

Deepening Health Insecurity in India: Evidence from National Sample Surveys since 1980s

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Drawing on evidence from the past morbidity and health surveys (1986–87 to 2004) and consumer expenditure surveys (1993–94 to 2004–05) of the National Sample Survey Organisation, this paper argues that public provisions of healthcare in India has dwindled to new lows. Outpatient and hospitalisation care in India in the past 20 years has declined drastically, leading to the emergence of private care players in a predominant way. While healthcare costs have shot up manifold in private provisioning, government health facilities are increasingly compelling patients to look for private outlets for procuring drugs and diagnostics. Due to these developments, millions of households are incurring catastrophic payments and are being pushed below poverty lines every year.

The health sector in India is at the crossroads. India is experiencing a “double burden of disease”. Many preventable communicable diseases are growing unchecked, nutrition-linked health problems continue to plague the country. Along with it, chronic health conditions are rising menacingly. Does our health system have the ability to confront this insurmountable task? India’s health system is in no great shape to take these issues head on. While public healthcare infrastructure has been allowed to decay, private healthcare sector is wooed with a plethora of incentives, in keeping with the pro-market agenda of the ruling regime. Due to these developments, access and affordability of healthcare has suffered enormously, leading to our failure to achieve good health and provide financial risk protection to the population in general, and the poor in particular. A nation aspiring to attain and sustain a double-digit economic growth cannot remain a mute spectator without a concomitant focus on its health of the workforce. A productive workforce and a healthy population are necessary components of any development strategy, which could be ensured only by providing adequate health security to its society. The causal link between health and economic development is well known (Thomas and Frankenberg 2002; Duraisami and Mahal 2005; Bloom et al 2006). Unfortunately, the “exclusive” growth strategy of the neoliberal variety followed since the early 1990s has exposed the population to extreme vulnerability in general, and health insecurity in particular.

By tying down our hands to an era of “fiscal discipline”, a la the Fiscal Responsibility and Budget Management (FRBM) Act, neoliberal policies practised since the early 1990s have resulted in declining public expenditure on health. Private provision of healthcare, on the other hand, has been on the rise, both in rural and urban India. International experience shows that the private sector tends to focus on profit maximisation and is less concerned with public health goals (Bennett et al 1997). While in hindsight it might appear that the State is withdrawing from healthcare provision, emerging evidence clearly points to a trend of gradual handing over vital national assets (public health facilities) to the private sector, promoted actively by the State.

Over the years, private sector in healthcare has gained a dominant presence in all the submarkets – medical education and training, medical technology and diagnostics, manufacture and sale of pharmaceuticals, hospital construction and ancillary services, and finally, the provision of medical services (Rao et al 2005). However, the service of private providers is usually fraught with problems of quality and lack of basic amenities at healthcare centres in rural areas. These essentially compel a large proportion

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of ailing persons to forego formal treatment or seek treatment from expensive private health centres located in urban areas.

In consequence, households' out-of-pocket (OOP) spending is not only alarmingly high, but rapidly rising. This has serious repercussions by the way of catastrophic payments¹ by households (Wagstaff and Doorslaer 2003; Xu et al 2005; Doorslaer et al 2006). A large majority of the economically vulnerable population and even a sizeable section of the middle class are susceptible to catastrophic health spending, particularly, if an earning member of the family is afflicted with serious hospitalisation (Ranson 2002). In the absence of an integrated public healthcare or universal social health insurance system, catastrophic payments are likely to plunge a sizeable section of even the well-off to abysmal poverty levels (Krishna 2004; Doorslaer et al 2006; Garg and Karan 2009). Voluntary private insurance, which is often offered as panacea to battle all health risks, suffers from serious market failures. It is characterised by adverse selection, moral hazard, cost escalation, etc. Apart from bloating administrative expenses of the insurance companies, the establishment of third party administrators (TPA) has become one more additional burden of cost that insurance holders have to bear.

Against this background, the present paper largely draws evidence from the different rounds of National Sample Survey (NSS) data (in the last two decades) on healthcare and consumption expenditure. It explores the scale and magnitude of unjust and unfair dependence of the ailing population in India on private providers and changes therein over the last two decades or so. Further, the main focus of the paper is to examine the nature and significance of the growing burden of health expenditure on households on account of the increased dependence on private providers. We study these issues by comparing the period of 1986-95 with that of 1996-2004, largely representing the pre- and post-liberalisation periods, respectively. The first section examines the trends in utilisation of healthcare institutions in India, both public and private. The second section assesses the current magnitude and pattern of healthcare spending in India in recent periods. Section 3 presents a broad contour of the estimates on catastrophic and impoverishment impact of household spending on health. Finally, the last section concludes with few policy observations.

