punjab geographer

A DOUBLE BLIND PEER REVIEWED JOURNAL OF APG AND ISPER INDIA INDEXED IN SCOPUS

VOLUME 17 ISSN- 0973–3485 OCTOBER 2021

PUNJAB GEOGRAPHER : ISSN- 0973–3485 Volume 17 October 2021

OUT OF POCKET EXPENDITURE ON HEALTH IN INDIA WITH REFERENCE TO SOCIO-ECONOMIC CLASSES IN HARYANA

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Abstract

Government of India, in its health policy document resolves to strengthen the public health care infrastructure and repeats its commitment to provide basic health to its population. Despite this, the share of public health expenditure in Gross Domestic Product (GDP) remains low and almost constant. It has been observed that the Out of Pocket Expenditure (OOPE) on health has grown many times and it puts financial burden on individual households which pushes the people into poverty. In this context, the present paper attempts to study the pattern of public health and OOPE on health in India and in high income state of Haryana. It also studies the socio-spatial differentials in OOPE on medical expenses in case of hospitalized and non-hospitalized illnesses. The study is based on secondary data drawn from National Health Accounts and household level data about OOPE on health from 71st round of National Sample Survey Organization on Health Consumption, for the year 2014. The study reveals that per capita public health expenditure in Haryana is equal to all India average, which does not commensurate to its economic prosperity. The low public health spending is accompanied by high OOPE on health. The socio-spatial variations in OOPE on health reinforces that social status is a strong indicator in accessing curative health care. Further, the financial risk protection measured in terms of insurance coverage is also high among top 20 per cent households and those belonging to non-scheduled caste (SC) and non-other backward castes (OBC) population.

Keywords: Out of pocket expenditure, Public health expenditure, Socio-spatial, Hospitalized illness, Non-hospitalized expenses.

Introduction

There are glaring health inequalities in India and these are increasing with time. One may find clear rural-urban and rich-poor inequalities in health status and health care in terms of utilization of health services. Despite this, public health expenditure in India is very less, much lower than many poor nations from Southeast Asia such as Nepal, Sri Lanka, Bhutan, Indonesia and Thailand. India spends about 1.26 per cent of its GDP on health (National Health Profile (NHP), 2019) and it has shown only marginal increase during last 15 years. The Global Health Expenditure report released by World Health Organization (WHO) shows that before the COVID-19 pandemic, global spending on health increased at slower rate than GDP in many less developed countries (WHO, 2020). The report also shows that OOPE on health continues to be a major

component of health spending in low and middle-income countries. When OOPE on health is larger than government spending, it shows governments' lower priority to health. National Health Accounts (NHA) of India shows that prior to COVID-19 pandemic, the total health expenditure (public plus private) as proportion of GDP has declined in India from 4.2 in 2004-05 to 4.0 in 2015-16. NHA also shows that the majority of this expenditure (2.60 per cent of GDP) has been private and out of pocket, borne by households.

It is an observed fact that a public health system which relies mostly on high levels of government funding generally provides better and more equitable access to services, while excessive reliance on OOPE on health not only leads to financial burden for the less well-off, but also increases inequalities in access to health care. The introduction of user fee during the late 1990s to early 2000s in government hospitals, decline in government finances on health and weak public health service delivery system, indicate government's failure to meet the public's healthcare needs. It provides an opportunity to private sector to exploit the healthcare market. The deepening health insecurity may be understood from the estimate that, around 71 per cent of health spending in India is met out of individual's pocket of which 70 per cent is spent on medicine alone. Studies reveal that it has resulted in financial catastrophe and exacerbated poverty (Peters et al., 2002; Thakur et al., 2009; Hooda, 2017, Selvaraj et.al. 2014). This concern has been echoed at various national as well as international forums by stressing that public health spending is not a cost. It is an investment in poverty reduction, increase in national productivity, inclusive economic growth, and healthier, safer and fairer societies (WHO, 2018).

India has organized and reorganized its health care delivery system on the lines of Sir Joseph Bhore Committee's recommendations (way back in the year 1946) which aims to provide free basic preventive and curative care to all within easy reach through a network of referral public health care infrastructure. India in its new National Health Policy (NHP) of 2017 resolves to strengthen and prioritize the role of the government in shaping health systems in all its dimensions i.e., investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions. It also recommends: (i) increase in health expenditure by government as a percentage of GDP from existing 1.0 per cent to 2.5 per cent by 2025; (ii) increase in state sector health spending to more than 8 per cent of their budget by 2020, and (iii) decrease in proportion of households facing catastrophic health expenditure from the current levels to 25 per cent by 2025 (catastrophic expenditure refers to more than 10 per cent of households' total consumer expenditure). The NHP also documents growing health care costs and further reinforces that OOPE on health is one of the major contributors to poverty (NHP, 2017).

