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# The Source of Financing of Healthcare of Household in Jharkhand

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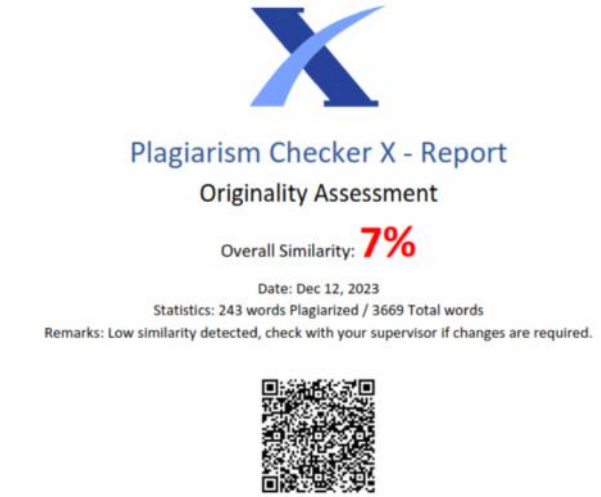



## ABSTRACT

*In healthcare system, financing of healthcare is an important function. With the help of health service coverage and financial protection, it can enable the Universal Health Coverage. Good financing of healthcare means the out-of-pocket expenditure should be low. For an efficient healthcare system, the need of affordable health care is a must. But a large part of the population of the country could not afford the expensive healthcare service or they receive inferior quality of healthcare service after the out-of-pocket expenditure. The main source of health financing is tax-based health insurance, Government health insurance, private health insurance and out-of-pocket expenditure. Most people of Jharkhand's main source of health financing is out-of-pocket expenditure, because they do not have any kind of health insurance. Under out-of-pocket expenditure own saving comes first as financing of health care, then comes selling of property, borrowing from families and friends, loan from banks, etc. There is lack of knowledge among people about Government or private health insurance scheme, due to which they could not avail the health insurance facility. The Government of Jharkhand should need to focus on this problem.*

## KEY WORDS

*Health, Finance, Economic, Insurance, Out of Pocket Expenditure, Patient.*

## INTRODUCTION

Well financing of healthcare means the out-of-pocket expenditure should low. For an efficient healthcare system, the need of affordable health care is a must. Commercial growth of the health services and physical facility give reasons for the condition of wide inconsistency in the outreach of the healthcare

system to the population across the countries of the Globe and even in different parts of the country. To achieve Universal Health Coverage for all the people, a properly justified and healthy commercials would be the most important factor. A large part of the population of the country could not afford the expensive healthcare service or they receive inferior quality of healthcare service after the out-of-pocket expenditure. It is a wide problem for the people on how to direct the expenses of the healthcare. The Government must make sure that the population are not deprived of the healthcare services if they are unable to pay for the increased expenses. In our country India, there are multiple ways of paying up people's healthcare expenses which includes tax-based health insurance, Government health insurance, private health insurance and out-of-pocket expenditure.

## Objective of the Study

- To study the source of health financing in Jharkhand.
- To examine the types of health insurance among the Jharkhand population.

## Methodology

The analysis has been based on the desk research. The secondary data research has been acquired from various print sources including but not limited to study of National Health Profile Report, NFHS reports, Jharkhand Economic Survey, WHO reports, etc. As per the analysis, variables are chosen to quantify and examine the healthcare system in Jharkhand health insurance, Government health insurance, out of pocket expenses, etc. Tabular and Graphical analysis has been done where deemed needed.

## Review of Literature

The memorandum of health scheme in India presently prescribes an insurance-based funding process to cover the Universal Health Coverage, overlooking the part of panoramic health care system through the Government. Hooda (2017) explains that the health insurance is not able to achieve success in keeping away a family from poverty which is caused by the out-of-pocket expenditure as it literally only works for the welfare of the traditional health funding system. The services of free or affordable health care by the State will be supportive addition to the health of the population, attending deficiencies and inconsistencies across the districts, and making the affordable medicine and lab diagnostics reach for all.

