



‘Out of Pocket Expenditure’ of Health Care Services in India: Factors, Consequences and Solution

Shatabdi Bagchi¹ and Priyanka Bakhshi²

Introduction:

Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of the private health expenditure (World Health Organization National Health Account database).

Countries having universal or close to universal access to healthcare generally have single payer mechanisms in which either a single autonomous public agency or a few coordinated agencies pool resources to finance healthcare. This accelerates the equity in healthcare as well as contributes towards low levels of poverty in these countries. Countries which have the capacity to buy healthcare from the market most often get healthcare without having to pay for it directly because they are either covered by social insurance or buy private insurance. In contrast, a large majority of the population, who suffers a hand-to-mouth existence, is forced to make direct payments, often with a heavy burden of debt, to access healthcare from the market because public provision is grossly inadequate or nonexistent.

Thus, the absence of adequate public health investment not only results in poor health outcomes but it also leads to increase of poverty. Only in countries like India and some other developing countries, health financing still rely mostly on out-of-pocket payments, where universal access to healthcare is intangible. In India, despite improvements in access to health care, inequalities are related to socioeconomic status, geography and gender, and are compounded by high out-of-pocket

¹ Research Officer, Institute of Health Management Research (IHM), Jaipur – 302029, Rajasthan (India) email: bagchishatabdi@gmail.com

² Research Officer, Institute of Health Management Research (IHM), Jaipur – 302029, Rajasthan, email: priyanka.bakhshi@yahoo.com

expenditures, with more than three-quarters of the increasing financial burden of health care being met by households.

Out of Pocket Expenditure [OOPE] in South East Asia

Out of Pocket Expenditures are non-reimbursable fees which a patient or family is responsible for paying directly to health practitioners or suppliers, without intervention of a third party. It often occurs, when publicly funded facilities are unable to provide the required health services and supplies for free or through insurance. Out of pocket Expenditures is the major health financing mechanisms across most of the South East Asian and other developing countries (O'Donnell et al. 2005; O'Donnell 2008; Leive et al. 2008; Jogelkar 2008).

Often this out of expenditures poses a colossal burden on poor households (Duggal 2007; Sun et al. 2007; Fun et al. 2005; Garg 1998). The costs are frequently high enough so that households are unable to recuperate them from existing resources, and, hence, ultimately slip deeper into poverty. However, unfortunately, the option of financial protection mechanism to mitigate such burden is very limited (Su et al. 2006; Xu et al. 2003; Vaishnavi et al. 2009; O'Donnell et al. 2005; Flores et al. 2008). As a result, protecting households from catastrophic health expenditure continues to remain as a formidable challenge, particularly for countries with high levels of poverty.

Risk of falling in debt crisis after the hospitalization is generally a common consequence caused by out of pocket expenditures. Findings from a study indicated that, every year, about one quarter of the hospitalized people slip into poverty due catastrophic payment for availing such care (Peters et al 2002). Anirudha Krishna (2006) has mentioned that the debt for health care have robust associations with poverty creation and the interaction of these factors is very significantly implicated with the analysis of households' descent into poverty. Also out-of-pocket payments on health care have been identified as one of the main reasons why people receiving microfinance credits default on loan repayments and trapping into poverty⁴ (WHO 2006).

India was ranked as having the 42nd highest average OOPE, with 74.4 percent of private expenditure being paid as out of pocket. (WHS 2011) In the year of 2012, India ranked third in the World Health Organization's latest list of "countries with highest out of pocket expenditure on health" in the south-east Asia region. (WHS 2012). The WHO's World Health Statistics 2012, says almost 60% of total health expenditure in India was paid by the common man from his own pocket in 2009. In comparison, Nepal's OOP health expenditure stands at 49%, Sri Lanka (44%), Indonesia (41%), Maldives (28%), Thailand (15%) and Bhutan (13%). Myanmar has the worst OOP expenditure at 82%, followed by Bangladesh (65%) in the same region. (See Table -1)