NITI Aayog Report (2018) has also highlighted that there are significant health related disparities across states in health outcome, governance and health delivery. It does show that low-income states with low revenue capacity spend significantly lower on health and the differences in the cost of delivering health services have contributed to health disparities among and within states. Despite all these facts and acknowledgements, the public spending in Indian states remains low. The disease pattern in India is also

undergoing a change where proportion of deaths from non-communicable diseases is continuously increasing (Rajeshwari, 2008; Rajeshwari and Mehra, 2021). Further, the economically well-off population and those working in organized sector are to some extent covered under some form of social security, while those working in unorganized sector do not have the benefit of any social security.

OOPE on health is a burden on households as this incurs during a health event (sudden happening such as accident or critical hospitalization) when the household is under distress. The impact of OOPE is much higher when the household's income is low or the OOPE incurred is huge, especially in the events of inpatient (hospitalized) care or critical illnesses. OOPE on health especially among low-income households therefore, results in reducing their spending on other essential and basic needs such as food, shelter, clothing, education etc. in the family. It also forces households to borrow money from friends/ relatives/money lenders or take loan from some financial institutions, which further pushes the household into financial burden of debt. If household's OOPE on health is higher than 10 per cent of the total household's income (or consumption expenditure) then it is considered to be catastrophic which may push the household below the poverty line. According to health expenditure survey, 18 per cent households in India during 2014, faced catastrophic health expenditures (NSSO, 2015). It suggests that the high OOPE on health has either pushed the bottom 40 per cent of population to poverty or left them to the mercy of informal care (provided by *'tantriks'*, faith healers or other magic healers). In this context, it is pertinent to study OOPE on health in India and particularly in a high per capita income state of Haryana. It is equally significant to study the financial security and insecurity faced by population of different socio-economic strata and to suggest policy implications in achieving the goal of equitable and accessible health for all.

Objectives

Major objectives of the study are:

- to analyse the pattern of public and OOPE on health in Indian states and
- to evaluate the differential in OOPE on health and financial risk protection with respect to socio-economic characteristics of the households in Haryana.

Study Area

The state of Haryana is located in the north-western part of India. The state with about 2 per cent of India's population is one of the economically developed states. It contributes 3.9 per cent to national GDP. The per capita income of state at current prices as well as constant prices has shown an increasing trend over the preceding years. The per capita income of the state has been Rs. 1,80,026/- during 2019-20. However, at constant prices (base year 2011-12) it has increased by 69.7 per cent against 49.6 per cent recorded by India as a whole (Govt. of Haryana, 2020). It thus shows that the per capita income and rate of increase at constant prices of Haryana is higher than that of India during this period. The state of Haryana has depicted the average annual growth rate of 3.4 per cent in primary sector, whereas secondary and tertiary sectors have recorded the average annual growth rate of 8.3 per cent and 9.5 per cent, respectively prior to COVID-19 period. Hence, it shows that in line with national experience, the economic growth in Haryana has been primarily driven by service sector. The

state has well developed infrastructural facilities like road network, water supply, sanitation, electricity, banking, communication and market network. On account of health care infrastructure, the state is also one among the well-developed states of India (Devi and Rajeshwari, 2016). Though, the status of health infrastructure in Haryana is better than national average, yet it is far behind the best performing state of Kerala. It may be noted that about 35 per cent of its population is urbanized. The scheduled castes (SCs) population constitutes 19.3 per cent of its total population, while the state has no scheduled tribes (STs) population. Its total literacy rate is 75.6 per cent (2 per cent higher than national average of 74.0 per cent) with substantial inter-district disparity ranging from 56 to 85 per cent.

Database and Methodology

The present study is based on two secondary sources of data i.e., Govt. records and household data. The Govt. records relate to National Health Account Estimates for the year 2004-05, 2013-14, 2014-15 and 2015-16. The household data relates to the year 2014 collected by National Sample Survey Organization (NSSO) on Health Consumption, through its 71st round. For detailed analysis, household level data have been used, which have been collected from a well distributed sample of 90 villages and 90 urban blocks of Haryana. The OOPE on healthcare refers to all payments made by an individual/household at the point of receiving healthcare goods and services. For example, if an individual falls ill and visits a doctor's clinic, he/she pays for consultation fee and for other services (injection, wound dressing etc.) provided by the doctor at the clinic. Similarly, he/she also pays separately for medicines at pharmacy, diagnostic tests (X-ray, Blood test etc.) at the laboratory. It also includes insurance premiums contributed by individuals in health insurance schemes. The OOPE on health is computed for hospitalized illness as well as for non-hospitalized illness. The non-hospitalized illness relates to those that have happened during last 15 days and require out-door patients (OPD) services, while hospitalized expenditure is taken for any illness that has happened during last 365 days and has required hospitalized treatment. Hospitalization due to ailments is taken into account, while associated with child birth is not considered. The sources of financial support i.e., insurance coverage in the treatment of ailments with reference to socio-economic background of households have also been studied. These insurance schemes are Rashtriya Swasthya Bima Yojana (RSBY); Central Government Health Scheme (CGHS); Employee State Insurance Scheme (ESIS) and other private insurance coverage availed by the household. In case of no insurance, major sources of expenses on medical and non-medical, such as household income/savings, borrowings, contributions from friends and relatives and other sources have been computed in reference to socio-economic characteristics of the households.