Jaitly et al. (2018) suggests that the state provided health insurance facilities do not completely focus the absolute needy, meanwhile the Government is also not able to completely control the private sector. These factors again went overlooked by the Government when it declared the National Health Protection Schemes. Indirectly these schemes will again form another means for the prosperity of the private sector and regional affairs section.

Priya (2004) studies the budget on health sector for the year 2004. Budget 2004-05 allot a greater section of money for improvising the health state of the middle class and poor families. She talks about three areas of health, family welfare and AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy). She mentions that the Budget plan is inadequate. The standard of health service readily needs to improve more focusing towards the rural areas, as there is scarcity with only 1 doctor per 100 bed facility.

According to the factual results of Garg et al. (2018), the proportion of deliveries that took place in public facilities increased by three times in rural areas and by 1.5 times in urban areas between 2004 and 2014, with most of them happening in district hospitals. Moreover, the average out-of-pocket expenditure for childbirth at Government facilities reduced by 36% in rural areas and by 5% in urban areas. However, there was a significant variation in the out-of-pocket expenditure on medicine, diagnostics and transportation. The Government policies to encourage institutional delivery have led to an improvement in the utilization of public facilities and a decrease in out-of-pocket expenditure, but more efforts are needed to extend the benefits to the disadvantaged groups in urban areas.

The study by Falkingham et al. (2010) investigated the changes of out-of-pocket spending in Kyrgyzstan. The study revealed that, there was a considerable enhancement in the financial access to healthcare among

people. The introduction of co-payments for only hospital care resulted in less patients reporting paying medical personnel, but when they did, the payments were higher. Although financial access to outpatient care increased, the effect of health payments on the low-income group was still significant.

The study by Ozturk et al. (2013) investigates the link between health expenditure and economic growth in both short-run and long-run in a country that is a member of the European Union. The study shows that, the favorable link between health spending and growth in these countries is mixed, with no effect and is two-way. The study implies that the direction of the effect between health spending and growth is specific to each country.

Jakovjevic et al. (2016) explain how the proportion of global health spending in low- or middle-income countries kept increasing over the long term. The BRICS countries were the main contributors to this change since the 1990s. The study examined Government, private and out-of-pocket health spending based on WHO data. The study also forecasted the national health spending until 2015 using a macroeconomic fiscal surplus growth model. Despite the diversity of the BRICS, all countries succeeded in increasing their spending on health care significantly. Out-of-pocket spending was largely reduced. The remarkable progress of China was the reason for the increasing share of most of the BRICS in global health spending.

Jakovljevic (2014) evaluates how the global conditions affect many sectors of the economy, including the global demand for and supply of health care services. A major element of this economic growth is the existence of a large middle class in each of the BRIC countries. Both health insurance coverage and package of services covered by the health insurance schemes are growing in BRIC countries. Equally important is the global rise in wealth capacity in BRIC countries, followed by the increasing accessibility of a large portion of medical goods and services that are usually paid for out-of-pocket by the general public.

The willingness to pay for health care services was affected by both the ability to pay and the factors that limit the ability to pay of poor families working in the informal sector in an urban slum of South Delhi. Nair and Dhingra (1998) report on the study that only 46% of the sample's households had the ability to pay for health care and develop a regression model that the household would spend about 3.82% of their monthly income on health care.

Dong et al. (2004) examines the study of Indonesia health insurance preparedness to pay for the self, compared to for other family members. It was observed that in an average the preparation by the head of household to pay for insurance for self was double the average to pay per member of the household. Elder member of the household, women and those who were less educated were also unwilling to pay compared to the younger people, male, poor and the one with higher education.

Akhter and Larson (2010) conducted a study in Bangladesh on the willingness to pay among rural population for zinc treatment. They found that higher socio-demographic status, higher education level of father and younger age of mother positively influenced the willingness to pay. They concluded that selected protection and selected communication activities, especially for lower income and less educated populations, could be helpful to achieve program objectives.