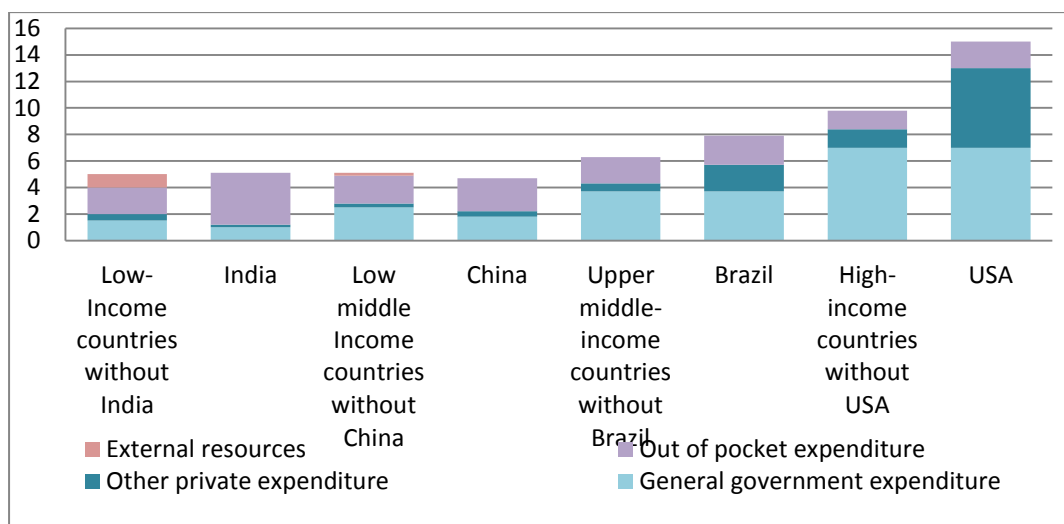
The data shows that, Myanmar's OoPE is the highest amongst all of the similar like Afghanistan, but India stands in a threshold of Financial Catastrophe due to out of Pocket Expenditure. High relative levels of such payments have been highly correlated with the incidence of financial catastrophe and impoverishment. Prepayment approaches – such as taxes or insurance – with subsequent pooling of available financial resources spread the risk across the population, and help to ensure that people can use health services without fear of financial ruin. It seemed that 3.2% Indians would fall below the poverty line because of high medical bills with about 70% of Indians spending their entire income on healthcare and purchasing drugs. (WHO 2011 & 2012). OoPE accounts for an average increase in poverty by as much as 3.6 and 2.9 percent for rural and urban India respectively (Duggal 2009). The World Health Statistics (2012) also depicts some other global facts. Among the other third world countries Pakistan's OOP stands at 41 percent, while China's is 38 percent. Globally, Myanmar and Afghanistan recorded the highest OOP expenditure on health at 82 percent.

Table: 1 Percent Out-of-pocket health expenditure as a proportion of total health expenditure in South East Asian Region Countries

Countries	OOPE as a % of total health Expenditure
Myanmar	82
Bangladesh	65
India	60
Nepal	49
Sri Lanka	44
Indonesia	41
Maldives	28
Thailand	15
Bhutan	13

Source: World Health Statistics 2012

Figure 1: Percentage of GDP used for health, 2005



Source: WHO, World Health Report 2008

Out of Pocket Expenditure [OOPE] in India - Factors

India ranks third in the World Health Organization's latest list of "countries with highest out of pocket (OOP) expenditure on health" in the south-east Asia region. Though, the country has a well-structured 3-tier public health infrastructure, comprising Community Health Centers, Primary Health Centers and Sub-Centers spread across rural and semi-urban areas and tertiary medical care providing multi-specialty hospitals and medical colleges located almost exclusively in the urban areas. Still the progress has been quite patchy across the regions (large scale inter-State variations); gender (male-female differences) as well as across space (with significant rural-urban differences).

The Out-of-pocket health expenditure (% of private expenditure on health) in India was last reported at 86.35 in 2010, according to a World Bank report published in 2012. In India, health-care expenditures aggravate poverty, resulting in about 39 million people falling into poverty every year as a result of such expenditures. Therefore, identification of the key challenges for achieving the equity in health service provision, equity in financing and financial risk protection in India is an immediate. These factors or challenges include an imbalance in resource provision, inadequate physical access to high-quality health services and human resources for health, high out-of-pocket health expenditures, inflation in health spending, and also the behavioral factors that affect the demand for appropriate health care.

Proper usage of equity metrics in monitoring, assessment, and strategic planning; investment in development of a thorough knowledge base of health-systems research; development of a refined equity-focused process of deliberative decision making in health reform; and redefinition of the specific responsibilities and accountabilities of key actors are needed to try to achieve equity in health care in India. The execution of these principles with strengthened public health and primary-care services will ensure a more equitable health care.

The Planning Commission too accepts that OOP to pay for healthcare costs is a growing problem in India. (Times of India - May 17, 2012). It says 39 million Indians are pushed to poverty because of ill health every year. Around 30% in rural India didn't go for any treatment for financial constraints in 2004. In urban areas, 20% of ailments were untreated for financial problems the same year, said a recent study in the Lancet. About 47% and 31% of hospital admissions in rural and urban India, respectively, were financed by loans and sale of assets.

