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IMPOVERISHMENT DUE TO HEALTH EXPENDITURE IN INDIA: FOCUSING ON THE "UNIVERSAL" IN UNIVERSAL HEALTH COVERAGE

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Abstract. Universal Health Coverage is a desired goal of all governments across the world to improve availability, affordability, and access to health services. However, more than fifty percent of the world's population remains uncovered by essential health services, and out-of-pocket expenditure (OOPE) for health remains an important financing mechanism leading to the impoverishment of vulnerable households. This paper has two objectives: it estimates the extent of impoverishment in India due to OOPE on health based on four existing measures of poverty, using data from the 75^{th} round of the National Sample Survey on health. This exercise is done to understand if the results on impoverishment are broadly consistent across poverty measures. Secondly, the paper analyses the movement and composition of those who fall into poverty due to OOPE, to understand if non-poor households are also being impacted. The results indicate that the increase in poverty after considering OOPE is quite similar between rural and urban areas. Also, while for urban areas, there is a clear negative association between economic status and likelihood of poverty due to OOPE, this is less clear for rural areas. Rural upper quintiles are significantly impacted by OOPE and are seen to have fallen into poverty. Overall, the analysis indicates that OOPE causes a big dent in the economic status of households and a significant percentage of the households reaches the lowest quintile when OOPE is accounted for. The implication of the results is that to move towards universal health care (UHC), India will need to cover the uncovered population and uncovered services like out-patient services irrespective of a household's economic status.

Keywords: Poverty, Health, Out-of-Pocket-Expenditure, Universal Health Care.

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1. Introduction

A recent symposium on "Estimation of Poverty in India" by Ideas for India (Ghatak, 2022) has highlighted the debate over the extent of poverty in India. The absence of recent official data on poverty has resulted in a major evidence gap that has prevented both detailed analysis and informed policymaking on poverty. The last poverty line was given by the Rangarajan Committee in 2014 using the National Sample Survey Organization (NSSO) 68^{th} Round of Consumer Expenditure Survey (PIB, 2014).

Poverty measures have traditionally been based on income and consumption. The World Bank has recently adjusted its global poverty line from $1.90 to $2.15 using 2017 prices. According to the World Bank "The national poverty line for a country is typically a monetary threshold below which a person's minimum needs cannot be met, taking into account the country's economic and social circumstances". In India, due to lack of reliable income measures, poverty estimates are calculated using consumer expenditure surveys.

Recent studies on the extent of poverty in India have come up with contradicting results. Extrapolating the 2011-12 CES and taking into account in-kind food transfers, one study (Bhalla et al., 2022) finds that in 2019-20 and 2020-21, extreme poverty in India was less than 1%. Analysing household survey data collected by Centre for Monitoring Indian Economy, another paper (Sinha Roy & Van Der Weide, 2022) gives contrasting results. They estimate that the poverty rate went down from 22.5% in 2011-12 to 10.2% in 2019-20. Using leaked data on of consumption expenditure from NSSO 2017-18 survey, a study (Subramanian, 2019) reports poverty at 35% for 2017-18, which is an increase in poverty by 4 percentage points compared to the earlier estimate. Using data from the Periodic Labour Force Survey (PLFS) on consumption for the years 2019-20, and 2020-21 two papers report higher poverty headcount ratios of 25.9% and 17.9% respectively (Mehrotra & Parida, 2021).

For coherent policymaking on poverty, it is critical to have estimates that are robust and agreed upon by experts. This is more so, if the focus is on sector-specific policies like health policy to alleviate poverty.

The importance of including health costs in poverty measures has been a common thread in the criticisms of the conventional poverty line (Deaton and Dreze, 2014; Korenman and Remler, 2016; Oshio, 2019; Clarke and Erreygers, 2020) . It is now widely acknowledged that out-of-pocket (OOP) health spending in the developing world is significant. According to the WHO: "Governments provide an average of 51% of a country's health spending, while more than 35% of health spending per country comes from out-of-pocket

expenses. One consequence of this is 100 million people pushed into extreme poverty each year" (WHO 2019).

