of private health care facilities than rural set-up. Across the religion, households from 'Other category' reported more OOPS than rest of the categories. When we analyse OOPS by MPCE quintile (Fig 4), it is witnessed from the figure that, total OOPS (both inpatient and outpatient expenditure) found to be increased when household's economic status improves. From the figure it is learnt that, total OOPS found to be Rs 67 for poorest households, Rs 831 for richest households and OOP expenditure has positive association with level of household's economic status. That is, higher the economic status higher will be the OOP expenditure on health. However, it should be noted here that, higher expenditure among economically better-off does not mean that, members of such households more likely to be having sick, but it means that, their economic ability to pay for health expenditure is better than their counterpart (IIPS 2020). Thus, total health expenditure among poorest is Rs 67, poorer Rs 119, Middle class Rs 200, Richer Rs 353 and Richest Rs 831.

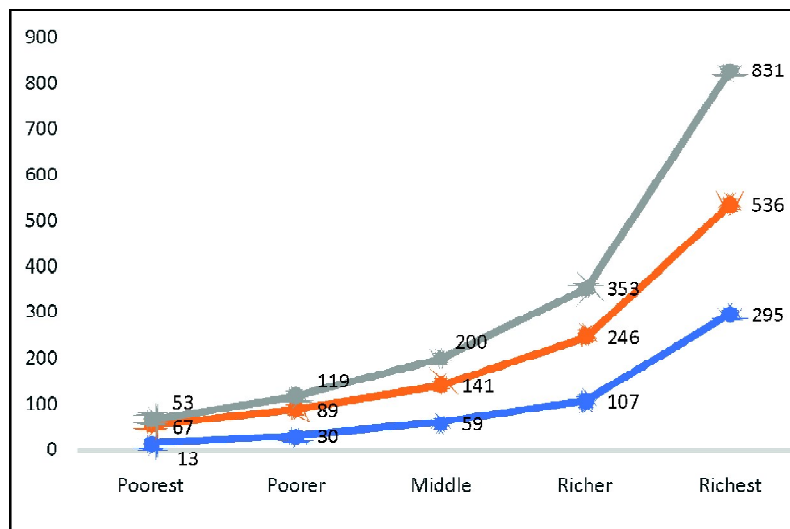


Figure 4: OOPS by MPCE Quintile in Karnataka LASI Wave I

Figure 5 shows monthly out of pocket expenditure on health as a share of MPCE by background characteristics. The share of out of pocket expenditure in MPCE is around 9.5 percent. This percentage is near to what is the demarcation/threshold laid for catastrophic health expenditure by LASI. The catastrophic health expenditure is defined as household health spending exceeding 10% of household consumption expenditure. As a whole 'mean' of OOP expenditure for sampled household has not reached to

catastrophic threshold limit however it is near to the limit defined. Across the different socio-economic groups considerable variations can be observed as for as proportion of monthly out of pocket expenditure a share of MPCE. Proportion of OOPS found to be high with household size is 1-3 than other household size, more in rural area (9.8%) than urban area (8.9%), higher among 'other religion' and under caste category 'OBCs' (9.6%) having high expenditure. It is very much evident **from the figure 5 that**, OOP expenditure proportion found to be increased as the economic level of the household (*in terms of consumption expenditure*) increases. ie poorest, poorer, middle, richer and richest having proportion of OOP expenditure in their MPCE to the extent of 4.3%, 4.9%, 6.4%, 7.9% and 11.1% respectively. This indicates that, as economic capacity to pay increases the households are willing to pay out of their pocket on health if such health event is encountered in order to protect with better health care. Such consumer behaviour also implies that as the level of income increases they likely to prefer more of private health facilities. Such preference would contribute for increase in OOP expenditure for health. Infact India's health sector is characterized by low Government expenditure on health, high out-of-pocket expenditure and low financial protection for adverse health events. The actual current coverage is lower since not all households eligible for Government subsidized insurance are currently covered, and due to the overlaps between different health insurance schemes. (Niti Aayog 2021). Thus OOPE is regressive and affect the poor the most, and that reliable measures need to be sensitive to the lower strata of the population (Mohanty and Dwived 2021). Better-off households can respond more often to medical needs, but are less likely to face permanent impoverishment. This calls for a comprehensive insurance system to protect the poor.

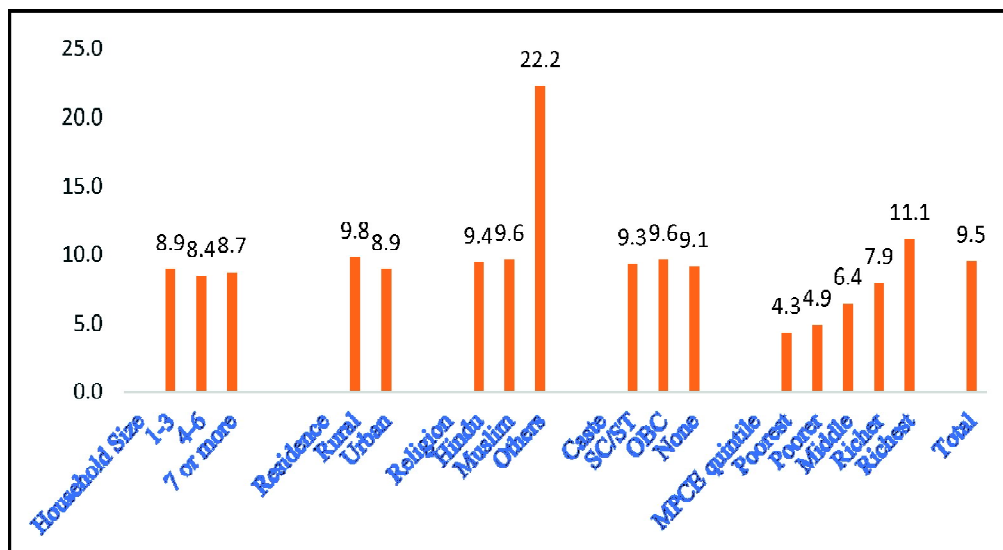


Figure 5: Monthly per capita OOP expenditure as a share of MPCE (%)

