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Examining the Role of Access to Public Healthcare Facilities in Reducing Out-of-Pocket Healthcare Expenditure of Poor People

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ABSTRACT

The study explores the impact of access to public healthcare facilities on out-of-pocket (OOP) healthcare expenditure among poor populations. The study aims to understand whether improved access to public healthcare services can alleviate the financial burden on economically disadvantaged urban populations. By analyzing data from national health surveys and literature present, the study directs to understand the barriers and and out-of-pocket healthcare expenditure faced by the poor and vulnerable population in accessing public healthcare services. The findings indicate that improved access to public healthcare significantly reduces OOP healthcare expenses, leading to enhanced financial stability and better health outcomes for the poor. The study recommends for a comprehensive approach to public healthcare that aligns with the principles of justice and equality enshrined in the Indian constitution. The paper supports for a shift in mindset among policymakers and healthcare providers to better serve the demands of the most vulnerable population of India.

Keywords: *Public healthcare facilities; OOP expenditure; Healthcare expenditure; Vulnerable population; Access to healthcare.*

1.0 Introduction

Access to affordable and quality healthcare is a fundamental right and a critical component of social welfare. However, for many poor populations around the world, this access remains a remarkable challenge. Healthcare expenses are a major cause of financial distress in many low and middle-income countries.

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Out-of-pocket (OOP) healthcare expenditure, which refers to direct payments made by individuals for healthcare services, constitutes a large portion of total healthcare spending for these populations. This financial burden can lead to catastrophic health expenditure, pushing families further into poverty.

A vital component of human rights, access to healthcare is essential to the health and advancement of societies. However, there are notable deviations in healthcare accessibility between rural and urban populations in many parts of the world. (Rubina & Ahmed 2024). The urban poor, in particular, face unique challenges in accessing healthcare. Rapid urbanization and the resultant strain on public services have often led to inadequate healthcare infrastructure in urban slums and low-income neighborhoods. As a result, the urban poor are frequently forced to rely on private healthcare providers, who often charge exorbitant fees, thereby increasing their OOP healthcare expenditure. This scenario underscores the urgent need to understand and address the factors that can enhance access to affordable healthcare services for the urban poor. The availability of appropriate, high-quality healthcare has an effect on people's general well-being as well as societal productivity and economic growth. In the past, India's public healthcare system has received little attention. (Jhunjhunwala, 2019)

In India, Public healthcare is provided by the government and is either free or available at nominal cost. In contrast, Private healthcare facilities are predominantly for-profit and tends to be quite expensive. Private healthcare amenities are mostly located in urban areas and are known for their high quality of care. Public healthcare primarily focuses on primary care, encompassing both preventive and curative services. The federal governance system in India places the responsibility for public healthcare on individual states rather than the central government. This has resulted in significant variations in healthcare quality across different states. State spending on healthcare has been inconsistent and often insufficient, leading to systematic neglect of public health (Peters, 2002). Additionally, public health funding has predominantly benefited the middle and upper classes. Renowned medical institutions like the All India Institute of Medical Sciences (AIIMS) are state-owned, which has created unequal access to healthcare for economically and socially disadvantaged communities who do not benefit from this funding (Gupta, 2005).

Access to affordable healthcare is a critical antecedent of health equity. Access to primary healthcare centres (PHC) for susceptible population is often highly shattered and lacking sufficient resources (Richard *et al.,* 2016). For poor populations, out-of-pocket healthcare expenditure often constitutes a significant financial burden, potentially exacerbating poverty. Public healthcare facilities, if accessible and adequately resourced, can play a vital role in reducing these expenses. Rural and Urban Healthcare services

accounted for 70.11% of public expenditure on public health maintenance in 2018-19. This percentage decreased to 69.54% in 2019-20 (NHP, 2022).

Public healthcare facilities, if adequately resourced and accessible, can play a crucial role in mitigating the financial burden of healthcare on poor populations (Richard et.al, 2016). These facilities are typically funded by the government and offer services either free of charge or at a subsidized rate. By providing essential healthcare services at reduced costs, public healthcare facilities can significantly lower the OOP expenses for the poor, thereby improving their overall financial stability and health outcomes. However, the mere existence of these facilities is not sufficient. Factors such as geographic accessibility, quality of care, availability of medical supplies, and cultural appropriateness of services also determine the extent to which these facilities can effectively serve the urban poor.

