Chapter VIII

A Summary of Findings and Emerging Policy Perspective

Poverty is the cause and consequence of poor health. Poverty is detrimental to health because it restricts access to medical care and healthy living conditions, thereby making the poor more vulnerable. Also, since prevention and effective treatment of adverse health events cost money, the poor are not only likely to suffer from ill health more often, but also to have more severe sequel. Poor health and illness are universally dreaded as a source of destitution, partly because of the costs of health care but also, the income lost due to illness. Health financing mechanism in a particular country therefore assumes significance in issues of poverty as a consequence of poor health. The nature of financing defines the structure, the behaviour of different stakeholders and quality of outcomes. Access to health care, utilization of health services and for that matter, even morbidity pattern, at times, is crucially influenced by the extent of public-private mix in health financing.

8.1 Background, Scope and Organisation of the Study

Although India spends about 6 per cent of its GDP on health, public (Central, State and Local Governments combined) expenditure as a percentage of total health expenditure amounts to a meagre 20 per cent while households account for almost 70 per cent of the total health expenditure, almost all of which is in the form of out-of-pocket spending. Given that good health is the most basic of all necessities, such high levels of out-of-pocket spending by the households have certain adverse implications. While for some, access to health care is reduced considerably, others who opt for treatment face
catastrophic burden of health care expenditures and are in consequent danger of becoming impoverished.

The budget of a typical household broadly accounts for expenditure under food, tobacco and intoxicants, fuel, light, clothing, bedding, footwear, education, medical, rents, taxes, premiums, purchase/construction and, maintenance of durable goods, miscellaneous/others. Poor households are forced to economise on the other components in order to protect their food expenditure. Household medical expenditure is the most difficult to conserve on because of its unforeseen and unavoidable nature and the issue of foregone income or even death associated with it. An economically vulnerable household facing a health shock therefore has to instantly devise its own strategy of coping with the related expenses. If the magnitude of shock is large enough, the expenditure share of food in household budget is also tampered with, raising serious questions of nutritional adequacy and the resultant vulnerability to diseases. A health shock of still higher magnitude lead to the well documented issue of indebtedness and intergenerational poverty traps. Thus morbidity is a shock and its treatment is potentially catastrophic to a poor household.

The financial burden of health care is a universal issue, cutting across socio-economic co-ordinates of households. However, health has often been perceived as a luxury good. The perception of illness in general and severity of illness in particular has been found to be affected by socio-economic and psychological characteristics of an individual. This therefore means that the definition of ailment is not universal. Simply put, a rich person may identify a relatively minor indisposition as ailment and go for treatment, while the poor might perceive an ailment only when it is work-disabling in nature. Their subsequent choice of service providers is often in conformity with their respective financial status. The resultant burden of illness therefore is inherently asymmetrical as far as its nature and origins are concerned. If we incorporate the largely urban elite specific instances of life-style diseases and cosmetic surgeries catering to aesthetic makeovers, the issue of asymmetry only gains further credence. This should remove any doubt whatsoever about the group that deserves special attention when we discuss economic
burden of illness. It has to be the poor, who often continue to bear the burden of illness, long after it has been cured.

Prevalence of this alarming phenomenon is invariant of the place of residence of the poor households – rural or urban. However, it might be contended that the extent and severity of the burden of disease is more in the case of the urban poor vis-à-vis his rural counterpart. Apart from the higher cost of living and an extremely competitive informal job market, the burden of disease among the urban poor is enhanced, thanks to unhygienic living conditions, deplorable status of basic necessities like water and sanitation, increased exposure to accidents and poor environmental condition that increases the vulnerability to indispositions and hence the economic burden. High rate of growth of urban population and consequent increase in population residing in slums has lead to over straining of infrastructure and deterioration in public health and wide inequalities in accessing services. Such hostile circumstances coupled with the lack of social network and fall back options, arguably leads them to the "medical poverty trap". Development experts and agencies concerned about poverty generally focus on rural development. While the significance of rural poverty cannot be underplayed especially in a country like India, there is a need for a better understanding of the nature and causes of urban poverty and the underestimation of its magnitude.