1 Declining Public Provisions

Many preventable communicable diseases are growing unchecked and under-nutrition-linked health problems continue to plague India, with a new set of infectious diseases rearing their ugly heads (HIV/AIDS, drug-resistance TB). Along with it, chronic diseases have begun to rise rapidly and significantly (NCMH 2005). Although the increase in reporting of ailments in general cannot be considered necessarily as an indicator of deteriorating conditions of population health, the same can be the reflection of two important situations: (a) an increased morbidity burden in the country, and (b) increased health-seeking behaviour of the population in general (Yazbeck and Peters 2003). On both counts, the demand for healthcare treatment is likely to significantly increase leading to considerable pressure on the existing healthcare facilities in the country.

Evidence from large household sample surveys (NSSO) suggests that reporting of short-duration ailments (based on 15-days

recall) has increased almost by four times during the last two decades from approximately 2.4% in 1986-87 to more than 9% in 2004. During the same period, the percentage of population reporting hospitalisation has been around 2 to 3%. Since the proportion of non-treated ailments has remained stagnant around 15-17% of the total ailing population, it logically follows that healthcare utilisation has risen at the same rate as that of reporting of ailments during the same period (Table 1).

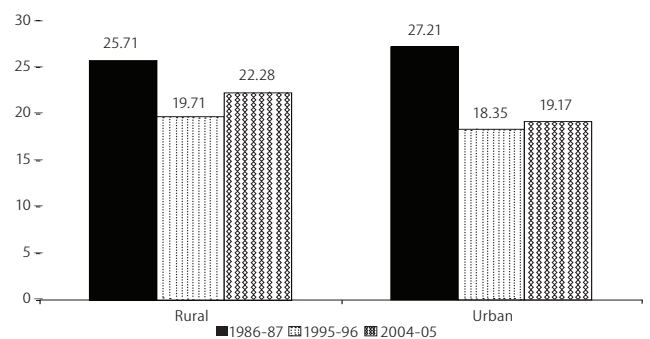
Table 1: Reporting of Short Duration Ailment, Hospitalisation and No Formal Treatment (1987-88, 1995-96 and 2004; in %)

Particulars of Ailment and Treatment	1987-88	1995-96	2004
Population reporting ailing (short duration)	2.4	5.5	9.1
Short duration ailment reporting no formal treatment*	17.7	15.3	15.7
Population reporting hospitalisation	2.6	1.6	2.7

* includes cases of self-treatment.
Source: NSSO (1998); NSSO (2006).

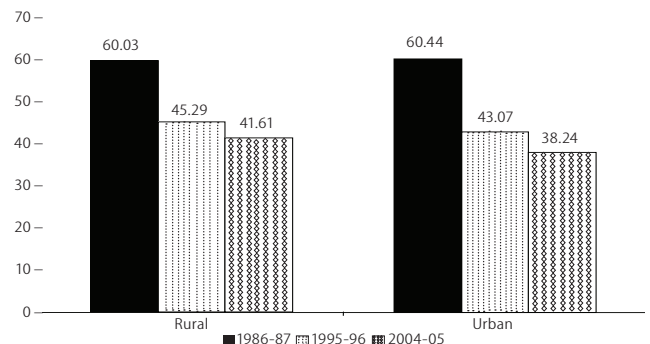
Given a considerable rise in the dimensions of the disease burden, concomitant with a significant increase in healthcare utilisation, the population is subjected to inefficient and inequitous treatment due to inadequate government financing and utter neglect of public provision of health services. During the period under consideration, the role of private sector in healthcare delivery has witnessed a manifold rise. Evidence from nationally representative large-scale household surveys indicates a diminished role for government healthcare provision, both on outpatient and inpatient facilities in the last two decades. In 2004, public sector provision of outpatient healthcare accounted for approximately one-fifth of the total outpatient care as against over one-fourth (26%) in 1987-88 in India (Figure 1). As far as hospitalisation care is

Figure 1: Share (Percentage) of Public to Total Short-duration Treated Ailments in Rural and Urban India (1986-87, 1995-96 and 2004)



Source: Based on authors' estimates from unit records of NSSO 42nd (1986-87), 52nd (1995-96) and 60th (2004) rounds.