According to Multa (2011), the study reveals that in India, people who can afford health care are receiving it for free, while the BPL have to pay immediately and incur high costs for health care that they cannot bear. The study recommends that improving services and securing Government health care facilities and regulation of the private health market are potential solutions.

The study by Mudgal et al. (2005) shows that, using the 52nd round of NSSO data and excluding some ST families, only 3 out of 73 regions in India seem to be unaffected by rural health problems. The results are robust to spatial diversity and data adjustments based on ethnicity and occupation.

According to George (2005), the 55th round of NSSO data reveals that a significant part of the population spends a big part of their monthly income on health care. People who earn the least spend a varying amount of their income on health. The study argues that Kerala needs to offer affordable quality health care, as its private health sector is growing without regulation and its public health care has limited coverage.

The study by Danish et al. (2007) presents a scheme that offers extreme health benefits to a population that is educated but has no experience with health insurance. The analysis in this report gives the assurance that there are different options of package structures that can be distinguished even within a limited premium and that the premium is the main factor that determines the health insurance coverage.

## Out-of-Pocket Expenditure

In India, households finance their healthcare mainly through out-of-pocket expenditure. Although most health insurances offer at least 24 hours of hospitalization, many healthcare services are daycare or fulfilled from outpatient departments, which are not covered by health insurance. Even in cases where these services are covered, the expenditure is capped to a minimum amount. Additionally, medicine expenses for outpatients are also covered as part of out-of-pocket expenditure, making it difficult for people to manage their lifestyle in case of illness. The cost of treatment in private healthcare institutions is higher compared to Government healthcare institutions, resulting in higher out-of-pocket expenditure for the former. However, private healthcare institutions benefit from the lack of human resources and facilities in Government healthcare institutions, providing better quality and timely service to people.

**Table 1:** Average out-of-pocket expenditure per in-patient case in last 365 days in Jharkhand (excluding childbirth)

| Types of Hospitals | Male | Female | Person |
|---|---|---|---|
| Government Hospital | 5,396 | 3,141 | 3,959 |
| Private Hospital | 33,767 | 20,127 | 26,753 |
| NGO/Trust/Charitable | 8,228 | 59,877 | 22,047 |
| All | 20,841 | 13,034 | 16,554 |

*(Source: National Health Profile 2021)*

It is clear from the above table that maximum out-of-pocket expenditure (average) undergo for the people in-patient in private hospital. Then next out-of-pocket expenditure is costed for the people in NGO/ Trust/Charitable. Lastly, out-of-pocket expenditure costed for the people in Government hospital.

**Table 2:** Average out-of-pocket medical expenditure for institutional delivery

| Types of hospitals | Rural | Urban | Total |
|---|---|---|---|
| Government Hospital | 1,238 | 2,236 | 1,348 |
| Private Hospital | 13,209 | 17,545 | 14,816 |
| NGO/Trust/Charitable | 11,330 | 16,870 | 14,948 |
| All | 3,071 | 9,679 | 4,197 |

*(Source: National Health Profile 2021)*

It is clear from the above table that maximum out-of-pocket expenditure (average) go through for institutional delivery by the people in NGO/Trust/Charitable. Then next out-of-pocket expenditure born by the people in private hospital. Lastly, out-of-pocket expenditure endures by the people in Government hospital.

## Health Insurance in Jharkhand

Diseases are a significant cause of poverty for many households. In many households, one can hear stories of people being in debt or having sold their land because they could not afford the treatment of the disease. Health insurance can provide a great protection to households by degrading financial risk during a health emergency. It further assists in subtracting any monetary stress, better health services, enhanced reach to healthcare, etc.

**Table 3:** Health insurance covered among women and men in Jharkhand

| Health Insurance Coverage | Rural | Urban |
|---|---|---|
| Percentage of Female Covered by Any Health Insurance | 39.0 | 28.0 |
| Number of Females | 19,971 | 6,524 |
| Percentage of Male Covered by Any Health Insurance | 45.1 | 32.7 |
| Number of Males | 2,291 | 846 |

*(Source: National Family Health Survey-5)*

It is clear from the above table that most of the population in Jharkhand is not covered by any kind of health insurance. People who are covered by health insurance in Jharkhand, where in rural area the percent of female is less (39%) in comparison to male (45.1%) and in urban area also the percent of female is less (28%) in compared to make (32.7%).