Against this backdrop, the current study attempts to establish the impoverishing effects of private healthcare spending on urban households in general and the urban poor in particular. It also conducts a detailed comparative analysis of the indirect cost of illness measured in terms of the loss of household income due to ailment, which is often the neglected component in research and subsequently policy. The degree and distribution of indebtedness due to health care payments is also dealt with elaborately. Recognising the profound impact of socioeconomic and demographic factors on morbidity perception as well as treatment seeking, the study also looks at the variations in the economic burden of morbidity across states as well as selected household characteristics. Finally, through a suitable econometric exercise, this work identifies the household level determinants of the "medical poverty trap". The ulterior objective of the study is to underscore the need to explicitly incorporate health expenditure in the current poverty line in view of the gradual
withdrawal of the state from provision of health services and the consequent exposure of the poor to the operational anomalies of the current health care ‘market’ in India.

The proposed methodology for computing the economic burden of illness consists of two elements—the catastrophic burden of out of pocket expenses on health and illness induced impoverishment. The catastrophic burden of household health expenditure is computed from the distribution of households by share of health payment in total expenditure, and the average degree by which the share exceeds/overshoots a specified threshold, across socio-economic categories. On the other hand, the impoverishing impact of out of pocket health expenditure is computed by recalculating poverty ratios and gaps after deducting health expenditure from total household expenditure. Thus, while the first measure is fundamentally normative in view of the arbitrarily determined threshold, the second measure is more pragmatic and as such has a better possibility of influencing policy decisions. Household level determinants of the medical poverty trap are estimated by applying the binomial logistic technique. Unit level data from the 52nd and 60th Rounds of the National Sample Survey Organisation on aspects of morbidity forms the secondary data source on the basis of which the above mentioned objectives are pursued. The secondary source is supplemented by a case study of two slums in South Delhi, which examines in detail the morbidity pattern, health service utilisation, out of pocket expenses and its burden on this marginalised group of the urban population.

The study was organised into eight chapters. The first chapter provided an introduction and review of literature on the notion of economic burden of illness, in light of existing systems of health financing in the world in general and India in particular. The second chapter examined the pattern of morbidity and health service utilisation in urban India that has important bearing on the cost of treatment. The third chapter started with an exploratory analysis of the patterns in treatment cost, its components and variation across ailment category, type of service provider etc. in extensive detail. It then computed the catastrophic burden of health care payments on the households and presented its variation across selected socio-economic characteristics. It also analysed the indirect cost of ailment using loss of household income due to ailment as a proxy variable. The fourth chapter measured illness induced impoverishment and the extent of indebtedness among
urban households on account of uncovered health payments. The fifth and the sixth chapter replicated the analyses for the marginalised sections of the urban population on the basis of data collected from a case study of two slums in Delhi. The seventh chapter dealt with the household level determinants of the medical poverty trap. The estimation of the econometric model with certain modifications was carried out at three levels—urban India as a whole, separately for selected states as well as for the sample of slum dwellers. In what follows we present a summary of findings from each chapter.