Attempts have been made to include health costs in poverty measures. Using data from 11 low-to-middle income Asian countries, a highly cited paper (Van Doorslaer et al., 2006) finds that actual poverty in these countries is 14% more than is estimated by standard estimates that do not take into account OOP payments for health care. According to another frequently cited study (Wagstaff et al., 2018), household spending is diverted from essential items such as food and shelter due to OOP health expenditures. This pushes the household's consumption after accounting for OOPE below the poverty line; this impoverishment adds to the poverty headcount.

A study from Kenya estimates the burden of OOP payments (Chuma & Maina, 2012) and measures Kenya's national poverty estimates after accounting for catastrophic health care expenditure. It finds that Kenyans have a large burden of OOP health payments. Households in Kenya are spending nearly one-tenth of their budget on health care payments. A detailed literature review on the economic consequences of and household responses to health shocks and payments for the resulting health care is done in another paper (McIntyre et al., 2006). They report that for the household economic impacts of illness and consequent income loss are serious. They find growing evidence of households being pushed into poverty when they face substantial OOPE on health care combined with a loss of income due to illness in low-income and middle-income countries. Using National Sample Survey data from India, a study (Berman et al., 2010) finds that in 2004 healthcare expenditure pushed 63.22 million below the poverty line. Similar findings are mentioned in studies of other countries (O'Donnell et al., 2008; Wagstaff et al., 2020; Xu et al., 2003).

The recently released "2023 Universal Health Coverage Global Monitoring Report" (WHO, 2023) by the World Health Organization (WHO) and the World Bank points out that essential health services are out of reach for more than half of the world's population. It also brings to light the alarming fact that catastrophic OOP health spending ("expenditure on health exceeding 10 percent of a household budget") continues to rise. In their latest estimation, one billion people - about 14 percent of the global population - experienced catastrophic OOP health payments relative to their budgets. Thus, OOP health expenditure has a strong link with poverty in developing and underdeveloped countries. Additionally, the impact of this expenditure is felt not only in the current period, but in the subsequent time periods as well, leading to welfare reduction. For low-income households, even small absolute health expenditures can be catastrophic.

Clearly, it is important to account for health costs when calculating poverty, an exercise which has been done for many countries. However, it is equally important to know whether and to what extent economically non-vulnerable households fall into poverty. The aim of Universal Health Coverage or UHC is to cover individuals and households across both risks and income via a pre-pooled system (Pre-pooling refers to the practice of combining different sources of public revenue to collect and group healthcare funds to provide health services to ensure UHC). A truly useful and functional UHC system, is, therefore, one that is universal offering comprehensive coverage across risk and income groups.

In this analysis we have two objectives: first, to estimate poverty after including OOPE using several existing measures of poverty. This is done using the NSSO's 75^{th} round data on Social Consumption, which has a focus on health. This is the last round of data from the NSSO which is available for health expenditure in India. This exercise is done to validate that the numbers thus obtained are largely consistent with each other. The second objective is to analyse the composition of those who fall into poverty due to OOPE, to see whether only the lower quintiles are impacted by health expenditure or whether individuals from non-poor households are also vulnerable to economic health shocks. This would allow us to examine whether India is close or far from a system of true universal coverage.

The rest of the paper is divided as follows: Section 2 presents a literature review on OOPE and poverty. Section 3 details the methodology and discusses the data used in the analysis. Section 4 talks about the results and in Section 5 we present our conclusions and recommendations.

2. **Literature Review**

In this section we do a brief review of papers – mainly on India - that confirm that OOPE can lead to catastrophic expenditure, which in turn is related to other socio-economic and demographic variables.

A paper uses data from three health-care utilization surveys and four national consumer expenditure surveys conducted between 1993 and 2014 in India (Pandey et al., 2018), and finds that households with older people and female-headed households are at a higher risk of high OOP health expenditure.