Figure 2: Share (Percentage) of Public to Total Hospitalised Episodes for Rural and Urban Ailing Population (1986-87, 1995-96 and 2004)



Source: Based on authors' estimates from unit records of NSSO 42nd (1986-87), 52nd (1995-96) and 60th (2004) rounds.

concerned, the share of public provisions which used to cater to around 60% in 1987-88, has registered a steep decline to approximately 40% in 2004 (Figure 2, p 56). Altogether, currently public sector provides care to only 26% of the ailing episodes in India.

As far as outpatient care is concerned, it has been widely documented that the majority of private providers in rural areas are not fully qualified. Further, the private providers in rural areas are fraught with problems of quality and lack of basic amenities at healthcare centres. A large proportion of these providers are not registered, with an additional 25% only as ayurveda, yoga, unani, siddha and homeopathy (AYUSH) practitioners (Rao et al 2005). In case of inpatient care, a large chunk of the private health facilities are located in urban areas and are highly expensive. Apart from this, except a few “five star” providers, variety, cost, quality and quantity have been a matter of concern in inpatient care for most of the private providers located in smaller towns and cities.

As for example, Rao et al (2005: 91) note that “in a survey of 24 hospitals in Mumbai, half were found to be operating from sheds and lofts, congested spaces, with leaking operation theatres (OTs) and over 90% of unqualified nurses and doctors with degrees in alternative medicine providing care in allopathic medicine”, an ethically and legally prohibited practice. Private care is characterised by unnecessary diagnostic tests, repeated consultation and superfluous surgery, without providing any information on diagnosis or treatment, a reflection of supply-side moral hazard.

It is patently erroneous to assume that fast expanding private providers can fill the gaps created by declining government participation in the health sector. Apart from the concern for the quality of private providers, there remains a serious concern related to affordability of and access to private healthcare providers. This has repercussions for equity and access to healthcare services. Compelling evidence indicates that although the proportion of non-treated ailments has remained largely constant over the years, among the reasons of no formal treatment, unavailability of healthcare services and high costs of treatment have been on rise in the last two decades.

An ever more sizeable share of untreated ailments in recent years is owing to runaway healthcare cost precipitated mainly by the private sector, in addition to collection of user fees in public facilities. Further, households seeking care in public health hospitals are increasingly asked to buy expensive drugs and diagnostics from private outlets citing unavailability of these facilities in the existing set-up.

Although inaccessibility of medical facilities has been responsible for untreated ailments in a little over 12% in rural areas of

Table 2: Percentage Distribution of Untreated Spells of Ailments by Reason of No Treatment in Rural and Urban Areas (1986-87, 1995-96 and 2004)

Reason for No Treatment	Rural			Urban		
	2004	1995-96	1986-87	2004	1995-96	1986-87
No medical facility	12	9	3	1	1	0
Lack of faith	3	4	2	2	5	2
Long waiting	1	1	0	2	1	1
Financial problem	28	24	15	20	21	10
Ailment not serious	32	52	75	50	60	81
Others	24	10	5	25	12	6
All	100	100	100	100	100	100

Source: Authors' estimate from unit records of NSSO 42nd (1986-87), 52nd (1995-96) and 60th (2004) rounds.

the country, financial reasons accounted for well over one-fourth of the untreated ailments. This proportion was only 15% in 1986-87 indicating better access of the poor population to government-run subsidised healthcare facilities in rural areas at that time. In the urban areas too, a growing financial burden to pay for over-heated private healthcare was responsible for one-fifth of untreated ailments in 2004 as against only 10% in the year 1986-87 (Table 2).

2 Increasing Cost of Treatments

The declining public share in healthcare provision has direct implications for those who pay for healthcare services. Latest estimates for the year 2004 shows that per episode, the burden of medical expenditure on households for outpatient care is Rs 295, while for hospitalisation care it is Rs 7,116. Per episode, the medical expenditure for outpatient care is Rs 214 in government facilities and Rs 286 in private sector health facilities. For hospitalisation cases, private sector cost is more than Rs 9,000 per episode as against less than Rs 4,000 per episode in the government sector (Table 3).