8.2 A Summary of Findings

The pattern of morbidity in urban India was mixed in the sense that it demonstrated a simultaneous presence of the severity of illness factor, as well as the perception angle. While on one hand the truly vulnerable groups in terms of health status such as the individuals belonging to the lowest expenditure quintiles, infants and the aged etc. displayed higher morbidity, the presence of a weak positive socio-economic gradient in morbidity reporting and treatment thereof was also noticeable. The higher morbidity prevalence in Kerala for example could be convincingly attributed to the higher educational attainment of the population as well as the relatively better developed and well functioning health infrastructure in the state, comprising of public as well as private institutions. The nature or type of ailment also demonstrated noteworthy association with the economic status of individuals and resulted in a dichotomy of some sorts. Diseases that are preventable through effective public health intervention were found to be disproportionately prevalent among the urban poor while the urban rich were found to increasingly suffer from a different set of diseases altogether which are generally referred to as life-style diseases. There is little doubt therefore on the particular group of population who were most severely affected due to a defunct public health system in the country. The patterns in health service utilisation demonstrated distinct biases towards the private sector as a substantial portion of the population were dis-satisfied with the quality of services in public institutions.
The third chapter started with a detailed study of the share of treatment cost by expenditure components. It also looked for the presence of possible variation in the share of these components across ailment categories. Next, variations in the magnitude of average treatment cost per treated case were examined across selected spatial, demographic, socio-economic and epidemiological characteristics of the sample. Acknowledging the catastrophic impact that out of pocket health expenditure could possibly have on the general well being of a household, the subsequent part of the analysis was conducted at the household level. Putting forward an oft used definition of catastrophic burden of illness, the study computed the same and examined its variation across states and selected household characteristics. The burden was also computed for the immediately preceding NSS round (52nd Round) on Morbidity and Treatment of Ailments in order to provide a comparative framework to the analysis. Using a suitable index of concentration, the within-group variation with respect to economic position of the households was also calculated. Finally the chapter made a preliminary attempt to explore the indirect cost of ailment and its burden on the households, an issue that is largely ignored in studies on burden of illness. The relevant findings of the analysis are as follows.

Expenditure on medicines, predominantly purchased from outside constituted the major share of health expenditure and it was invariant of the nature of service provider or the type of ailment. Cost of treatment from a private source was thrice the cost incurred in a public source in case of hospitalised treatment. For non hospitalised treatment too, private sources were 1.3 times more expensive then a public source. This is an alarming result since more than 60 percent of all inpatient cases and nearly 80 percent of all outpatient cases were treated in private hospitals. Treatment of cancer and other tumours, cardiological ailments, psychiatric ailments, diseases of the kidney and tuberculosis were found to be the most expensive in terms of the treatment cost incurred. Share of out-of-pocket health expenditure in total consumption expenditure of the household was estimated at around 8 percent, nearly double of what it was in the nineties. It is to be noted that the consumption expenditure surveys of the NSS place the health share of household budget in urban India at around 5 percent. Therefore one is tempted to say that regular consumption expenditure surveys underestimate the health care costs of the
households and the consequent degree of economic burden. The distribution of the health share in household budget was pro-rich in the sense that the households in the higher expenditure quintiles spent a smaller proportion of their total resources on health care. This is in spite of the higher perception of ailment among high income groups, the predominance of life style diseases which necessitates expensive treatment and a demonstrated preference for private sources of treatment within this group that generally involves higher costs. Almost a fifth of the urban households in India experienced catastrophic burden of out of pocket expenditure and there were considerable inter state variations in its incidence. Kerala, Uttar Pradesh, and West Bengal had the highest incidence of catastrophic payments among its households. However for Kerala and West Bengal it was the relatively richer households who had to face this burden. In terms of household characteristics, the Muslims, general category, female headed and self-employed households were relatively more affected by the catastrophic impact of uncovered health payments as compared to other categories within each group. Indirect costs or foregone income as a proportion of household consumption expenditure was considerably higher for the households belonging to the poorest expenditure quintile. In terms of the principal occupational characteristic of the households the casual labour households were found to be the most vulnerable to the indirect cost of illness.

The third chapter made an attempt to provide a more formal definition to the economic burden of illness. It tried to enumerate the households who were impoverished on account of health care payments. It also examined the variation in illness induced impoverishment across states and selected socioeconomic groups. It went further by acknowledging the role of health financing arrangements on future economic solvency of households. Therefore it performed a disaggregated study of the components of health financing and successfully identified the groups that were more vulnerable to the potential poverty trap in the form of health related indebtedness. The salient findings of the analysis were as follows.