Another study (Panikkassery, 2020) uses the India Human Development Survey (IHDS) data for 2011–2012 and finds that poor households are inclined to secure a share of food in consumption by reducing their expenditure on items like clothing, footwear, education, entertainment etc. States with high public health expenditure witness a reduction in

education expenditure by poor households with a high share of out-of-pocket health expenditure, whereas low public health expenditure states see a decrease in consumption of mostly all non-food items by poor households facing high OOPE.

The effect of OOPE on the state of the poorest households in the 68^{th} round of NSSO is examined by one paper (Hooda, 2017). He estimates that high healthcare OOPE pushes a big section of society, including the well-off, to dismal poverty levels. A paper (Akhtar et al., 2020) examines CHE over the decade 2004–2014 in India. They find that the mean OOPE has increased over the decade, especially for inpatient care of poorer households.

Using NSSO data for 2004 and 2014, another study (Sangar et al., 2018) measures the disastrous burden, pauperising impact and different coping mechanisms associated with OOPE in India. They find that out-of-pocket health expenditure and its subsequent economic burden vary considerably among the rural and urban populations. They conclude that in rural areas, people face a greater brunt of catastrophic OOP health expenditures and subsequent poverty with more dependence on distress coping mechanisms like sale of assets and borrowing from different sources.

Studies examining mechanisms to cope with OOPE report using income and savings, selling assets and livestock, borrowing from family and friends and, using loans or mortgages as the main mechanisms (Alam & Mahal, 2014; Leive & Xu, 2008) . A recent WHO report (Selvaraj et al., 2022) contends that Indian households have a heavy reliance on OOP spending to finance their healthcare needs. They find that over 17 percent of households incur catastrophic levels of health expenditures every year.

Another study (Goli et al., 2021) analyses the trend in OOPE on institutional deliveries. This study looks at the trend in light of conditional cash transfer schemes like Janani Suraksha Yojana (introduced in 2005). They look at the NSSO health data from the 2004, 2014 and 2017-18 rounds for rural and urban areas and conclude that except for rural public facilities, institutional delivery has seen a significant increase in the average OOPE in both areas from 2004 to 2017-18.

Again with the help of NSSO data for the various health rounds, researchers (Mohanty & Dwivedi, 2021) calculate the incidence of catastrophic health expenditure (CHE) (Health expenditure is said to be catastrophic if either “OOP payment to household consumption expenditure/income exceeds 10%” or “OOP payments exceeds 40% of capacity to pay”.) for health services in India. They find that it has changed over the years from 12.5% in 2004 to 13.4% in 2014 and 9.1% by 2018. They conclude that in the last 14 years, despite a decline in impoverishment and CHE, inequality in CHE has increased.

The latest data relating to key health statistics from the National Health Accounts brought out by the Ministry of Health and Family Welfare in India is presented in Table 1. The table shows that the share of OOP health expenditure is still high at 48.2 percent in FY19. Clearly, Universal Health Coverage (UHC) will be a critical tool for reducing OOPE in India, and, therefore, an important health policy focus. The need for financial protection is a core objective of UHC and, globally, countries have embarked on various paths to reach their UHC goals.

Table 1. **Key aggregates from National Health Accounts**

Indicator	**2017-18**	**2018-19**	**2019-20**
Total health expenditure (THE) as a % of GDP	3.3	3.2	3.3
Government health expenditure as a % of GDP	1.35	1.28	1.35
Per capita THE (at constant 2011-12 INR prices)	4297	4470	4863
Government health expenditure as a % of THE	40.8	40.6	41.4
Out-of-Pocket expenditures (OOPE) as a % of THE	48.8	48.2	47.1

"Source: Ministry of Health and Family Welfare, National Health Accounts"

In India, the health coverage scenario is a fragmented one, with different pools covered by different health coverage programmes, with implications for both efficiency and equity. The recent flagship programme of the Government of India, the Prime Minister's Jan Arogya Yojana (PM-JAY) under Ayushman Bharat, has been seen as a major initiative towards UHC. This programme covers the hospitalization expenses of the 40 percent vulnerable population of the country, to prevent impoverishment.