The right to health, encompassing access to the public healthcare system, has been recognized as a fundamental right by the Supreme Court of India in numerous cases. Healthcare has three dimensions-availability, accessibility, and affordability. Availability means the necessity of having a sufficient quantity of operational public health and healthcare facilities, goods, services, and programs accessible to everyone. Accessibility requires that healthcare facilities must be accessible to everyone without any discrimination, physical barriers and information accessibility. Affordability requires the health facility, goods and services are within the reach of everyone without facing any financial constraints.

The paper is classified as follows: Section 2 reviews relevant literature on healthcare access and OOP expenditure. Section 3 describes the objective of the study. Section 4 outlines the research methodology. Section 5 presents the barriers to access to public healthcare**.** Section 6 contains the discussion. In the end, Section 7 concludes with a summary of key insights and recommendations for future research.

2.0 Literature Review

Access to healthcare is an elementary human right, yet disparities persist globally, particularly in rural areas (Palozzi *et al.*, 2020). A study by (Viramgami *et al.*, 2020) analysed that limited public healthcare facilities and lack of social security coverage causes significant out-of-pocket healthcare expenditures for informal sectors in rural areas. The study also examined the relationship between socio demographic and occupational factors and Catastrophic healthcare expenditure among rural non-standard sector families with the data of 429 households in Gangad, Gujarat.

The findings showed that 61.8% of families acquired government healthcare services, with 71% of these families belonging to the lower-middle and socioeconomic classes with 57.9% of these families experiencing CHE. The incidence of CHE was notably low among families accessing public health facilities (13.2%), but higher among families of factory workers (45.5%) and agricultural laborers (25.5%). (Onah & Govender 2014) has examined the propagated effect of OOPs on healthcare utilization and access to healthcare facilities in southeastern Nigeria. The socioeconomic and demographic vulnerabilities of female-headed households were found to exacerbate gender identity disparities in healthcare access, cost implication, choosing of healthcare providers, methods of financing healthcare, and managing strategies. OOP payments are the predominant method of healthcare payment for both types of households male headed and female headed.

O'Donnell *et al.* (2008) has analysed health care financing in different Asian countries, and concluded that the high income households in lower and middle-income countries, contribute a larger proportion in health care financing comparative to their ability to pay. In Countries like Nepal, Bangladesh, Kyrgyzstan, India, and Sri Lanka finance health care primarily through out-of-pocket (OOP) healthcare expenditures and general government revenues. In these countries, OOP payments are particularly burdensome for lower-income households. The study indicates that the poor tend to receive more health care than the wealthy in high-income countries with universal coverage, as utilization is determined by need rather than ability to pay. However, this is not the case in lower-income countries, where the poor often receive less care due to financial constraints.

The disproportionate allocation of public healthcare funds has adversely affected the health of marginalized communities in India. Research by (Balarajan *et al.* 2011) indicates that India accounts for 25% of all child deaths and 20% of all maternal deaths globally. Furthermore, 34 out of every 1,000 children in India die before reaching the age of five. Immunization rates are also low, with only 58% of urban residents and 39% of rural residents being immunized. These statistics, while reflective of the entire Indian population, highlight a higher prevalence of unnatural deaths and prolonged illnesses among socially and economically disadvantaged communities due to barriers in accessing public healthcare. Another study by (Richard *et al.,* 2016) accentuate the importance of addressing both supply and demand factors to enhance access to healthcare services for vulnerable populations.

The study highlights persistent inequities in healthcare access, particularly affecting vulnerable populations with complex healthcare needs, as explained by the Inverse Care Law, which propounds that people in utmost need frequently utilize services

the least. It emphasizes that access to healthcare is a foundational human right and should be equitable, regardless of demographic features. It also discusses the global agenda focused on improving access to PHC, which remains inadequately addressed at the population level despite various health reforms. (Chatterjee & Laha 2016) examined the difference in the access of public healthcare facilities in different states and found that increased government financing of healthcare enhances the reach of public healthcare services within a state. Consequently, substantial investment in health financing would improve access to public healthcare affecting the delivery of healthcare services in the Indian economy. The study also reveals significant interstate variation in health care financing and access, with some states excelling while others lag behind. This variation emphasize the necessity for targeted interventions to improve health care access in lower-performing states.

3.0 Objectives of the Study

The study aims to examine the role of access to public healthcare facilities in reducing OOP healthcare expenditure among poor populations and understand the barriers faced by the poor in accessing public healthcare services. Provide policy recommendations to enhance access to public healthcare for the urban poor.