Poverty headcount in urban India increased by 6 percentage points on deducting monthly per capita health expenditure from per capita total consumption expenditure of the households for the year 2004. This increase in poverty headcount was double that of the
increase in 1995-96. The difference in poverty gap pre and post health care payments increased from Rs. 8.57 in 1995-96 to Rs. 27.44 in the year 2004. Substantial disparity in poverty figures was noted across states. Households from Kerala were found to be the most vulnerable to the phenomenon of ‘medical poverty trap’ in the current year. By the proposed methodology, treated illness induced an increase of 11.6 percent in the head count ratio of Kerala which was way above the other states. Poverty gap normalised for state specific poverty lines rose by 10 percentage points for Kerala on account of out of pocket health expenditure. The impoverishing effect of out of pocket health expenditure was relatively more pronounced in case of Muslim and Scheduled Caste households in urban India for the current year. Poverty ratio increased by close to 9 per cent among Muslim households when health care costs were explicitly incorporated in poverty calculations. The female headed households displayed a higher incidence of ‘medical poverty’ vis-à-vis the male headed ones, though the difference in pre and post payment poverty gap was slightly higher for the males for the current year. When compared to the last decade female headed households demonstrated increased vulnerability to the phenomenon of illness induced poverty. The regular salary and wage earning households were the least susceptible to adverse economic impacts of a health shock. The ‘others’ type of households which mainly refers to pension earners and rent and remittance recipients were the most vulnerable groups in this respect. Expenditure quintile wise variation show that households belonging to the second poorest quintile had the highest proportion of those who were pushed into poverty on account of health payments. Surprisingly even households belonging to the richer quintiles registered cases of illness induced impoverishment.

The financing aspects of household health expenditure was elaborately examined with respect to hospitalised treatment as it entailed a higher cost and hence required multiple sources of financing. Financing of hospitalisation expenditure was done predominantly from household income and savings. The share of borrowing in total health expenditure decreased over time. However, there exists substantial variation in financing arrangements across economic class category of the household with poorer households being the borrowers of health expenditure and the percentage share of the borrowed funds increased across time. As an expected behaviour, household borrowing as percentage of
total health expenditure declined as one moved from a lower to a higher consumption expenditure quintile. The households from the southern states of Kerala, Tamil Nadu and Andhra Pradesh were unable to finance even half of their hospitalisation expenditure from current income and savings in 2004. In fact, around 33 percent of the hospitalisation expenses of an average household were financed via borrowing in urban Kerala which is the highest in India. Another alarming finding was the relative vulnerability of female headed and casual labour households to hospitalisation related indebtedness. Also, the pattern of vulnerability has remained constant over time while the magnitude has increased especially in case of the casual labour households. Currently 53 percent of the hospitalisation expenses of a casual labour household are financed by borrowing. The problem is more severe than it appears since the generally uncertain residential status of an urban casual labour disallows him from access to institutional credit and most often he resorts to an informal money lender charging unregulated interest rates. This leads him to a vicious circle of ill health, poverty and indebtedness with none to provide him a big push.

The fifth and sixth chapters were based on the case study of two slums in Delhi. Chapter V undertook a detailed analysis of morbidity, health service utilisation and treatment cost of the urban poor on the basis of a case study of two slums in South Delhi. There were certain significant observations that essentially had a bearing on the economic burden of illness. Firstly, the major share of ailment cases occurred for the highly productive age group 25 to 39. Secondly, among those working, the casual wage labourers were the most vulnerable occupational group in terms of morbidity prevalence. Thirdly, the lower three income quintiles accounted for almost sixty percent of all ailment cases. Fourthly, gastrointestinal diseases emerge as the major ailment among the sample of urban poor dwelling in slums. These results were consistent for inpatient and outpatient treatment alike. Fifthly, while people preferred the public hospital for inpatient treatment, for ailments of relatively lesser intensity, they avoided a public source. This was in spite of the costs being much higher in a private source. However, they have been found to adopt a hazardous alternative of seeking treatment from unqualified doctors within the slum. Sixthly, the high indirect cost of illness might have prevented the ailing poor to seek
treatment from a public hospital or dispensary as the whole process was admittedly time consuming.