However, as a recent report by Niti Aayog (Sarwal & Kumar, 2021) points out, to truly move onto the path of UHC India still needs to cover the 'missing middle' or the uncovered population, which it estimates at 30 percent of the total population. While it is not possible to truly measure the uncovered population, households are left out of the coverage map usually due to a variety of reasons: either they do not belong to the vulnerable section that is provided government health coverage, or they are difficult to reach due to the nature of their jobs in the informal and unorganized sector, or are those who are unable to purchase expensive private insurance. Such households are potentially vulnerable to economic impacts due to health shocks.

In the background of these findings, our main contributions are the following: (i) comparing the change in poverty rates across different measures of the poverty line to see whether the findings are similar across different poverty lines; (ii) examining the impact of OOPE on poverty for all income quintiles and not just the lower income quintiles, and (iii) based

on the results advocating for 'universal' coverage covering all quintiles and not financial protection for only people with low incomes.

3. **Data and Methodology**

The 75^{th} round of NSS is on the subjects 'Household Consumer Expenditure', 'Household Social Consumption: Health' and 'Household Social Consumption: Education'. The data used in our paper is the 'Household Social Consumption: Health'. This is a pan-India dataset excluding a few union territories like Lakshadweep, Chandigarh, Dadra & Nagar Haveli and Andaman & Nicobar Islands. The survey examines the diseases for which different age groups required hospitalisation, the use of government vs private hospital facilities, and the expense on treatment received from private and government healthcare centres. It also estimates the different heads of medical expenditure like doctor's fees, diagnostic tests, medicines, room/bed charges and other expenses.

The data contains information on 113,823 households, out of which 64,552 are in the rural sector and 49,271 are in the urban sector. The households were interviewed between July 2017 and June 2018. The sample contains information on the household size, household weight, household monthly consumption expenditure, total hospital expenditure for individuals in each household in the last 365 days, expenditure incurred by individuals in each household in the last 15 days for treatment without hospitalisation (includes doctor's fees, money spent on medicines and diagnostic tests and other expenses by healthcare service provider), total amount reimbursed by medical insurance.

We use the methodology followed in another paper (Wagstaff & Doorslaer, 2003) for adjusting poverty lines that include health expenditure as described below.

Suppose that the poverty head count is calculated including OOPE. Then the head count ratio (HCR) H^{gross} can be written as:

$$H^{gross} = \frac{\sum_{j=1}^{N} n_j t_j^{gross}}{\sum_{j=1}^{N} n_j}$$

where $t_j^{gross} = 1$ if $pc_j < Poverty\ Line$ and is 0 otherwise, where n_j is the size of the j^{th} household and pc_j is the monthly per capita consumption expenditure of the j^{th} household including health payments. N represents the total households in the sample collected. We have used the household weights given in the data while calculating the HCR.

The HCR net-of-health payments is calculated by using $t_j^{net} = 1$ if $(pc_j - E_j) < Poverty\ Line$ and 0 otherwise in place of t_j^{gross}, where E_j is the j^{th} households per capita health expenditure. So now the monthly per capita consumption expenditure (MPCE) of the j^{th} household is measured net of the per capita health expenditure incurred by it in that month. This gives us the poverty levels after accounting for OOPE.

The estimates are done by varying the definition of the poverty line, indicated below.

(1) Rangarajan Poverty Line: This uses MPCE of Rs. 972 for rural areas and Rs. 1,407 for urban areas measured in 2011-12 prices as the poverty line. The Rangarajan poverty line has been adjusted to 2017-18 using CPI data. The poverty line for each household was generated based on the month and year of the interview.

(2) Relative Poverty Line: MPCE of the 1^{st} quintile is treated as the poverty line for both rural and urban areas since this is the lowest 20% in the economic ladder of households.

(3) World Bank $1.9: The older international poverty line of $1.9 per person per day is used to determine HCR for both rural and urban areas. The World Bank poverty line has been converted to rupees in 2017-18 using PPP exchange rates from the OECD Data Explorer[1]. The poverty line for each household was generated based on their year of interview.