Table 3: Per Episode Average Cost of Treatments for Outpatient and Inpatient in Government and Private Sector, Rural, Urban and Combined (2004)

Source	Outpatient			Inpatient		
	Rural	Urban	Combined	Rural	Urban	Combined
Medical expenditure						
Government*	210.76	222.76	214.00	3,399	3,893	3,543
Private	266.56	328.49	285.70	7,465	11,753	8,867
Total	254.09	308.21	270.37	5,783	8,822	6,732
Other expenditure						
Government	31.21	20.98	28.45	526.6	371.6	482.9
Private	25.99	19.48	23.98	587.4	711.5	626.5
Total	27.15	19.76	24.94	562.1	583.3	568.5
Total expenditure						
Government*	241.97	243.74	242.45	3,788	4,029	3,859
Private	292.55	347.97	309.68	7,932	12,285	9,352
Total	281.24	327.97	295.31	6,199	9,126	7,116

* Expenses made in government sector include expenses made on purchase of drugs from markets.

Source: Authors' estimates from unit records of NSSO data 60th round (2004).

Further, it is evidently clear that for outpatient treatments, private healthcare facilities are, on an average, one and a half times more expensive than the public facilities. The comparative cost of hospitalisation indicates that households end up in the private healthcare institutions paying more than double that in the government setting. Unfortunately, government healthcare facilities, which used to offer services free of cost have been forcing patients to procure drugs and receive diagnostic services from private sector providers. This has grave implications for the cost of care even in public health facilities, which is responsible for the narrowing of cost difference between public and private sector health facilities.

Apart from the fact that private healthcare is substantially more expensive than public care, the rural-urban difference of per episode expenditure is less stark in the case of public care. For outpatient care, expenditure in the public sector is more or less similar both in rural and urban areas. Even in the case of inpatient care, per episode expenditure in government health institution is only marginally higher for urban patients. In contrast, private sector health facilities show large rural-urban differentials, with significantly higher per episode expenses incurred by the urban population. This also essentially indicates the constrained paying capacity of rural population.

Further, the cost of treatment has significantly increased over the years both for inpatients and outpatients. The real (inflation

adjusted) cost of hospitalisation has doubled during the last one decade and a half. Earlier findings suggest that there are high levels of borrowing and sale of assets required to pay for OOP expenses in hospitalisations. Hospitalisation cost has risen from less than Rs 1,000 in 1986-87 to approximately Rs 2,000 in 2004 at real prices. Similarly, per episode cost of treatment for outpatient has increased in real terms from Rs 33 in 1986-87 to Rs 68 in 2004.

The cost of treatment has increased both in private and government sources. However, the increase has been much faster in the former (Table 4). Per episode hospitalisation cost has accelerated by more than 100% in the private sector, while cost escalation has been slower in the public sector. Moreover, most of the cost increase in the public sector is shared by the purchase of drugs from market as increasingly fewer and fewer drugs and medicines are available in public health centres and hospitals. As per earlier estimates, purchase of drugs constitutes up to 80% of the total cost incurred for treatment in government hospitals in rural areas (Garg and Karan 2009; Sakthivel 2005).

Table 4: Average Cost (Rs) of per Hospitalisation from Government and Private Sources at Constant 1986-87 Prices in Different Years

Source/Year	Rural	Urban	Combined
Government			
1986-87	585	580	585
1995-96	863	975	910
2004	1,108	1,063	1,066
Private			
1986-87	1,055	1,687	1,147
1995-96	1,786	2,374	2,002
2004	2,320	3,240	2,583

Price deflators used for rural and urban areas are consumer price indices for agricultural labour (CPI-AL) and non-manual workers (CPI-NM), respectively. Source: Authors' estimates using unit records of NSSO data from the three rounds.

3 Impact on Living Status of Households

The rising cost of healthcare has serious implication for living standards of households in general, and for those households who have one or other ailing family members hospitalised. Households responding to medical needs end up spending a large share of the household budget on healthcare. Recent evidence shows that a large proportion of households are required to pay for their medical needs much beyond their paying capacity incurring expenditure that of catastrophic nature. Garg and Karan (2005) and O'Donnell et al (2005 and 2006) have shown that approximately 11% of households in India paid for medical needs which was more than 10% of their total expenditure during 1999-2000. Such a high proportion of households' resources are absorbed by healthcare markets that are predominantly led by the private sector. Further, Peters et al (2002, 2003) showed that hospital spending made people particularly vulnerable to poverty. In 1995-96, findings from their study indicate about 2.4% of population were pushed below poverty levels due to huge payments made for hospitalisation. Following a similar methodology,² Garg and Karan (2009) and van Doorslaer et al (2006) using the norm of one dollar poverty line,³ conclude that during 1999-2000, approximately 32-37 million (32 by the former and the latter estimates at 37 million) people in India were pushed below poverty line due to high OOP payments for healthcare.