The sixth chapter went on to compute economic burden of illness among the urban poor by examining the catastrophic and impoverishing effects of out of pocket expenditure on the slum households. It also enlisted the coping strategies adopted by households facing a health shock in order of prevalence. Half of the surveyed households spent 10 per cent or more of their income on healthcare, which also happened to be the median for the entire sample of households with at least one treated ailment. The burden of disease or the catastrophic headcount declined as one moved from a lower to a higher quintile for the 10 percent threshold. The depth of burden presented a more or less similar picture. The average overshoot was consistently higher for the lower expenditure quintiles across all thresholds and it declined subsequently except for the second richest class. More female headed households incurred a health expenditure of 10 and even 15 per cent of total income in percentage terms, vis-à-vis male headed households. For still higher thresholds however male headed households dominated. The catastrophic gap was also consistently higher for the male headed household at all thresholds. The average share of out-of-pocket (OOP) health expenses in total income was the highest for households whose main earner was a casual labour. They were also found to bear a disproportionate economic burden of illness both in terms of headcount as well as gap at almost all thresholds. A look into the disease wise average OOP share showed that treatment of accidents and injuries required the highest financial resources as proportion of income. This was closely followed by orthopaedic and gynaecological ailments. People suffering from these ailments had to spend around 18 per cent of their household income on treatment. The issue of major concern is therefore that even the most common and apparently inexpensive diseases such as fever and diarrhoea were imposing a major financial burden on the lives of the urban poor. Average OOP share across treatment sources exhibited wide disparity. Share of health expenditure in household budget was highest for people who opted for treatment from a registered private source. The average share was more than double in comparison to those who opted for a public mode of treatment i.e. a government hospital or dispensary. Those who were treated by the
unregistered or unqualified private practitioners i.e. the quacks within the slum had predictably incurred the lowest OOP share.

Out-of-pocket expenditure on health raised poverty levels within the sample by around 13 per cent. In absolute terms this meant that out of the 871 individuals surveyed 110 became poor exclusively due to household expenditure incurred on treatment of ailments as an outpatient. The gap also rose by Rs. 50. While impoverishment due to treatment cost among female headed household increased by 17 percent among the selected sample, for the male headed households the corresponding figure was 12 percent. The depth of poverty however was more pronounced in case of the male headed households. Alarmingly, individuals suffering from tuberculosis were the worst affected in terms of the impoverishing impact of health care payment within the selected slums. Private sources of treatment contributed largely to the impoverishing effects of out of pocket payments for health care. Poverty headcount increased by around 16 percent for those individuals who availed a private source for treatment of their ailments. The corresponding figures for the unqualified private source and the public source were 3.6 percent and zero percent respectively. Regarding coping strategies prevalent within the slums, after the initial shock was met from income or savings the households resorted to borrowing. Personal communication with the respondents revealed that these borrowings mostly took place within the slum at a high interest rate. The strong social network within the inhabitants ensured that they could arrange for money when they needed it most. However, the apparently simple account of the range of coping strategies was disturbing because it revealed that the burden of illness can extend well beyond money. As high as 44 percent of the affected households had to reduce their food expenditure to finance health. The severe adverse nutritional implication of this strategy also lends support to the ongoing debate on poverty measurement in India. Non-food expenditure, especially of such unavoidable nature as medical costs, has been on one hand eating into food share of household budget and on the other, inflating the total consumption expenditure thereby rendering such households as non-poor.