Social status refers to social groups based on castes affiliation. The broad four social groups considered are Scheduled Tribes (ST), Scheduled Castes (SC), Other Backward Castes (OBC) and Others (all other castes excluding STs, SCs and OBCs). In this study, only three broad social groups have been taken as the state has almost negligible ST population. Economic characteristic has been studied by taking monthly per capita consumer expenditure (MPCE) classes. In the absence of wealth index in the household survey, the

estimate of monthly consumption expenditure has been used as a proxy for monthly income. The households based on their reported monthly expenditure, have been grouped into five classes or quintiles. The first quintile represents the bottom 20 per cent population (most vulnerable) and the 5th quintile represent the top 20 per cent (most wealthy) population group. The spatial aspect has been dealt with reference to rural and urban areas of the state. Besides this, age-wise health expenditure pattern has also been studied.

Results and Discussion

Status of Health Financing in India

The health expenditure in India primarily comes from two sources public and private. Besides, public and private sectors, non-profit institutions serving households (NPISH), enterprises/firms, insurance sector and external or foreign funds also contribute in health funding, but their share is very low (not more than 5 per cent). Public sector funding includes funding by state and central governments. Health being 'State' subject is primarily financed by the state. The central government's contribution is primarily for family welfare and certain centrally sponsored schemes such as national disease control programs and immunization etc. The center-state ratio in public funding on health is almost 70:30. In 2015-16, the center's contribution in public health expenditure has been 31 per cent (NHSRC, 2017). In 2015-16, public sector expenditure has been about 30 per cent of total health expenditure (Table 1). The private sector contributes about 67 per cent of total health expenditure, which includes individual OOPE on health and private insurances; hence health care sector is predominantly catered by private sector. As per national health accounts estimates, total per capita health expenditure has been on the rise, but majority of this has been borne by individuals. Table 1 reveals that during 2004-05, per capita OOPE on health has been Rs. 959/-, which has gone up to Rs. 2670/- by 2015-16. This needs to be seen with reference to increase in population income during this period. It may be mentioned that if more than 10 per cent of a households' consumption expenditure is spent on health, then it is considered catastrophic and it might push the household below the poverty line. NSSO data suggest that during 2014, 18 per cent households in India faced catastrophic health expenditure as compared to 15 per cent during 2004 (NSSO, 2015). Increase in the proportion of households with catastrophic OOPE on health is critical in less developed states where the level of poverty has been already high. Hence, high OOPE on health is a pointer towards decreasing health priority of the country.

Pattern of Public and OOPE on Health in India

The state-wise per capita public health expenditure, its share in Gross State Domestic Product (GSDP) and in budgetary allocation during 2016-17 has been presented in Table 2. The state-wise per capita public health expenditure shows wide variations ranging from Rs. 491/- in Bihar to Rs. 5862/- in Mizoram state (Table 2). In general, north-eastern states (except Assam) have the highest per capita public expenditure on health (average Rs. 2878/- during 2015-16, while it has been lowest in Bihar, Madhya Pradesh and Uttar Pradesh (average less than Rs. 750/-) states (Fig.1). It may be noted that socio-economically less developed states, termed as Empowered Action Group (EAG), have lower

Table 1
India: Status of Health Financing Indicators regarding Various Rounds of National Health Accounts

Indicators	NHA 2004-05	NHA 2013-14	NHA 2014-15	NHA 2015-16
Total Health Expenditure (per cent of GDP)	4.20	4.00	3.90	4.00
Govt. Health Expenditure (per cent of GDP)	0.90	1.10	1.10	1.00
Per capita Total Health Expenditure (Rs.)	1,201.00	3,638.00	3,826.00	4,181.00
Per capita Government Health Expenditure (Rs.)	242.00	650.00	1108.00	1,112.00
OOPE on Health (per cent of GDP)	2.90	2.50	2.43	2.60
Per capita OOPE on Health (Rs.)	959.00	2,336.00	2,394.00	2,670.00
Current Health Expenditures (per cent of Total Health Expenditure)	98.90	93.00	93.40	92.80
Government Health Expenditure (per cent of Total Health Expenditure)	22.50	28.60	29.00	30.40
OOPE on Health (of Total Health Expenditure)	69.40	64.20	62.60	62.40
Social Security Expenditure on Health (per cent of Total Health Expenditure)	4.20	6.00	5.70	4.10
Private Health Insurance Expenditures (per cent of Total Health Expenditure)	1.60	3.40	3.70	3.70
External/Donor Funding for Health (per cent of Total Health Expenditure)	2.30	0.30	0.70	0.40
Household Health Expenditure (per cent of Total Health Expenditure)	73.80	67.70	66.30	66.10

Source: Compiled by Authors.