In the wake of escalating healthcare costs largely led by private sector providers, both the catastrophic and poverty impact on the households have been substantial and rising. In consonance with earlier literature as cited in the foregoing paragraphs, we have used consumer expenditure survey (CES) data of the NSSO for the

period 1993-94 (50th Round), 1999-2000 (55th Round) and 2004-05 (61th Round) to show the catastrophic and poverty impact of OOP. However, on account of the change in the recall period of the consumption expenditure data during the 1999-2000 survey, these three periods are not strictly comparable.⁴ In order to have comparable estimates, we present two estimates of the poverty ratio and poverty impact of OOP for the year 2004-05 based on "mixed recall period" (MRP) and "uniform recall period" (URP).⁵ Estimates for 2004-05 based on the MRP are comparable with those of 1999-2000, while URP are comparable with 1993-94. Further, it has to be noted that although the official poverty line, used as a yardstick to measure headcount of poverty, has been widely observed as a narrow interpretation of poverty, we use the same mainly to show the comparative position of headcount of poverty before and after making OOP expenditure by the households.

The latest estimates for the year 2004 show that approximately 13% of households spend 10% or more of their expenditure on healthcare. The OOP expenditure (for healthcare)-adjusted monthly per capita expenditure of households goes down by approximately Rs 41 (Rs 37 in rural and Rs 55 in urban areas), pushing an additional 3.6% of Indian population below poverty line in the year 2004⁶ (Table 5).

As per the latest estimates from the CES of the NSSO, India's per capita OOP (URP) is Rs 42 in 2004-05 (Rs 37 in rural areas and Rs 55 in urban areas). It is important to note here that private

Table 5: Household Expenditure on Healthcare and Percentage of Households Facing Catastrophic Impact and Poverty Deepening (1993-94, 1999-2000 and 2004-05)

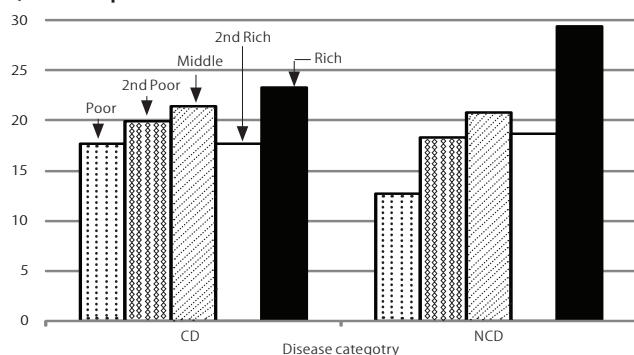
OOP-Related Parameters – Catastrophic and Poverty Impact on Households	Year of Estimates			
	1993-94 (URP)*	1999-2000 (MRP)*	2004-05 (MRP)*	2004-05 (URP)*
All India				
Average per capita monthly OOP (Rs) at current prices	16.78	33.08	41.83	41.82
OOP of total household expenditure	5.12	5.78	5.87	6.12
Households reporting OOP	59.19	69.23	64.42	63.32
Households paying more than 10% as OOP**	11.92	10.84	15.37	13.09
Population below official poverty line	36.0	26.10	21.97	27.50
Population below official poverty line after discounting for OOP	38.97	29.17	25.44	31.20
Increase in poverty ratio	2.91	3.07	3.47	3.55
Rural				
Average per capita monthly OOP (Rs) at current prices	15.28	29.62	36.47	36.97
OOP of total household expenditure	5.30	6.21	6.30	6.53
Households reporting OOP	59.94	69.97	64.05	62.94
Households paying more than 10% as OOP**	12.69	11.70	15.82	13.77
Population below official poverty line	37.30	27.10	21.82	28.30
Population below official poverty line after discounting for OOP	40.40	30.35	25.51	31.94
Increase in poverty ratio (%)	3.10	3.25	3.79	3.64
Urban				
Average per capita monthly OOP (Rs) at current prices	20.99	43.33	57.64	54.59
OOP of total household expenditure	4.60	4.76	5.22	5.43
Households reporting OOP	54.61	69.13	65.41	64.35
Households paying more than 10% as OOP**	10.78	8.70	14.17	11.60
Population below official poverty line	32.40	23.60	22.44	25.70
Population below official poverty line after discounting for OOP	34.82	26.06	25.24	29.05
Increase in poverty ratio (%)	2.42	2.46	2.80	3.35

*URP is usual reference period and MRP is mixed reference period; ** OOP as a share of household expenditure.