Chapter VII tried to find out the household level determinants of the medical poverty trap with the help of the binomial logistic regression technique. The exercise was carried out
at three levels with slightly different models, the basic structure however remaining the same. The salient finding of the analysis is that the pattern of vulnerability discernible with respect to illness induced poverty is not different from the pattern that is evident on other dimensions of human development. In other words the groups that were identified as prone to the 'medical poverty trap' were with some exceptions, the ones who were deprived in many other aspects such as education, access to livelihood, income etc. Larger households with more dependents, self-employed households, households with a female head, Muslim households etc. were relatively more likely to experience the phenomenon of illness induced impoverishment than their counterparts, in urban India, keeping other factors constant. With some exceptions, this pattern was in view in many of the states of India. Kerala for example is a state which compares with or even excels the developed nations in terms of its health achievement levels. The analysis however shows that Kerala is paying a price of this achievement in terms of equity in the finance of health care. All the perceived vulnerable groups registered a much higher probability of impoverishment from high OOP expenditure. In the case of the urban poor, income (if thought of in terms of working members in the household), occupation and choice of service provider emerge as principal determinants of economic burden of illness.

8.3 Limitations of the Study

The study therefore proves with considerable conviction that health care imposes an economic burden and that the conventionally marginalised sections of the society bear a disproportionate brunt of this burden. However, although this work attempts a holistic presentation of the notion of burden of illness by examining the welfare effects of direct and indirect cost of treatment, it crucially overlooks the problem of foregone treatment which may be the most extreme and least preferred coping strategy. A sustained focus on health expenditure ignores the fact that many of the poor and possibly most of the very poorest spend very little on health care. The potentially immiserising effects of non-access of health care when needed might be of even gigantic proportions due to the consequent reduction in household production and further exacerbation of treatment cost at a later stage. Another important issue is that on most occasions expenditure on health
care primarily by the poor is wasted, at least in clinical terms, on inappropriate, futile, needless or even hazardous treatments often prescribed by providers with no formal qualifications as was evident from the case study of urban slums. So any institutional financial assistance to purchase such treatments can generally be counterproductive. The variable nature of health problems also obscures the linkage between ill health and well being. For example, individuals suffering from dengue fever, tuberculosis, diabetes or AIDS might all be classified as morbid. However in terms of the risk to life, level of disability and distress, duration of illness, ease of diagnosis, physical availability and cost of treatment, and a range of other factors, their situations may differ radically.

Coming to the data and methodological aspects, financial impact of health care costs on household welfare has been computed primarily on the basis of consumption expenditure surveys, especially in India. This study is however based on the specific survey on morbidity, treatment cost and related aspects occasionally conducted by the NSS. The motivation of using this alternate data source is the extensive detail with which parameters on treatment cost have been dealt, which is absent in case of the consumption expenditure data. Though the choice of data source bestows the possibility of a more accurate representation of the economic burden of morbidity, there are certain caveats regarding the methodology and hence the interpretation of the results. Firstly, unlike consumption expenditure surveys, this particular survey collects data on health expenditure in greater detail with a consequent associated possibility of overestimation of the same. Also, responses on household consumption expenditure in this schedule are collected through a truncated set of questions and therefore are likely to underestimate total household expenditure. A combination of these two aspects might lead to an inflated health share in the household budget. However, by a similar logic one might also argue that NSS consumption expenditure surveys do underestimate the health costs borne by the households. Another important methodological issue is the scaling up of 15 day period outpatient expenditure to a month for estimation of catastrophic payments and impoverishment. This however could be intuitively defended by acknowledging that incidence of morbidity is a stochastic factor and therefore for every case of ailment within the reference period of 15 days, there might be another who fell ill prior to this period and hence was not counted as sick.
8.4 Emerging Policy Perspective

An urban equivalent of the three-tier health structure at least theoretically prevalent in the rural areas is largely absent in India. Urban India has a mixed health system where ministries of health, private insurance, social insurance and targeted schemes coexist to serve different sections of the population. For example in Delhi, health planning is undertaken independently by the MCD, the NDMC, the Government of Delhi, ESI, CGHS, Railways, Defence etc. If we add to this the numerous private providers of health care and the independently working NGO’s what emerges is an extremely complex system that requires an unlikely synergistic effort to achieve the ultimate goal of providing health care to the urban populace. Such a system tends to fragment, increase administrative costs, limit pool sizes and undermine both equity and efficiency objectives. Since streamlining this fragmented system looks like a distant possibility, the policy initiatives needed to offset the economic burden of health care spending among households, essentially must be an assortment of programmes that have been successfully tested under diverse national and international settings.