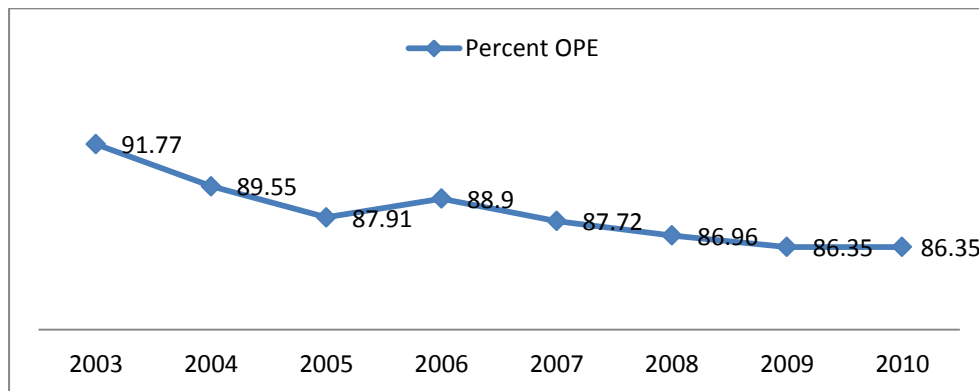
Many studies (Narayanan et al. 2000; Peters et al. 2002; Pradhan 2002) have indicated that the marginalized in India become utterly vulnerable when they seek medical intervention for major ailments. A recent study on out-of-pocket expenditure and poverty has clearly shown that OOP health expenditures account for an average increase in poverty by as much as 3.6 and 2.9 percent for rural and urban India respectively. (Gupta 2009).

Analysis of healthcare expenditure from the Union Budget and State Budgets in India clearly shows that the country's overall magnitude of public expenditure on healthcare is very low. As a result of this, India's healthcare system is among the most privatized healthcare systems across the world. In India, people have to depend significantly on the private sector for availing different kinds of healthcare services. Consequently, the burden of spending for healthcare falls directly on households and a major part of healthcare expenditure in India is out-of-pocket expenditure by people, which has strong adverse implications for the poor. According to NSSO 60th round data it has been observed that around 6.2 percent of total households in the country fell below the poverty line as a result of healthcare expenditure in 2004; among which around 1.3% of the households fell below poverty line as a result of expenditure on inpatient care, while 4.9% of the households fell Below Poverty Line as a result of outpatient care.

The latest available National Health Accounts (NHA) of 2004-05, which has been provisionally estimated the total health expenditure of 2008-09, shows that, out of total healthcare expenditure in our country, only 26.7% was public expenditure and 71.6% was private expenditure with external assistance accounting for a very small share of 1.7%. Out of the total private expenditure on healthcare, out-of-pocket expenditure accounts for a very large chunk as the healthcare expenditure financed by

health insurance and expenditure done by other private bodies are very low (National Health Accounts 2004-05)

Figure 2 – Percent Out of Pocket expenditure from 2003 to 2010



Source: <http://www.tradingeconomics.com/india/out-of-pocket-health-expenditure-percent-of-private-expenditure-on-health-wb-data.html>

OPE consequences - Overburden of Health Expenditure in India

In India, inadequate public expenditure on health (estimated to be 1.10% of the share of the gross domestic product during 2008–09) and imbalance in allocation of resources with much variation between state expenditures on health, restricted the capacity to ensure adequate and appropriate physical access to quality health care services. For example, public health expenditures per person in Bihar were estimated to be INR 93 compared with INR 630 in Himachal Pradesh in 2004–05. Additionally, a greater proportion of resources were directed towards urban sectors and curative services that suggest an urban bias and rural disadvantage in access to health-care services. (Gupta 2009)

More than three-quarters of health spending in India is paid privately. High out-of-pocket health expenditures, therefore, are a major source of inequity in financing of health care and in financial risk protection from health adversities. This effect is disproportionate across population groups; health expenditures account for more than half of Indian households falling into poverty, with about 39 million Indian people being pushed into poverty every year.