Table 2
India: Expenditure on Health, 2015-16

States	Government Health Expenditure (2015-16)			Out of Pocket Expenditure on Health (2014)	
	Per Capita Govt. Expenditure (Rs.)	State Budgetary Allocation (per cent)	GSDP (per cent)	Average per Household (Urban) (Rs.)	Average per Household (Rural) (Rs.)
Non EAG	**1,172**	**5.34**	**0.76**	**25,480**	**16,688**
Andhra Pradesh	1,013	3.50	0.82	33,671	15,411
Gujarat	1,189	5.80	0.72	26,401	32,503
Haryana	1,119	3.50	0.63	30,400	17,266
Himachal Pradesh	2,667	6.60	1.68	35,217	20,945
Jammu and Kashmir	2,359	5.90	2.46	31,160	22,004
Karnataka	1,124	5.00	0.69	15,011	12,578
Kerala	1,463	5.80	0.93	24,202	16,118
Maharashtra	1,011	5.00	0.63	26,374	15,326
Punjab	1,173	5.80	0.87	22,713	12,616
Tamil Nadu	1,235	4.99	0.74	15,751	12,648
Telangana	1,322	4.80	0.82	26,092	13,968
West Bengal	778	5.30	-	27,883	10,476
EAG	**871**	**5.05**	**1.36**	**26,029**	**14,635**
Assam	1,546	7.00	2.21	52,368	8,520
Bihar	491	3.90	1.33	28,058	13,626
Chhattisgarh	1,354	5.20	1.33	24,891	14,043
Jharkhand	866	4.80	1.25	14,043	10,777
Madhya Pradesh	716	4.10	1.04	17,117	19,385
Odisha	927	4.80	1.19	18,477	7,750
Rajasthan	1,360	5.60	1.44	31,978	29,779
Uttar Pradesh	733	5.00	1.42	13,931	7,242
Uttarakhand	1,765	6.00	1.06	33,402	20,594
NE States	**2,878**	**6.30**	**2.76**	**19,355**	**13,232**
Arunachal Pradesh	5,177	5.70	3.29	10,715	8,042
Manipur	2,061	5.40	2.79	31,028	22,486
Meghalaya	2,223	6.70	2.40	13,810	9,058
Mizoram	5,862	8.30	4.20	21,789	4,098
Nagaland	2,450	5.80	2.97	17,216	11,652
Sikkim	5,126	5.60	1.81	18,346	15,609
Tripura	2,183	6.60	2.41	22,584	21,683
All India	**1,112**	**-**	**1.42**	**26,455**	**16,956**

Source: Compiled by Authors.