The health sector in India currently reflects three separate trends. Firstly there is a greater valuation placed on health with increasing education and public programme on awareness generation on health issues. This has resulted in even poor households willing to spend and incur debt to ensure minimal healthcare. Secondly, there has been a worsening of quality and spread and therefore considerable reduction in access to reliable public health services. This has allowed the unbridled expansion of private providers with better access to technology but no regulation of the prices and quality of services offered. Thirdly, there has been an increase in user charges and other effective charges upon consumers even in the public health system, as government-run hospitals and clinics that are starved of public funds resort to making citizens pay more for medicines, diagnostic procedures and surgical aids. The burden on citizens is particularly high because, even as households bear the brunt of aggregate health spending in the country, systems of affordable health insurance are non-existent or poorly developed.

Against this backdrop this study proves that private (household) health care spending constitutes an important pathway to poverty among urban households in India and
reiterates the perception that alleviation of poverty requires better targeting of the causes of poverty rather than the poor per se. While the identification of the poor is and should continue to be an important tool there is a danger that it will be seen as the end rather than the means of poverty reduction. One cannot really predict who will be poor at a future date but this study has with much greater certainty identified a reason that lead people into poverty. Policy prescriptions are therefore expected to target this reason before targeting the people.

One potentially significant policy programme in this direction is the Rashtriya Swasthya Bima Yojana (RSBY), which was formally launched on the 1st of October 2007, and was operationalised from 1st of April 2008. This seems to be one of the very few programmes that acknowledge the frequent incidence of illness and the consequent financial catastrophe accruing to about 93 percent of the total workforce in the country who are out of the organised sector domain. The Scheme envisages to provide smart card based cashless health insurance cover up to Rs.30,000 to all the BPL families in the unorganized sector in the next five years under the Health Insurance Scheme. The programme intends to cover an estimated six crore BPL workers in all 600 districts in the country in a phased manner. The services under the programme are restricted to hospitalisation episodes within the households. The Government of India shall provide 75 percent of the estimated annual premium of Rs.750, subject to a maximum of Rs. 565 per family per annum. Besides, the cost of smart card designed to electronically identify the beneficiary, will be borne by the Central Government. The remaining 25 percent will be paid by the respective State Governments. State governments are also entrusted with the duty of selecting a public or private insurance company licensed by the Regulatory Development Authority (IRDA) to provide health insurance. The insurer must provide a list of empanelled hospitals that will participate in the cashless arrangement. These hospitals must meet certain basic minimum criteria and must agree to set up a special RSBY desk with smart card reader and trained staff. The list should include both public and private hospitals. The BPL (as prescribed by the Planning Commission) families are entitled to more than 700 in-patient medical procedures with a cost of up to 30,000 rupees per annum for a nominal registration fee of 30 rupees. Pre-existing medical conditions are covered and there is no age limit. Coverage extends to the head of household, spouse and
up to three dependents. The scheme also deserves credit for partially covering the cost of transport that has also emerged as a key but often neglected component of treatment cost.