DISCUSSION AND POLICY RELEVANCE

The share of Consumption expenditure on food and medical needs decide overall wellbeing of that household. It is witnessed that more than half of the expenditure in households with older adults is incurred towards non-food expenditure and little less than half of expenditure is incurred towards food. MPCE is found to be decreased as the household size increases. When a household is poor, relatively share of expenditure on food is more and therefore non-food curve below the food curve. More or less food expenditure and non-food expenditure are same at the middle level of standard therefore both the curves are coincided at this point and as the standard of living improves non-food expenditure is greater than food expenditure therefore non-food curve is above food curve. This pattern of consumer/HH behaviour has an important policy implication in terms of pro-poor pricing and subsidies through fiscal measures to ensure equity.

OOP expenditure (both inpatient and outpatient expenditure) found to be increased when household's economic status improves. OOP expenditure has positive association with level of household's economic status. Ie higher the economic status higher will be the OOP expenditure on health. Higher expenditure among economically better-off does not mean that, members of such households more likely to be have sick, but it means that, their economic ability to pay for health expenditure is better than their counterpart. As a whole around 9.5 percent of expenditure reported to be incurred for medical purposes indicating the burden of medical expenses. The overall share of medical expenditure (9.5%) in MPCE which is very close to the predefined threshold limit for catastrophic expenditure. The cost of medicines is one of the main concerning components of health OOP spending. About 50 percent of OPD spending by households are for medicines. Hence, it has become essential to keep healthcare costs trifling without hindering the access to quality care. Therefore, consumption of generic medicines can improve the accessibility of health care to the population with limited available resources without any compromise in the quality of care. Jamshed SQ *et al.* (2012) The studies of Dylst P *et al.* (2012) also showed that generics medicines are substitutes for innovator (branded) medicines with the same quality, safety and efficacy. The price of generic medicines is usually 10-80% lower than their innovator equivalent. This can be helpful for the government and healthcare payers to cover ever-increasing healthcare costs. Further, increasing consumption of generic medicines will give a major breakthrough in improving accessibility of the health care without any compromise in quality Singhal AK *et al.* (2019) especially for such households where dependency ratio is quiet high with elderly household members. Since OOP and CHE effect poor the most there is likely chances of increase in autonomous consumption expenditure and economic impoverishment this group. One of the possible solutions to reduce or to prevent the economic shock is promoting 'appropriate package of Insurance and community-based health insurance schemes can be effective in protecting poor households from unpredictably high medical expenses(Mohanty K *et al* 2013). In addition, higher public expenditure on health, provision of affordable health care and improved geriatric health infrastructure may reduce the burden (Pandey *et al* 2018) of households

with older adults. Besides, in order to reduce the incidence of catastrophic health expenditure government should focus on increase the share of total health expenditure that is pre-paid particularly through taxation and mandatory contributions Wagstaff A et al (2018), so that poor households with older adults can be protected from economic impoverishment.

Note

1. Utility: usefulness of any goods or services for a person, usually a subjective matter. An individual may willing to pay more for a good if expected utility from that good for that person is higher and vice-versa.
2. Speculation: Expectation/anticipation of future course of economic events by the consumers/HHs
3. Non-food consumption expenditure: All type of consumption expenditure for goods and services other than expenditure on consumption of food items.
4. Demonstration effect: Demonstration effect refers to the consumption habit of the people to imitate the consumption trends adopted by other/neighbouring people. The impact of demonstration effect believed be more in urban areas due to wide diversification.

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Annexure 1 Reference period and estimation approach by kind of expenditure LASI wave 1			
<i>Si No</i>	<i>Expenditure head/Items</i>	<i>Reference period</i>	<i>Calculation approach</i>
1	Food expenditure	Past seven days	Use approach; The consumer expenditure of a HH on food items related to the actual consumption within the HH
2	Non food expenditure		Expenditure approach: Consumption of goods and services takes place when corresponding expenditure is incurred.
	a) Expenditure on durable items/services like expenditure on Tobacco and tobacco product, personal toiletries, communication fees, fuel, hose rent local travel etc. b) OPD expenses; medication, tests, doctors fees, others	Expenditure during last 30 days	Expenditure approach: Consumption of goods and services takes place when corresponding expenditure is incurred.
	c) Inpatient health expenditure: Hospitalisation and Nursing, tests, medicines, doctors fees, other medical expenditures	Expenditure during last 12 Months	-Do-
	d) Expenditure on non-frequent events/issues Education, Durables, Jewellery and Ornaments, rituals, Loan repayment, donations, etc.	Expenditure during last 12 Months	-Do-
	e) Any other expenses; Vehicle repair, long distance travel etc	Expenditure during last 12 Months	-Do-