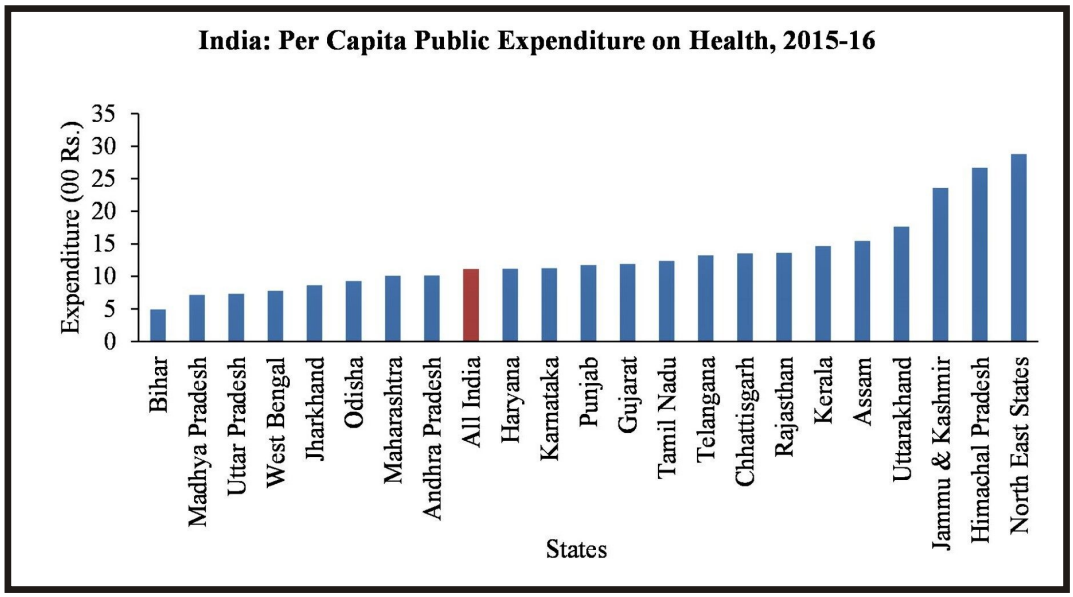

Fig. 1

per capita public health expenditure. A group of 8 EAG states, namely Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Odisha and Rajasthan have high infant mortality and lag in demographic transition. The low per capita public health expenditure in these states indicates lower commitment of state governments to health needs of population. In five out of eight EAG states, the per capita public health expenditure is still less than Rs.1,000/-. In all EAG states, the level of poverty is high and the size of economy is small. A low amount of public health expenditure (less than Rs. 1,000/-) is a clear pointer about the failure of the system meant to equalize public expenditures on healthcare service. With an exception of West Bengal, in all non-EAG states, the per capita public health expenditure is above Rs.1,000/. The two hill states namely Himachal Pradesh and Jammu & Kashmir, followed by Kerala have high per capita public health expenditure. As far as public health expenditure as a percentage of gross state domestic product (GSDP) is concerned, the north-eastern states are better placed (2.76 per cent) during 2015-16. The health care budgetary allocation reveals that the highest health spending from total state spending is in north-eastern states (6.30 per cent of state budget), followed by non-EAG states (5.34 per cent) and the least is in EAG states (5.05 per cent). The lower public spending has many negative consequences in health outcomes, such as high infant and child mortality, poor maternal health as well as more OOPE on health in case of disease outbreak and curative needs of population. Thus, EAG states need high attention in terms of human resource development, particularly health and the lower spending on public health pushes population in vicious circle of poor health status.

As already mentioned, OOPE on health is private expenditure borne by individuals. It includes two types of expenditures: medical and non-medical. Medical expenses include expenditure on medicines, bed charges, charges

for diagnostic tests, and fees for doctor/surgeon. While, non-medical expenses constitute, all expenses relating to transport in connection with the treatment and food and lodging charges of the accompanied person. Thus, OOPE on health is sum total of these two. The non-medical expenditure is 4 to 5 per cent of total health expenditure. The OOPE on medical for all India average comes out to be Rs. 16,956/- and 26,455/- for rural and urban areas, respectively (Table 2). The OOPE on health has more variations in EAG states in both rural and urban areas. In rural areas, the spending ranges between Rs. 7,242/- to Rs. 29,779/- in Uttar Pradesh and Rajasthan states respectively, while in urban areas, it varies from about Rs.14,000/- in Uttar Pradesh to about Rs. 52,000/- in Assam. In EAG states namely Uttar Pradesh, Madhya Pradesh, Odisha, Jharkhand and Bihar, not only the public per capita spending is low, but the private OOPE on health is also low in rural areas, because of low purchasing power, denial of illness, less care and low access to health care facilities. The OOPE on health is also related to availability and utilization of public health care facilities in these states. The public health system is weak in these states and primary care is among its weakest components. Therefore, poorer people still have to pay substantial health costs. This also suggests deepening health insecurity as studies indicate that a major proportion of OOPE on health is spent on medicines and even in public hospital treatments as patients have to spend large amount on purchase of medicines and tests (Jain, 2013; Selvaraj et al, 2014). Thus, high OOPE on health has several negative implications as it pushes households into poverty or even impoverishing their living standard which leads to direct welfare loss in households' well-being. The level of household OOPE on health is more than national average in seven states of India and the state of Haryana is listed among these states of high OOPE on health in both of its rural and urban areas (Fig. 2). The empirical evidence also suggests that high proportion of households depending on OOPEs on health have little financial risk protection (HSHRC, 2016).

Social Dimensions of OOPE on Health in Haryana

In this section, household expenditure on health from 71st NSSO round has been analyzed which relates to expenditure on hospitalized and non-hospitalized treatment. There is no internationally accepted definition of what constitutes "high" levels of OOPE on health and there is no amount of OOPE on health that can be considered as "acceptable". The lower levels of OOPE on health may reflect a reduction in health service utilization related to low perception of illness as well as affordability problems. The expenditure for hospitalized and non-hospitalized (outpatient care) treatment, classified on the basis of characteristics of population is presented in Table 3. It may however be noted that social group of 'Others' have spent significantly higher amount on both hospitalized and non-hospitalized illness when compared with social group of SCs and OBCs, that may be due to their access to better-quality care and as well as affordability and financial risk protection in terms of insurance cover. However, among the historically disadvantaged groups, the OOPE on health of SCs has been more than OBCs, in both types of illnesses.