4.0 Data and Methodology

The research has exclusively used secondary sources of data that were collected from discrete government reports such as National Health Profile 2022, World Bank data, National health accounts and research articles. In this study an attempt has been made to investigate the extent to which access to public healthcare facilities can mitigate OOP healthcare costs for poor individuals.

5.0 Barriers to Access to Public Healthcare

Despite introduction of public health insurance, out-of-pocket health expenditure by households accounts for 47.1% of the total health expenditure in India (NHA, 2019). These healthcare costs push a substantial number of households below the poverty line annually. Additionally, the long-term productivity of individuals declines over time. Therefore, it is crucial to study the systemic barriers that hinder access to healthcare for

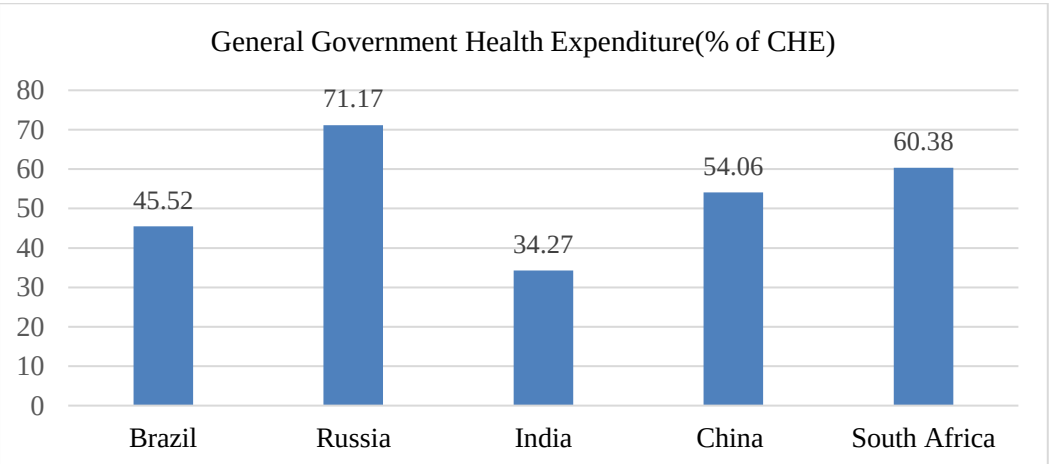
specific communities and groups in India and to reevaluate the system to ensure it fulfills its intended public service role.

1. **Healthcare Inequities**: Generally marginalized communities and migrated people face the challenges of access to healthcare services that significantly impact health outcomes. Poor communities face systemic barriers that lead to poorer health indicators, including higher rates of infant and maternal mortality.
2. **Economic Challenges**: Despite the Indian government's claim of providing free healthcare to those below the poverty line, many individuals are forced to seek expensive private healthcare due to inadequate public services. This economic burden disproportionately affects lower-income groups, who often cannot afford private medical insurance (Jhunjhunwala, 2019)
3. **Social Barriers**: The entrenched social hierarchies and cultural norms in Indian society create additional barriers to healthcare access. Women and transgender individuals face particular challenges due to societal stigma and discrimination, which further restrict their ability to seek necessary medical care (Rubina & Ahmed 2024).
4. **Caste Discrimination**: The prevalence of caste-based discrimination creates significant barriers for Scheduled Caste and Scheduled Tribe communities, limiting their access to public healthcare services.
5. **Gender Stigma**: There is a social stigma surrounding women's health, which further obstructs their access to necessary healthcare services. Traditional patriarchal norms contribute to this issue, making it difficult for women to seek healthcare (Onah & Govender 2014).
6. **Geographic and Transportation:** Some remote areas do not possess any healthcare facilitates and transportation of patients from one place to other place also posses a challenge for the rural poor people. In urban areas health centres are very far from their place so they preferred to visit nearby informal healthcare center or private clinics that make their out-of-pocket expenses.(Rubina & Ahmed 2024).
7. **Insufficient Public Health Funding**: The federal structure of governance in India leads to variable and often insufficient state spending on healthcare, resulting in systematic neglect of public health services. India's public healthcare expenditure is even less than the BRICS countries (Figure 1) India's expenditure is 34.27% of current health expenditure which is less than Russia (71.17) South Africa (60.38), China (54.06) and Brazil (45.52).