(4) World Bank $2.15: The latest international poverty line rupeesof $2.15 per person per day is used to determine HCR for both urban and rural areas. The World Bank poverty line has been converted to rupee in 2017-18 using PPP exchange rates from the OECD Data Explorer. The poverty line for each household was generated based on their year of interview.

We estimate the health poverty line measure by considering OOPE, which includes both outpatient department or OPD and inpatient department or IPD expenditure. We also look at the percentage of the population that is impacted (shifts below the poverty line) due to OOP health expenditure.

The household per capita OOPE on IPD is estimated by summing the net hospitalization expenditure (expenditure minus reimbursement) across individual household members, dividing it by household size, and dividing by 12 to make it monthly per capita. For the

[1] https://data-explorer.oecd.org/vislc=en&tm=PPP%20exchange%20rates&pg=0&snb=19&vw=tb&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_NAMAIN10%40DF_TABLE4&df[ag]=OECD.SDD.NAD&df[vs]=2.0&dq=A.IND...PPP_B1GQ.....&lom=LASTNPERIODS&lo=10&to[TIME_PERIOD]=false (accessed on June 19, 2025)

household per capita OOPE on OPD, we sum the net treatment without hospitalization expenditure (expenditure minus reimbursement) across individual household members and divide it by household size. Adding the monthly per capita OOPE for OPD and IPD gives us the monthly household per capita OOPE. The reimbursements are netted out because these are amounts that are returned to the households and are not part of their total expenditure.

The HCR measure of poverty is calculated using the methodology outlined above. The poverty HCR is calculated as the proportion of households with MPCE less than the poverty line. The Rangarajan poverty line is given separately for rural and urban areas and the relative poverty line has been calculated as the MPCE of the 1^{st} quintile for rural and urban areas. The MPCE cutoffs (household weights have been used in the calculation of the quintile levels) for each quintile are shown in Table 2 below. The two World Bank poverty lines are the same for rural and urban areas.

We calculate the total number of people pushed into poverty when OOPE is accounted forusing 3 poverty lines – the Rangarajan poverty line and the two World Bank poverty lines.

Table 2. **MPCE Quintiles**

MPCE Quintiles	**Rural (in Rs.)**	**Urban in (Rs.)**
1	<= 1075	<= 2000
2	1075 - 1405	2000 - 2800
3	1405 - 1750	2800 - 3750
4	1750 - 2250	3750 - 5050
5	>2250	>5050

"Source: Authors' own calculation from the NSS data"

Next, we look at the distribution of these numbers across the 5 income quintiles. The percentages given in Tables 4 and 5 are calculated from the above distribution, with the base being the total number that became poor due to OOPE. The percentage of households belonging to different income quintiles (as shown in Table 2) with and without deducting OOPE from MPCE is calculated in Tables 6 and 8 for rural and urban India, respectively. Tables 7 and 9 give the percentage distribution of the population under different income quintiles without deducting and after deducting OOPE from MPCE.

4. **Results and Analysis**

Table 3 presents the HCR measure of poverty with different definitions of the poverty line. Poverty is calculated with and without OOPE. The results show that, firstly, rural

poverty is always higher than urban poverty irrespective of the method used. Secondly, the increase in poverty after considering OOPE is quite similar between rural and urban areas. In three out of the four poverty lines considered here, rural poverty increases more than urban poverty. On average, the increase in poverty after accounting for OOPE in rural areas is between 4.6% and 5.3%. For urban areas, this range is between 4.2% and 5%.

Next, we examine the distribution of people who became poor by income quintiles using the three absolute poverty measures in Tables 4 and 5 for rural and urban India, respectively. The columns indicate the poverty lines being used. The percentages are calculated based on the total numbers being pushed into poverty due to OOPE. For example, in Table 4 for urban India, the 25% in income quintile 4 under WB $2.15 indicates that out of all people who became poor due to OOPE according to the latest World Bank poverty line, 25% belonged to income quintile 4 without accounting for OOPE.