In the absence of a 'wealth index' in the household survey, the estimate of Monthly Per Capita Consumer Expenditure (MPCE) has been used as a proxy for monthly income. An

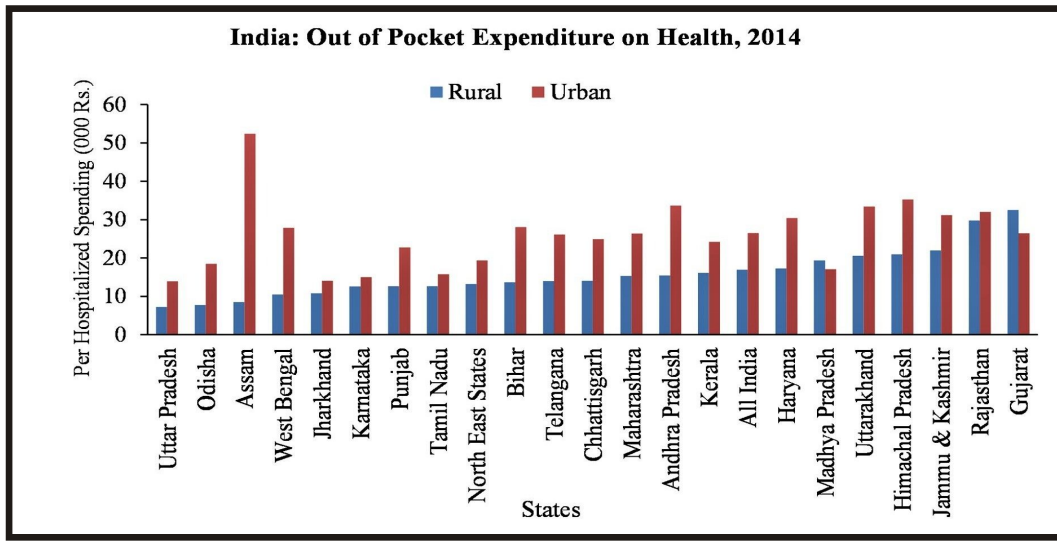

Fig. 2

Table 3

Haryana: Out of Pocket Expenditure on Health with Socio-Economic Characteristics of Population, 2014

Population Characteristics	Hospitalised Illness (365 days)			Non- hospitalised Illness (15 days)		
	Medical Expenditure (Rs.)	Non-medical Expenditure (Rs.)	Total Expenditure (Rs.)	Medical Expenditure (Rs.)	Non-medical Expenditure (Rs.)	Total Expenditure (Rs.)
Age Groups (Years)						
0-4	2,103.42	749.68	3,572.02	279.86	0.00	279.86
5-9	22,013.31	2,421.72	24,257.12	148.86	120.00	161.00
10-14	13,750.18	958.74	13,958.52	223.56	150.00	244.16
15-29	17,323.90	4,171.50	21,658.40	549.01	177.34	626.89
30-44	20,142.56	1,485.89	21,492.94	572.69	45.07	606.69
45-59	22,732.41	1,503.26	23,560.51	1,101.86	201.51	1,247.03
60+	22,640.20	2,102.48	22,911.71	699.68	50.83	804.73
Social Groups						
Scheduled Castes	16,472.18	1,269.33	16,020.44	521.65	46.64	571.66
Other Backward Castes	14,681.67	1,221.18	15,625.36	454.45	61.00	483.47
Others	25,902.83	1,970.89	27,536.84	1,077.81	184.70	1,226.82
MPCE Classes						
Quintile 1	12,932.26	1,373.59	14,465.87	437.04	61.72	471.71
Quintile 2	17,823.93	1,347.48	18,216.49	590.19	81.75	656.44
Quintile 3	21,048.52	1,399.66	23,485.90	1,360.54	78.08	1,436.43
Quintile 4	24,233.03	1,539.71	25,932.44	1,405.78	124.62	1,870.49
Quintile 5	39,635.20	5,355.19	45,475.99	1,421.62	475.26	1,521.74
Total	**20,547.11**	**1,625.25**	**22,272.36**	**752.16**	**87.40**	**840.10**

Source: Compiled by Authors.

analysis of household spending on health reveals that spending at an absolute level increases with income. The top 40 per cent households spend more than the other income quintile groups on both hospitalized and non-hospitalized treatment (inpatient and outpatient care). The average spending of top 20 per cent households is three times higher as compared to bottom 20 per cent in inpatient admissions as well as in outpatient services. The household spending has been analyzed with respect to age group also (Table 3). The data indicates that OOPE on health increases with age in case of hospitalized treatment as well as in non-hospitalized illnesses. The private spending is least for children under 5 years of age but shows sharp rise among children aged 5 to 9 years in case of in-patient care (hospitalized ailments). The OOPE on health however has its peak in 45 to 59 years age-group in all illness whether in-patient or out-patient.