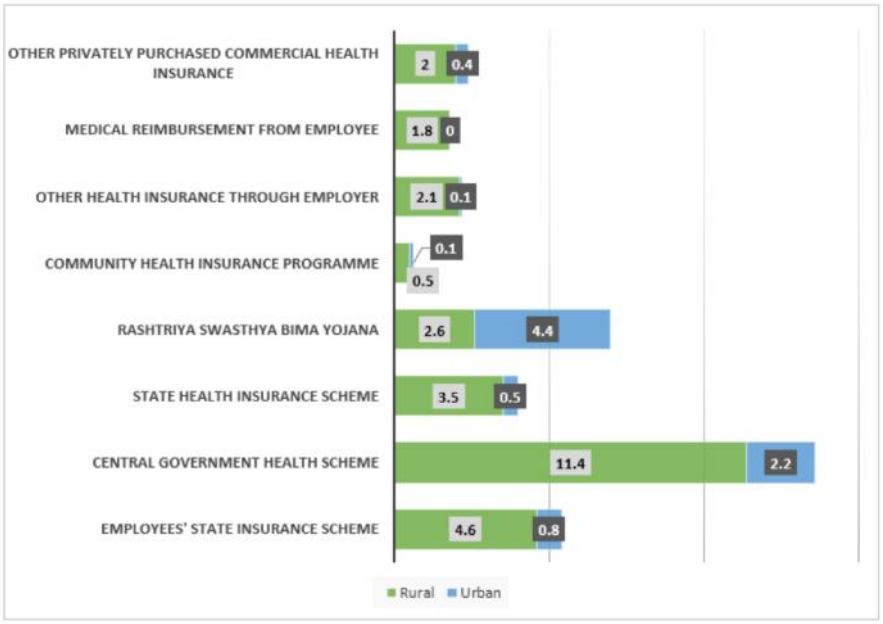
**Table 4:** Percentage of health insurance coverage among households in Jharkhand

| Type of Health Insurance Coverage Among Households | Rural | Urban | Total |
|---|---|---|---|
| Employees' State Insurance Scheme | 4.6 | 0.8 | 1.6 |
| Central Government Health Scheme | 11.4 | 2.2 | 4.0 |
| State Health Insurance Scheme | 3.5 | 0.5 | 1.1 |
| Rashtriya Swasthya Bima Yojana | 2.6 | 4.4 | 4.0 |
| Community Health Insurance Program | 0.5 | 0.1 | 0.2 |
| Other Health Insurance Through Employer | 2.1 | 0.1 | 0.5 |
| Medical Reimbursement from Employee | 1.8 | 0.0 | 0.4 |
| Other Privately Purchased Commercial Health Insurance | 2.0 | 0.4 | 0.7 |
| Number of Households | 2,289 | 9,214 | 11,502 |

*(Source: National Family Health Survey-5)*

It is clear from the above table that most people of Jharkhand who have health insurance is covered by Government health schemes Rashtriya Swasthya Bima Yojana (4%) and Central Government health scheme (4%). This is followed by the coverage of employees' state insurance scheme (1.6) for most people. Then next the people coverage is with state health insurance scheme (1.1%). This is followed by the coverage of other private sold commercial health insurance (0.7%), other health insurance through employer (0.5%), medical reimbursement from employee (0.4%) and community health insurance program (0.2%).

**Fig. 1:** Percentage of health insurance coverage among households in rural and urban area of Jharkhand



## Government Health Insurance Schemes

The state and central Governments of India have launched several health insurance schemes, which are funded entirely by the Government. These schemes aim to provide health insurance coverage to households below the poverty line and informal communities, with minimum or no contribution from beneficiaries. The shift towards a financing and insurance-based system entirely from public resources would bring about a significant change in the fundamental nature of healthcare financing for households. Until now, public investment in healthcare was almost exclusively used to finance the public health system providing services. However, with the introduction of these schemes, the same funds will be rerouted to finance and insurance-based systems.