As per cent of total expenditure, the expenditure on health was 4.8% and as per cent of social services expenditure, the expenditure on health was 19.1% in 2010-11. India spends 4.2 per cent of its Gross Domestic Product (GDP) on health care. The General Government (Central and State Governments combined) expenditure on

health was 1.27% of the GDP in 2010-11, which consists only one-fifth portion, rest 70 per cent is being spent by the households. Two-third of health care expenditure is on out-patient and the rest one-third is on hospitalisation. The main problem seems always that the individual with greatest need in India can't access the health care services due to the cost burden. If a household spends more than 10 per cent of household expenditure on health care, then it is termed catastrophic expenditure. In India, 13.68 per cent of household expenditure is spent on health care. (WHS 2011)

The World Health Organization (WHO) has found that generic medicines were available only in 20%-40% of public health clinics surveyed. In comparison, 40%-60% of private health facilities had adequate stock of generic drugs. The sub-national surveys were carried out in Chennai, Haryana, Maharashtra, Karnataka, Rajasthan and West Bengal. Surveys in over 40 mainly low and middle-income countries reveal that availability of selected generic medicines at health facilities was only 44% in public sector, and 65% in private sector. WHO says, "More than half of public facilities lack essential medicines." It was seen that low public sector availability forces patients to purchase medicines from private sector, where prices are generally higher and are not always affordable. The progress report of the prime minister's expert group that has been submitted to the Planning Commission says the proportion of private out-of-pocket expenditure is pegged at 78%. Of this, 72% is spent on medicines.

National Sample Survey Organization (NSSO) records show that the highest out-of-pocket expenditure on drugs in India is in Himachal Pradesh (87.95%), followed by Uttaranchal (87.75%), Bihar (84%), Rajasthan (83%), Uttar Pradesh (81.86%) and Chhattisgarh (81.38%).

In larger states like Maharashtra 60% of out-of-pocket expenses are for buying drugs, Karnataka (65%), Delhi (74%), Tamil Nadu (66%), Madhya Pradesh (71%) and West Bengal (65.80%).

As a percentage of GDP the overall health expenditure in India is low. It was estimated to be 4% in 2008, according to the most recent National Health Accounts and still haven't shown much changes during these years as the most recent WHS data shows that in the year of 2010 the total expenditure on health as percentage of the national GDP is only 4.1% (See table: 2). Given that the government share of health spending is low, out-of-pocket payments are the dominant source of health financing, resulting into 86.4%.

India's health-financing system is much more complex than those found in other developing countries. It does not fit into the definition of a tax-based or an insurance-based system. It is still evolving. The flow of money from communities, philanthropists and households, for example, is not well documented. While the amount and flow of government spending are known to a larger extent, estimates on private spending are based on responses from surveys of households. However, the

estimated share of household out-of-pocket expenses in total health spending is one of the highest in the world, with more than US\$ 40 billion spent.”

The Table 2 illustrates a decade’s trend in the level of health expenditure in India from the year 2000. As is evident the total health expenditure as a percent of the gross domestic product has remained constant. The government is still not spending as much as it should to reduce OOPE. The private expenditure is nearly three times the amount spent by the government which has catastrophic effects on the poverty stricken population of India.

Table 2: Level of Expenditure on health in India (trend from 2000 – 2010)

Selected National Health Account Indicator	2000	2002	2004	2006	2007	2009	2010
Total expenditure on health as % of GDP	4.4	4.5	4.0	3.6	4.1	4.2	4.1
General Government expenditure on health as % of total expenditure on health	24.5	20.3	20.9	25.0	26.2	30.3	29.2
Out of pocket expenditure on health as % of private expenditure on health	92.2	92.6	92.3	91.4	89.9	86.4	86.4

Source: World Health Statistics 2010, 2011, 2012, National Health Account

OPE in India – Solutions

In India, around 70 percent of the total expenditure on health² is out-of-pocket (OOP) payments by households (Government of India (GoI), 2005). Other major sources of financing health care are the government, insurance, and external sources such as grants and loans from international organisations. The share of the government in total health expenditure has remained low. It has reduced marginally from 18.4 percent in 1998 to 17.9 percent in 2001 (IIPS and WHO, 2006). Further, as a part of the health sector reforms initiated in the early 1990s most of the Indian states have introduced user charges in public health facilities for patients belonging to families above poverty line.

Due to low share of government in total health care expenditure and introduction of user fees in public sector, households have to bear most of the expenses in the event of health shock, which may lead to a fall in consumption expenditure below subsistence level, i.e., to catastrophic OOP health expenditure. Health insurance can provide financial protection to household in the event of health shock and can reduce

catastrophic OOP expenditure on health care. In India, health insurance coverage has been very low with only 1.6 percent of population covered in year 2003. (GoI, 2007)

As per Rama Joglekar (2008), poorer households are more vulnerable and have to spend larger proportion of their total budget on health care than the richer households. These findings point out the need to formulate the policy to financially protect poorer households from health shocks and reduce the economic burden of illness. Further, households with children and elderly persons are more vulnerable. Identifying vulnerable groups and formulating appropriate policies, such as expanding insurance coverage, is required to reduce the economic burden of health shocks.