Table 3. **Poverty Head Count Ratio (%)**

Poverty Line Used	**Rangarajan Committee**	**Relative (1st Quintile)**	**World Bank $1.9**	**World Bank $2.15**
Rural Poverty without subtracting OOPE from MPCE	36.5	19.9	24.8	35.5
Rural Poverty after subtracting OOPE from MPCE	41.0	25.3	30.1	40.2
Percentage increase in poverty	**4.6**	**5.3**	**5.3**	**4.7**
Urban Poverty without subtracting OOPE from MPCE	16.3	17.4	3.6	6.0
Urban Poverty after subtracting OOPE from MPCE	20.4	21.8	8.1	11.0
Percentage increase in poverty	**4.2**	**4.4**	**4.5**	**5.0**

"Source: Authors' own calculation from the NSS data"

Table 4. **Percentage pushed into poverty in rural India due to OOP health expenditure**

Income Quintile	**Rangarajan**	**WB $1.9**	**WB $2.15**
2	12	34	15
3	42	29	40
4	26	20	25
5	20	17	19

"Source: Authors' own calculation from the NSS data"

Table 5. **Percentage pushed into poverty in urban India due to OOP health expenditure**

Income Quintile	Rangarajan	WB $1.9	WB $2.15
1	16	34	33
2	31	22	23
3	24	19	19
4	18	15	15
5	11	10	10

"Source: Authors' own calculation from the NSS data"

For rural India, everyone in the lowest income quintile is poor by all three poverty line measures, and therefore, we do not use this category for our estimates. However, this was not so for urban India, so we retain the first quintile for our calculations.

The results indicate a clear economic gradient for urban areas, which is consistent with the expectation that people closer to the poverty line have a higher chance of being pushed into poverty due to OOPE. But this is not the case for rural India. In other words, while in urban areas, the percentage that gets pushed into poverty decreases with increases in consumption expenditure, this is not so for rural India. In rural areas, the 3^{rd} quintile is majorly affected by an increase in poverty for all the 3 methods of calculation, especially for the first and third methods of estimation.

It is important to note that even the highest quintiles can become poor due to OOP spending. This is true across both rural and urban areas, using all 3 methods. For example, the calculations using the Rangarajan method show that in rural and urban India, 20% and 11%, respectively of the highest quintile fell into poverty. In general, rural upper quintiles are significantly impacted by OOP expenditure and have fallen into poverty.

We examine this further by examining the change in the income quintile distribution pre and post-OOPE. Keeping the income quintile cutoffs same as pre-OOP, we look at the percentage that shifted to a lower quintile as well as the distribution of the population across the income quintiles before and after OOP spending. These shed light on the impact of health OOPE, not just in terms of absolute poverty but also in terms of household income. The results are presented in Tables 6 to 9 for the rural and urban populations, respectively.

It can be seen from Tables 6 and 8 that OOPE causes a big dent in the economic status of households. In rural India, approximately 10% of households in quintiles 2 to 5 move to lower-income quintiles due to OOPE. Interpretation of row 5 of Table 6 will be as follows: of all the households that belonged to the top income quintile before incorporating OOPE

92.5% households remain in the highest income quintile, 2% move to quintile 4, 0.6% move to quintile 3, 0.4% to quintile 2 and a sizeable proportion of 4.4% moves from the highest income quintile to the lowest one after accounting for OOPE. A similar trend is observed for 8% of households in quintiles 2-4 and 5% of quintile 5 households in urban India. The reduction in income level due to OOPE is not always very small, as is evidenced by the fact that across income quintiles, a major percentage of the households reach the first quintile if we consider OOPE.