Source: Authors' estimates from unit records of the respective NSSO rounds.

providers share more than 80% of the total OOP. Accordingly, the OOP payment has proved as a significant drain on the households' total resources as measured in terms of household total consumption expenditure. The OOP as a share of total household resources increased from over 5% in 1993-94 to approximately 7% in 2004-05. Because of low per capita consumption expenditure in rural areas, the OOP share accounts for more than 7% of total household consumption expenditure in 2004-05 reflecting a significant pressure on household living status. In fact, approximately 14% of households in rural areas and 12% of households in urban areas spend more than 10% of their total consumption expenditure on healthcare (URP). For these households, the OOP payment as a share of total non-food expenditure is quite high reflecting a catastrophic impact on these households. Garg and Karan (2005) and Van Doorslaer et al (2006) estimated that approximately six million households in 1999-2000 faced such a catastrophic impact in India. Even the catastrophic impact of OOP payment has been on the rise over the years. In an ongoing study Selvaraj and Karan have pointed out that although treatment of many chronic and serious diseases constitute some proportion of this catastrophic payment, several common diseases occupy centre stage in accounting for these catastrophic payments by households (Figure 3).

Figure 3: Percentage Distribution of Medical Causes of Hospitalisation by Quintile Groups



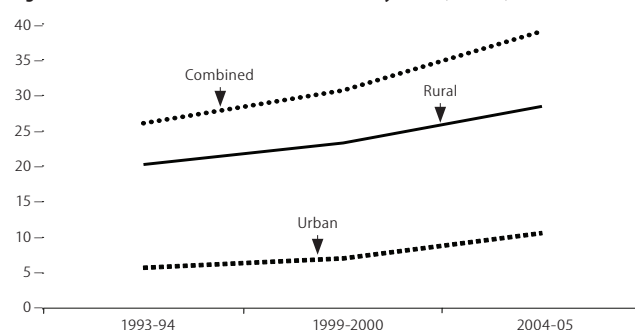
CD and NCD denote respectively to communicable and non-communicable disease. Source: Extracted from the 60th (2004) round of NSS.

Contrary to other results that show catastrophic payments are made only for uncommon expensive diseases, our findings suggest that along with chronic diseases even many common health conditions appear to result in catastrophic payments. Six out of 10 diseases, classified according to catastrophic threshold among households, are communicable diseases and maternal-related complications rather than non-communicable ones (Selvaraj and Karan 2009).

Lastly, we draw the attention to the fact that the high share of OOP in total household consumption expenditure has strong implication also for official poverty estimates. The OOP payments not only push a large number of households below the poverty line, but also cause further deepening of poverty for already poor households. In India, the latest estimates of population below poverty line (URP) is 27.50% for the year 2005-06 (28.30% in rural and 25.70% in urban areas) (GOI 2007). The underlying monthly consumption expenditure of households for poverty calculation includes expenditure on healthcare by households. If we discount the health expenditure of the households from the total household consumption expenditure, the headcount of

poverty estimates increases to 31.20% in 2004-05. This increase in poverty ratio is contributed mainly by households' expenditure on health, i.e., the OOP. In 2004-05, the difference is as high as

Figure 4: Increase in Number of Poor Due to OOP Payments (in million)



3.6% indicating the OOP-adjusted poverty in India increases by such a proportion. In absolute terms, this amounts to an additional 39 million people plunging into poverty because of OOP payments. Further, the poverty impact of the OOP has been increasing both in terms of proportion and absolute number of poor. The additional proportion of population pulled below the poverty line has increased from less than 3% in 1993-94 to more than 3.6% in 2004-05. Accordingly, the absolute number of additional poor population increased from approximately 26 million in 1993-94 to approximately 39 million in 2004-05 (Figure 4).