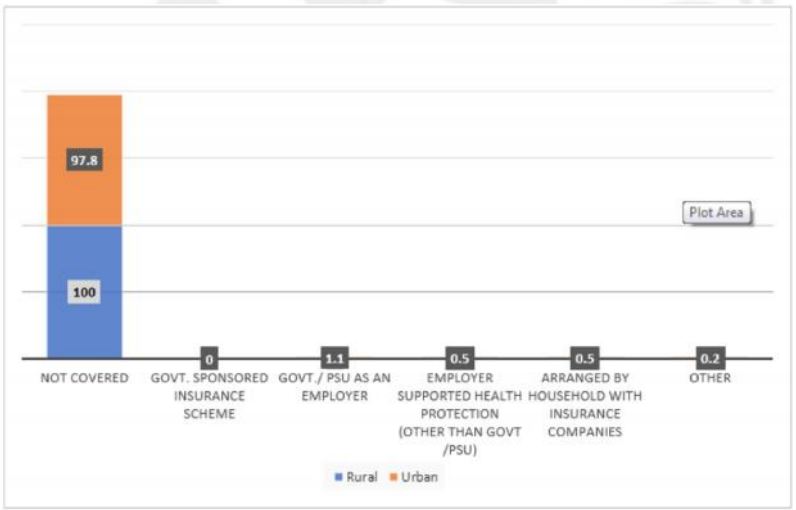
**Table 5:** Percentage distribution of people by coverage of scheme of health expenditure support in Jharkhand

| Different scheme of health expenditure support in Jharkhand | Rural | Urban |
|---|---|---|
| Not covered | 100 | 97.8 |
| Govt. sponsored insurance scheme | 0 | 0 |
| Govt./ PSU as an employer | 0 | 1.1 |
| Employer supported health protection (other than govt /PSU) | 0 | 0.5 |
| Arranged by household with insurance companies | 0 | 0.5 |
| Other | 0 | 0.2 |

*(Source: National Family Health Survey-5)*

It is clear from the above table that people in rural areas of Jharkhand are not covered by any health expenditure support schemes. In urban areas, 97.8% of people are also not covered by any such schemes. The next largest group of people, 1.1%, are covered by the Government or public sector as an employer. The next largest group, 0.5%, are covered by employer-supported health protection (other than Government or public sector) and arranged by households with insurance companies. Lastly, 0.2% of the people are covered by other schemes of health expenditure support in Jharkhand.

**Fig. 2:** Percentage distribution of people by coverage of scheme of health expenditure support in rural and urban area of Jharkhand




Rashtriya Swasthya Bima Yojana was launched in 2008 by central Government of India, its revised version was relaunched after a decade in 2018 named Ayushman Bharat Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY). The scheme provides financial coverage for hospitalization via insurance for the entire family. The usage of the scheme is dependent on handling of the assured health services through private hospitals. Moreover, there are inadequate justification on the availability of private hospitals due to the lack of a proper

database. Listing of private hospitals by insurance companies is comparatively rare in India in low per capita income states, where is considerable proportion of eligible beneficiaries under the scheme is focused. Even though, this scheme is only for the financially deprived section of people but to the issue of getting the right BPL families each poverty line families would have got the insurance card.

Seeing the success of the Central Government scheme AB-PMJAY, the State Government of Jharkhand has launched Ayushman Bharat Mukhyamantri Jan Arogya Yojana (AB-MMJAY) in 2022. The scheme is a state level version of AB-PMJAY. Under this scheme the state Government has to provide health insurance cashless and paperless treatment up to 5 lakhs Rs. to eligible claimants. The schemes Mukhyamantri Swasthya Bima Yojana and Mukhyamantri Gambhir Bimari Upachar Yojana has merged under this scheme. The state Government mission to provide health care services especially poor and remote areas households to decrease the no. of diseases and reduce the burden of financing of health of the households.