Financial Support, Coverage and Source of Health Expenditure in Haryana

The high amount of OOPE on health leaves households with little financial risk protection. The study reveals that 97 per cent households in rural area and 71.60 per cent in urban Haryana remain uncovered under any scheme of health insurance (Fig. 3). About 8 per cent households are covered under state funded insurance scheme with a huge rural-urban gap. In rural Haryana, only 1.3 per cent households are covered under state sponsored health schemes, against 18.80 per cent households covered in urban areas. It is because of CGHS and ESIS schemes which are for organized workers and majority of organized employment is urban located. The non-government employer protection is nil in rural Haryana. Though RSBY scheme is for unorganized workers residing in both rural and urban areas, yet its reach seems to be lower in case of rural Haryana. Studies have shown the poor reach of RSBY scheme in large part of the country and the reasons provided are, less knowledge of schemes about what they offer and the conditions for access. Jain (2013) has reported that the RSBY appears to contain a structural problem where the information

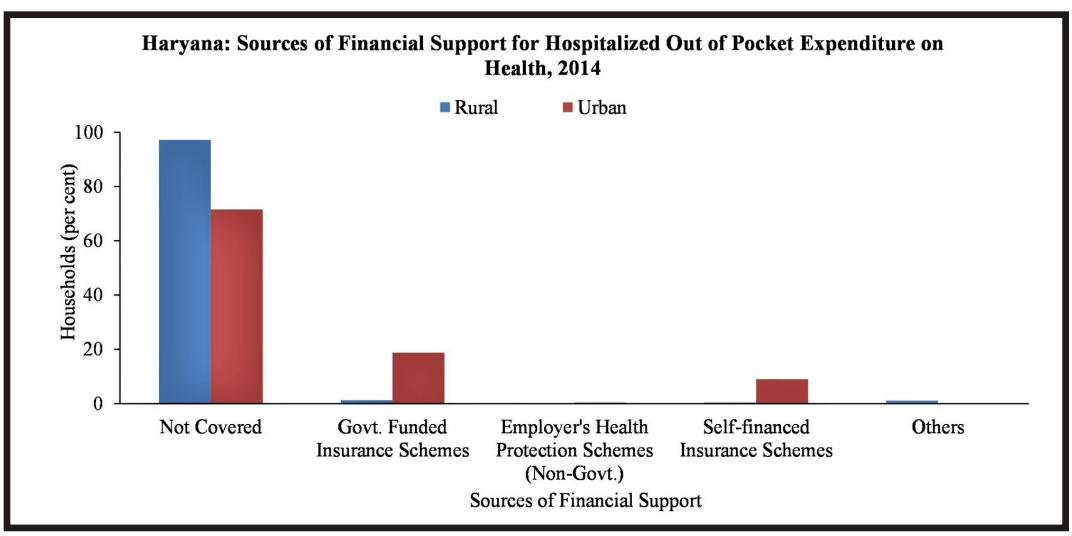

Fig. 3

function is not being adequately taken up either by the central or state government and the private insurance companies. In urban areas of the state, another 9 per cent households have been covered under self-financed insurance schemes.

The financial risk protection vis-à-vis social status or caste group affiliations reveal that the SC households have very little or no financial support (Fig. 4). It might be either due to their ignorance and low awareness or low access to government health coverage schemes. The financial risk situation seems to be equally alarming among OBCs where about 95 per cent households have not been covered under any financial support. Only 3.8 per cent households among OBCs reportedly took advantage of Govt. funded insurance schemes and another 1.4 per cent households could reimburse the health spending through private self-financed insurance schemes. It has been among 'Others' (non-SCs and non-OBCs) where one-fifth households have enjoyed any kind of financial protection (13.0 per cent from Govt. insurance and 6.30 per cent from private insurance). In general, it may be said that population belonging to non-SCs and non-OBCs group have largely appropriated the financial health benefits which might be due to their presence in organized sector of employment or having high purchasing power to buy private health insurance cover. The population on margin and belonging to lower socio-economic strata remains vulnerable to financial risk in case of any illness.

Source of Finance for Hospitalized Treatment in Haryana

As discussed above, a large proportion of households in rural areas are not covered under any financial support for hospitalized treatment in case of illness. The contribution of different sources of financing, to meet the total expenditure on hospitalization among different social groups in rural and urban areas in Haryana has been presented in Fig. 5. A perceptible difference has been noted in the relative importance of different source categories, even though the household savings/own income remained the prominent source of funding or expenditure. In rural Haryana, borrowings are more or less common