The increase in the additional number of poor because of OOP payments over the years essentially reflects a long-term and perennial impact of OOP payments on Indian households. Although over the years the poverty ratio has been declining, the impact of OOP on poverty has witnessed a rise. Moreover, what is important to note is that despite low per capita OOP in rural areas as compared to that in the urban areas the impact of OOP in terms of the poverty headcount was higher in rural areas in 2004-05. In earlier years the increase in the poverty ratio was higher in urban areas. This changing scenario is a further reflection of an increasing impoverishment impact of OOP in rural areas.

4 Concluding Observations

The "exclusive" growth strategy followed since the early 1990s has only widened the socio-economic divide, leading to heightened health insecurity in India. On the other hand, an inclusive policy initiative calls for affordable, accessible and decentralised public health services, be it primary, secondary or tertiary care. Recent policies and strategies of the government (made possible by the presence of progressive forces), have however, thrown open adequate opportunities and offer potential benefits. Among others these include employment guarantees to the vulnerable sections of societies (National Rural Employment Guarantee Programme – NREGP), enhanced access and availability of essential health-care services (National Rural Health Mission – NRHM), protecting households from financial risk protection (Rashtriya Swasthya Bima Yojana – RSBY).

Ever since the initiation of the development strategy in the post-colonial period, for the first time, Indian government has unveiled an integrated system of healthcare through the NRHM programme. While the NRHM is attempting to eliminate the distortion caused

by earlier vertical programmes, a decentralised administrative and financial apparatus is being put in place to serve the needs of community health.

On the other hand, in another unprecedented step, the government has begun efforts by initiating healthcare coverage (but only hospitalisation care to the extent of Rs 30,000 per annum) to its informal workforce below poverty line through health insurance. The RSBV seeks to provide health insurance coverage to informal workforce and its dependent households who are below poverty line. The coverage is likely to be expanded to informal workers above poverty line as well in the near future.⁷

These initiatives have the potential to usher in economic and social security to the larger masses of the country. But these measures hinge on scalability and sustainability of the policies. A regime

change could put a question mark on the continuation of these programmes. Sustainability of such schemes could come under a cloud, if the burgeoning fiscal deficit is used as a justification for substantial trimming of “soft” sector like healthcare. All these progressive and pro-people schemes could once again be subjected to “fiscal discipline”, a throwback to the 1990s, the spectre of such a scenario cannot be ruled out given the war cry of the neoliberals for such an eventuality in the near future. Moreover, an unintended consequence of RSBV may result in a strengthening of private healthcare providers. The “choice” element in RSBV could drive people to seek care from the supposedly “high quality” private providers, pushing up the cost further. Eventually, cost escalation could put the schemes’ sustainability under an intense cloud cover, further the endangering health security of the population.

NOTES

- 1 Catastrophic payments for health is referred to a situation when a household is required to spend more than a certain threshold of the ratio of its total earnings/household expenditure on healthcare.
- 2 For details on methodology see www.worldbank.org/poverty/health/, Van Doorslaer et al (2006) and Garg and Karan 2004.
- 3 Two absolute poverty lines developed and used by the World Bank – (international) are \$1.08 and \$2.15 per capita per day at 1993 purchasing power parities (Ravallion 1998; Chen and Ravallion 2001). The lower of these is the median of the 10 lowest poverty lines operational in a sample of low-income countries (Ravallion, Datt et al 1991). It represents a very low living standard that is often referred to as “extreme poverty” (Chen and Ravallion 2004).
- 4 The 61st round NSSO collected data on a few consumption items, viz, clothing, medical care (institutional), education, footwear and durable goods with two recall periods: 30 days and 365 days. Accordingly, two estimates of total consumption expenditure of households are estimated. These two estimates are referred to as estimates based on URP and MRP, respectively (for details on this see Deaton and Dreze 2002).
- 5 URP-consumption distribution data reports a poverty ratio of 28.3% in the rural areas, 25.7% in the urban areas and 27.5% for the country as a whole in 2004-05. The corresponding figures obtained from the MRP-consumption distribution data are much lower such as 21.8% in the rural areas, 21.7% in the urban areas and 21.8% for the country as a whole.
- 6 The Planning Commission, based on the NSSO 61st Round Consumer Expenditure Survey (CES), reported two poverty estimates during 2004-05. One is based on URP to compare with the period prior to 1999-2000, while another is based on MRP mainly to compare (but not strictly) with 1999-2000.
- 7 <http://www.rsbv.in/rsbvnew.aspx?ID=1>

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