5.1 Healthcare financing and out-of-pocket healthcare expenditure

India adopts a public healthcare system having both the sectors i.e. public and private. Public sector has three-tier healthcare system.

Figure 1: Government Health Expenditure as % of Current Health Expenditure



Source: World Development indicators (2021), World bank data

This system includes sub-centers (SCs), primary health centers (PHCs), community health centers (CHCs), sub-divisional hospitals, district/civil hospitals, and medical institutions. PHCs serve as the initial point of connection between the village community and a medical officer.

In India Health is considered as a state subject. In India public healthcare system is financed by general taxation. Central, state and local governments all provide public health services. Public health centres offer less-cost care, are sometimes overloaded, and mostly used by the impoverished people.

In spite of the low cost health care in public institutions, poor households have high OOP expenditure and a higher illness load. Due to the absence of organised public healthcare system for all, the large number of people are affected by inefficient and overpriced private healthcare provider (Dash & Mohanty, 2019). According to the National Health Profile 2022, the average medical expenditure for households is higher in private hospitals than public and charitable hospitals for both hospitalization and non-hospitalization cases. In rural and urban populations (Table 1).

Same is the case with out-of-pocket medical expenditures paid by households for the medical treatment taken from different healthcare providers. It is observed that during the last 365 days (OOPME) per hospitalization case is higher in private hospitals in comparison to government/public hospitals and charitable trust/NGO-run hospitals, for urban and rural populations (Table 2).

Table 1: Average Medical Expenditure of l an (Rs) Rural and Urban People for Outpatient and Inpatient

Healthcare service provider	Rural	Urban	Rural	Urban
	Outpatient		Inpatient	
Govt./Public hospital	325	344	4,290	4,837
Private hospital	1,081	1,038	27,347	38,822
Charitable/Trust/NGO run hospital	624	863	21,599	28,215
Private doctor/clinic	566	714	---	---
Informal health care provider	487	1,035	---	---

Source: National Health Profile 2022

Table 2: Average Out-of-pocket Medical Expenditure (Rs) for Inpatient and Outpatient

Healthcare service provider	Rural	Urban	Rural	Urban
	Outpatient		Inpatient	
Govt./Public hospital	326	346	4,072	4,408
Private hospital	1,141	1,082	26,157	32,047
Charitable/Trust/NGO run hospital	656	878	20,658	24,180
Private doctor/clinic	566	706	---	---
Informal health care provider	487	1,033	---	---
All	561	687	15,937	22,031

Source: National Health Profile 2022

6.0 Discussion

The study highlights a multifaceted barrier to healthcare access in rural and urban areas encompassing gender, social, financial and economic factors. Socio-economic challenges, primarily financial constraints, significantly impede individuals' ability to access timely medical care (Buriro *et al.*, 2023). The financial strain is worsened by the lack of affordable healthcare services and health insurance, leading to high out-of-pocket expenses. Addressing these financial barriers with subsidized healthcare services and expanded health insurance coverage could ease the burden on rural populations, promoting better health outcomes. The difficulty and expenses of travelling to public healthcare centres compelled the vulnerable people to take care from private clinics that exuberate their healthcare expenditure. The implementation of the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY) has the potential to reform the public healthcare system. The government aims to increase healthcare spending to 2.5% of the GDP, which

is expected to reduce out-of-pocket healthcare expenditure. Additionally, an estimated 150,000 health and wellness centers are planned to be established under PMJAY (Reddy *et al.*, 2011).

7.0 Conclusion

The study concludes that improved access to public healthcare facilities can substantially reduce out-of-pocket healthcare expenditure for poor populations. Enhancing the availability, affordability, and quality of public healthcare services is essential for promoting health equity and financial protection for economically disadvantaged individuals. The paper underscores the critical need for systemic changes in India's public healthcare system to ensure equitable access for all citizens, particularly those from marginalized backgrounds. By investing in infrastructure, increasing the public expenditure on health by the government, enhancing health education, expanding healthcare coverage, and improving institutional efficiency more equitable and effective healthcare system can be created. These efforts will not only improve access to healthcare but also foster healthier, more resilient poor population. The study recommends for a comprehensive approach to public healthcare that aligns with the principles of justice and equality enshrined in the Indian constitution. The paper advocates for a shift in mindset among policymakers and healthcare providers to better serve the demands of the most vulnerable population of India.

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