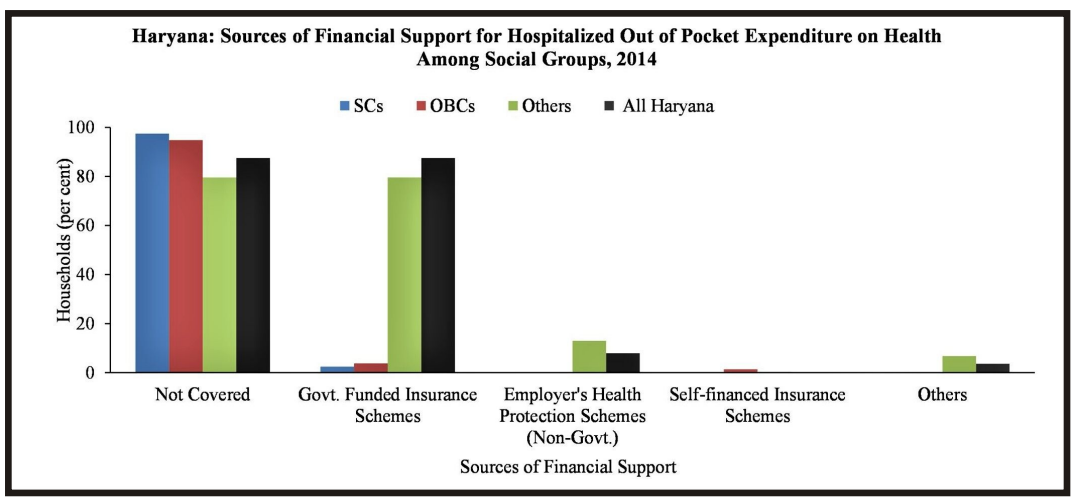

Fig. 4

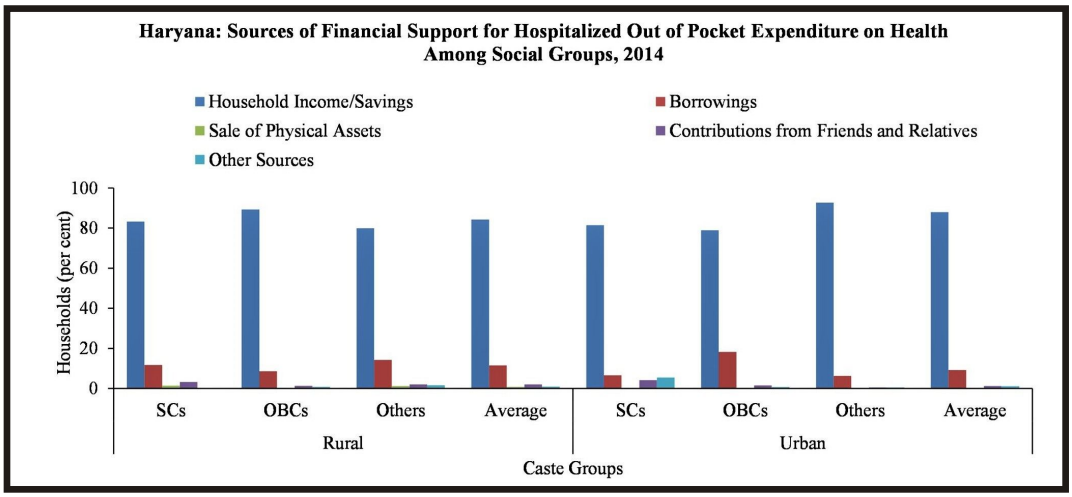

Fig. 5

as it constitutes the health expenditure source for 11 per cent. Another 2 per cent relied upon contribution from friends and relatives. In urban Haryana however, the non-SCs and non-OBCs have relied overwhelmingly upon their own income and savings, with a very little contribution from borrowings. In urban areas, a substantial proportion among SC and OBC households has been dependent upon borrowings for hospitalized treatment, indicating the deepening health insecurity or catastrophic expenditure which they could not meet from savings or income.

Conclusions

The public sector expenditure in India accounts for one-fourth of total health expenditure and hence India's health care is highly privatized. The major part of health care expenses is being borne by individuals and paid direct to private service providers. This means that the well-off can avail quality health services and it is institutional in reproduction of inequality in health care. The low public health spending is visible in all states but it is distressing to find that the economically and demographically backward states, listed as high focus states, continue for low public health spending. It indicates poor commitment of states towards the health needs of their population. Primary health care infrastructure is also weak in these states. This fact has been fully acknowledged by the government through its policy documents. In the absence of strong public health system and weak primary care, the poor have been either left to informal care or put to greater financial risk and insecurity. In case of Haryana, OOPE on health is higher than national average in both rural and urban areas and three times higher than per capita public health spending. The OOPE on health with reference to social and economic background of the households indicates that population belonging to lower social status and lower wealth quintile bear substantial financial risk and their access to health services is lacking. The health insurance coverage is least among SCs and OBCs as compared to 'Others' i.e., non-SCs and non-OBCs. The absence of such insurance or health coverage and low public health spending pinches the poor adversely as 13 per cent households had

catastrophic health spending during 2014 in the state. To reduce OOPE on health, it is very important that governments should consider OOPE on health as an important indicator about the performance of their health system. Both national and state governments have to realize that it is necessary to provide quality health services, medicines and diagnostics, and equally important is to provide all these services for 'free' to the vulnerable and low-income households. Other ways to reduce OOPE on health are: (i) to regulate the health sector to provide quality services at affordable cost and (ii) to provide comprehensive health insurance coverage to the vulnerable and poor population groups without any premiums/ contribution made by them.

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