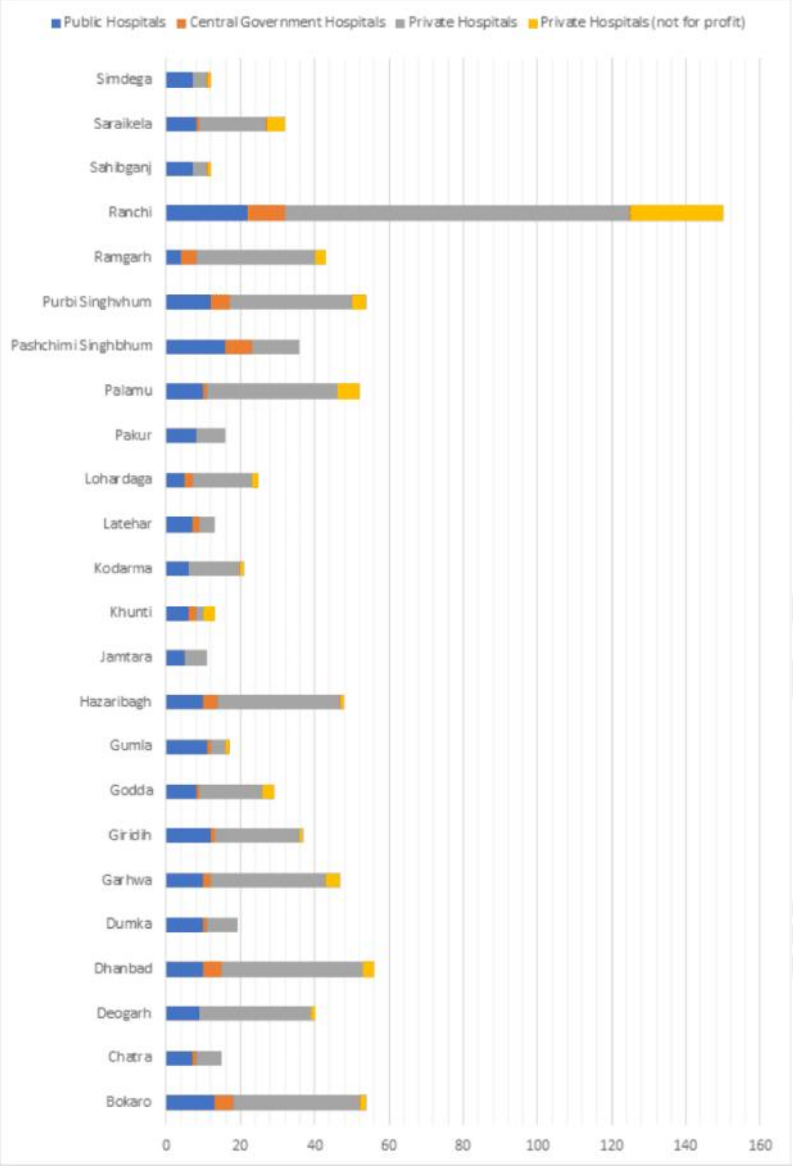
**Table 6:** List of hospitals under AB-MMJAY in Jharkhand