Table 6. **Consumption quintile distribution pre and post OOP expenditure for rural India**

Income Quintile		**Post-OOP distribution based on pre-OOP Quintile cut-offs (in %)**				
		1	2	3	4	5
Pre-OOP	1	100.0	0	0	0	0
	2	10.3	89.7	0	0	0
	3	6.7	3.3	90.0	0	0
	4	5.1	1.2	2.7	91.0	0
	5	4.4	0.4	0.6	2.1	92.5

"Source: Authors' own calculation from the NSS data"

Table 7. **Percentage of population under different income quintiles for rural India (in %)**

Income Quintile	1	2	3	4	5
Percentage pre-OOP	20.0	20.0	21.3	19.6	19.1
Percentage post-OOP based on pre-OOP Quintile cut-offs	25.3	18.9	19.8	18.3	17.7

"Source: Authors' own calculation from the NSS data"

Table 8. **Income quintile distribution pre and post OOP expenditure for urban India**

Income Quintile		**Post-OOP distribution based on pre-OOP Quintile cut-offs (in %)**				
		1	2	3	4	5
Pre-OOP	1	100.0	0	0	0	0
	2	7.9	92.1	0	0	0
	3	5.0	2.9	92.1	0	0
	4	3.9	0.6	2.8	92.7	0
	5	2.5	0.1	0.4	1.7	95.3

"Source: Authors' own calculation from the NSS data"

Table 9. **Percentage of population under different income quintiles for urban India (in %)**

Income Quintile	1	2	3	4	5
Percentage pre-OOP	22.3	17.7	20.2	19.9	19.9
Percentage post-OOP based on pre-OOP Quintile cutoffs	26.0	17.0	19.3	18.7	19.0

"Source: Authors' own calculation from the NSS data"

With the pre-OOP quintile cutoffs, the percentage of population in the lowest quintile increases with OOPE across rural and urban India, with the change being higher for rural India, as can be seen in Tables 7 and 9.

5. Conclusions and Recommendations

The analysis brings out a few key points about health spending by households in India.

Irrespective of the poverty line used, poverty increases by at least 4-5 percent in both rural and urban India due to OOPE. This is a significant increase and strengthens the argument for comprehensive health coverage. It is important to note that both OPD and IPD expenditures have been included in the estimations.

Secondly, and more importantly, people from different quintiles are impacted by OOPE; the first (poorest) quintile (defined based on pre-OOP consumption) gets expanded with population from other quintiles now being classified in the lowest quintile.

These two findings are sufficient to argue that an all-inclusive UHC programme - one that caters to all types of households and individuals – is a better option than offering health coverage to selected households. There may be uncovered populations in many of the upper quintiles as well since private health insurance is extremely expensive to buy and many middle-class households may not willingly spend that much on premiums. Such households also have a non-zero probability of suffering economic hardships due to high health costs and falling into poverty.

While this analysis has not discussed the contents of our current health coverage programmes, it must be mentioned that, apart from occupation-linked health coverage programmes, the Prime Minister's Jan Arogya Yojana or PMJAY under the Ministry of Health and Family Welfare's flagship programme- Ayushman Bharat - covers only hospitalization and not out-patient department visits[2]. It also covers only 40 percent of the vulnerable po-

[2] https://nha.gov.in/PMJAY#:~:text=It%20covers%20up%20to%203,are%20covered%20from%20day%20one. (accessed on June 19, 2025)

pulation as of now. These two features together comprise a big lacuna in the programme, preventing it from being universal. Even for the target group, not covering outpatient expenses is a significant omission, since there is sufficient evidence now that at least half of the total expenditure on health can be on OPD. Evidence also indicates that individuals spend a significant amount on drugs and medicines[3], which are not covered by PMJAY except those related to the hospitalization episode.

To qualify as a country that has UHC, India needs to cover the uncovered irrespective of their economic status and extend the coverage of government health insurance programmes to cover non-hospitalization expenses as well. One must also evaluate the existing programmes like PMJAY to understand whether these are truly reducing OOPE, and if not, what are the probable reasons. Some analyses show that PMJAY may not be as effective as it was hoped (Kamath & Brand, 2023). With increasing health costs and unchecked privatization of the health sector, only a comprehensive coverage programme that can truly qualify as UHC can bring about a significant change in impoverishment and financial hardships due to household health expenditures.

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