There is an urgent need to reduce OOPE considerably, the various solutions which can help include the following - First and foremost, the expenditure on medicine ought to be completely eliminated as is being done in some states like Rajasthan, where the government has introduced the MMNDY (Mukhya Mantri Nishulka Dawai Yojna). Under this scheme medicines are being made available free of cost. This model should be replicated in the entire country.

Secondly, other medical expenditure also should be reduced to zero or negligible in all public and trust (charitable) hospitals. OOPE relating to total medical expenditure should be considerably reduced, which can be done by increasing physical access. Thirdly, the quality of care provided by the health institutions is required to be strictly as per IPHS guidelines both in public and private sector. Although there exist a lot of constraint but the government should make efforts to reduce the same. Fourthly, the salary of doctors in the government health system should be equitable and justifiable and private practice by the providers of public health system should be completely banned. The user fee too should be completely abolished.

Fifthly, the government should try and establish standard treatment guidelines which should be mandatory followed by all health service providers and directorates of rational therapeutics should be established at national and state headquarters. And lastly, accessibility and quality of health services ought to be evaluated and monitored through community groups regularly for feedback and improvements. Although PRI involvement has gone a long way but more effort and better regulations are required to make this a success.

References:

- Duggal R. 2007. Poverty & health: Criticality of public financing. *Indian J Med Res* 126, October 2007, pp 309-317
- Fun J and Zick C D.2005. The Economic Burden of Health Care, Funeral, and Burial Expenditures at the End of Life. *Journal of Consumer Affairs*. 38(1): 35-55
- Garg C.1998. EQUITY OF HEALTH SECTOR FINANCING AND DELIVERY IN INDIA. [Online available <http://www.hsph.harvard.edu/research/takemi/files/rp144>]
- Gupta I. 2009. Out-of-pocket Expenditures and Poverty: Estimates From NSS 61st Round. Draft paper. Institute of Economic Growth, New Delhi.

- Jogelkar G. 2008. Can Insurance Reduce Catastrophic Out-of-Pocket Health Expenditure? Indira Gandhi Institute of Development Research, Mumbai, Working Paper No- 16 September, 2008.[Online available : <http://www.igidr.ac.in/pdf/publication/WP-2008-016>]
- Krishna A. 2006. Pathways Out of and Into Poverty in 36 Villages of Andhra Pradesh, India *World Development*. **34**(2):271-288
- Kurian N.J. 2010, *Financing Health care In India*, The Hindu, date 15th January 2010 Available at: <http://www.thehindu.com/opinion/lead/article80956.ece>
- O'Donnell O, Doorslear E V, Eliya R P, et al. 2005. Explaining the incidence of catastrophic expenditures on health care: Comparative evidence from Asia. EQUITAP Project: Working paper no-5. June, 2005. [Online available: <http://www.esocialsciences.com/data/articles/Document12472007530.5017511>]
- O'Donnell O. 2008. Who pays for health care in Asia?. *Journal of Health Economics*, **27**. Issue 2, March 2008:460-475
- Peters DH, Yazbeck AS, Sharma RR, Ramana GNV, Pritchett LH, Wagstaff A. 2002. Better Health Systems for India's Poor: Findings, Analysis, and Options. Human Development Network, (Health, nutrition, and population series). Washington DC: World Bank: 1-376.
- Pradhan, M and Prescott N. 2002. Social Risk Management Options for Medical Care in Indonesia. *Health Economics* **11**:431-46
- Planning Commission, Govt. of India (Website: <http://www.planningcommission.nic.in>).
- Sinha K. India ranks 3rd in region in 'out of pocket' med spend. Times of India, Date May 17 2012. Available at: http://articles.timesofindia.indiatimes.com/2012-05-17/india/31747967_1_india-ranks-expenditure-ill-health
- WHS 2009
WHS 2011
WHS 2012
World Health Organization, World Health Report 2000, Geneva, WHO.
WHO Global Health Expenditure Atlas 2012
World Bank Data 2012.
Web source : <http://www.tradingeconomics.com/india/out-of-pocket-health-expenditure-percent-of-private-expenditure-on-health-wb-data.html>