While the scheme aims at addressing the concern of health among the poor as well as the issue of financial protection, it is doubtful whether it does both, adequately. This work identifies at least two vital issues that have not been addressed by the RSBY. The first issue is that of non-hospitalised or regular outpatient treatment that emerges as the principal source of the economic burden of illness. While the hospitalisation rate in urban India is close to 3 percent, the incidence of non-hospitalised ailments is around 10 percent on an average with significant variations across states and socio-economic groups. Again, close to 38 percent of all hospitalisations and 57 percent of hospitalisations within the casual labour households (who might be assumed to be the target of the proposed scheme) took place in public hospitals that entails a lower cost when compared to a private facility. For non-hospitalised ailments, the corresponding percentage was only 26 percent for all households and 35 percent for the casual labour households. If we make a reasonable assumption that the casual labour households largely constitute the BPL group, 65 percent of these households are definitely exposed to the financial burden of health shock on account of non-hospitalised treatment of their ailments from a private source, an issue that is left unaddressed by the RSBY. This study further elucidates that while impoverishment on account of out-of-pocket expenses on hospitalisation stands at 1.6 percent, close to 4.6 percent of the urban population are impoverished by the burden of non-hospitalised ailments. For the urban casual labour households the corresponding figures are 1.4 percent and 5.5 percent respectively. In view of the above, there is scope for a reformulation of the scheme to include outpatient episodes also which are more debilitating for the households notwithstanding the relatively lower cost of treatment vis-à-vis inpatient cases. The other issue is that of indirect cost of illness that might be defined as the time cost of the person ill or the informal caretaker and the resultant loss of income. This work shows that the indirect costs of illness accruing to a household as a proportion of household consumption expenditure amounts to 3 percent and 8 percent for the households with inpatient and outpatient cases respectively. Foregone income as a proportion of household consumption expenditure was considerably higher for the households belonging to the
poorest expenditure quintile. In terms of the principal occupational characteristic of the households the casual labour households were found to be the most vulnerable to the indirect cost of illness. Addressing the issue of indirect cost of illness might also contribute to an enhancement in the general health seeking behaviour of the urban poor in particular.

In retrospect, schemes such as the RSBY are more of a rejoinder to the deplorable public health apparatus of the State. It seems that the State has accepted its failure to deliver good quality public health services at affordable cost to its citizens and is also reluctant to revamp the system with a judicious mix of financing, regulation, monitoring and implementation. The co-payment schemes are basically a suitably disguised attempt to further withdraw from the historically contemplated role of the state as a provider of public services and rather assume the role of a facilitator of these services. The best way forward would have been to turn a deaf ear to the pro-liberalisation clamours for fiscal stringency emanating from our international political masters and pump more financial and human resources into the overtly ailing public health sector of ours. Apart from the cost aspect this would go a long way in ensuring quality of service, which currently seems to be a luxury of some sorts, especially to the urban poor. A well functioning public health system involving preventive as well as curative health care can also reduce the indirect costs of illness that are largely hidden or are indirectly manifested in terms of choice of service provider. Also, given that expenditure on medicines constitutes the lion’s share of the medical bill, the enhanced levels of public health expenditure must be directed towards building up a buffer of essential drugs that could be provided free of cost or at a subsidised rate depending on the economic status of the patient. There is also a need for reformulation of the nation’s drug policy such that it would ensure the development of a self reliant industry, preferably the public sector for production of all essential drugs and medical supplies at affordable prices and of proper quality. The unchecked growth of the commercial private sector must be restrained if not stopped. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics and standard fee structure should be made obligatory. In view of the variation in treatment seeking behaviour of the urban populace, sufficient support should be
provided to traditional systems of medication too so that they can emerge as a low cost but equally effective alternative to the urban poor.

Thus, from a policy perspective, the time has come to target the reasons for impoverishment rather than the poor per se. This work has argued that morbidity and its treatment thereof is the key event affecting household economic solvency in the short run via implicative readjustments in household resource allocation, and in the longer run via possible indebtedness and its consequences. So, even in the context of counting the poor, this work is an appeal to the policy makers to explicitly incorporate health shocks and their aftermath in the existing poverty lines for an accurate representation of the marginalised sections of the society.