| Districts | Public Hospitals | Central Government Hospitals | Private Hospitals | Private Hospitals (not for profit) | Total |
|---|---|---|---|---|---|
| Bokaro | 13 | 5 | 34 | 2 | 54 |
| Chatra | 7 | 1 | 7 | 0 | 15 |
| Deogarh | 9 | 0 | 30 | 1 | 40 |
| Dhanbad | 10 | 5 | 38 | 3 | 56 |
| Dumka | 10 | 1 | 8 | 0 | 19 |
| Garhwa | 10 | 2 | 31 | 4 | 47 |
| Giridih | 12 | 1 | 23 | 1 | 37 |
| Godda | 8 | 1 | 17 | 3 | 29 |
| Gumla | 11 | 1 | 4 | 1 | 17 |
| Hazaribagh | 10 | 4 | 33 | 1 | 48 |
| Jamtara | 5 | 0 | 6 | 0 | 11 |
| Khunti | 6 | 2 | 2 | 3 | 13 |
| Kodarma | 6 | 0 | 14 | 1 | 21 |
| Latehar | 7 | 2 | 4 | 0 | 13 |
| Lohardaga | 5 | 2 | 16 | 2 | 24 |
| Pakur | 8 | 0 | 8 | 0 | 16 |
| Palamu | 10 | 1 | 35 | 6 | 52 |
| Pashchimi Singhbhum | 16 | 7 | 13 | 0 | 36 |
| Purbi Singhvhum | 12 | 5 | 33 | 4 | 54 |
| Ramgarh | 4 | 4 | 32 | 3 | 43 |
| Ranchi | 22 | 10 | 93 | 25 | 150 |
| Sahibganj | 7 | 0 | 4 | 1 | 12 |
| Saraikela | 8 | 1 | 18 | 5 | 32 |
| Simdega | 7 | 0 | 4 | 1 | 12 |

*(Source: Jharkhand Economic Survey 2022-23)*

Form the above table it is clear that, the hospitals are divided in four categories public hospitals, Central Government undertaking hospitals, private hospitals and private hospitals (not for profit). Ranchi has the highest no. of hospital and Jamtara has the lowest no. of hospitals under AB-MMJAY. In Jharkhand the total no. of hospitals is 815 under this scheme.

**Fig. 3:** List of hospitals under AB-MMJAY in Jharkhand




## CONCLUSION

In healthcare system, financing of healthcare is an important function. By the help of health service coverage and financial protection, we can achieve Universal Health Coverage. In India, there are multiple ways of paying up people's healthcare expenses which includes tax-based health insurance, Government health insurance, private health insurance and out-of-pocket expenditure. A large part of the population of the country could not afford the expensive healthcare service or they receive inferior quality of healthcare service after the out-of-pocket expenditure. It is a wide problem for the people on how to direct the expenses of the healthcare. The cost of treatment in private healthcare institutions is higher compared to Government healthcare institutions, resulting in higher out-of-pocket expenditure for the former.

Health insurance can provide a great protection to households by degrading financial risk during a health emergency. It further assists in subtracting any monetary stress, better health services, enhanced reach to healthcare, etc. Although most health insurances offer at least 24 hours of hospitalization, many healthcare services are daycare or fulfilled from outpatient departments, which are not covered by health insurance. Medicine expenses for outpatients are also covered as part of out-of-pocket expenditure, making it difficult

for people to manage their lifestyle in case of illness. Most of the people of Jharkhand have not got any kind of health insurance. Their main source of health financing is out-of-pocket expenditure, under which own saving comes first as financing of health care, then comes selling of property, borrowing from families and friends, loan from banks, etc.

The State and Central Governments of India have launched several health insurance schemes, which are funded entirely by the Government. These schemes aim to provide health insurance coverage to households below the poverty line and informal communities, with minimum or no contribution from beneficiaries. Government health schemes like Rashtriya Swasthya Bima Yojana, Ayushman Bharat Pradhan Mantri Jan Aarogya Yojana, central Government health scheme, the coverage of employees' state insurance scheme, state health insurance scheme like Ayushman Bharat Mukyamantri Jan Aarogya Yojana is most popular in Jharkhand. Some other insurance sources are private sold commercial insurance, health insurance through employer, medical reimbursement from employee and community health insurance program.

But there is a lack of knowledge among people about Government or private health insurance scheme, due to which they could not avail the health insurance facility. The Government has also not made any such arrangement to spread awareness about the health scheme to make people aware. The Government of Jharkhand should need to focus on this problem. Also, all the health insurance schemes of the Government are for BPL people only. Hence, private health insurance companies also need to keep their 'premium' costs low so that more people can avail their facilities.

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