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Review Paper

Out-of-Pocket Health Expenses During Post-Reform Period in India: A Survey of Recent Research

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ABSTRACT

This study is based on recent reviews on out-of-pocket health expenses in India during the post-reform period. With the economic liberalization and subsequent reforms, there have been significant changes in healthcare financing, leading to a rise in out-of-pocket expenditures. This paper critically examines the patterns, causes, and socio-economic implications of these expenses by reviewing recent literature. By analyzing the findings from various studies, the research highlights the persistent challenges faced by the Indian population, especially the poor, in accessing affordable healthcare. The study also evaluates the impact of government policies, insurance schemes, and healthcare privatization on out-of-pocket costs. The findings suggest that despite efforts to improve access to healthcare, out-of-pocket expenses remain a significant barrier to equitable healthcare in India.

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INTRODUCTION

In India when we talk about the household expenditure of the year, then in most of the cases the major part of the expenditure is made towards the health expenses. It is very important to study this factor because health services are some things that come under the welfare services in all the countries. The importance of this study is why in India the major portion of household or human expenditure is toward health care services. Health expenses can be defined as two types medical expenditure for treatment and non-medical expenditure. Medical expenditure for treatment includes package components (package of treatment for specific surgical or nonsurgical medical procedures, inclusive of different items like operation theatre (OT) charges, OT consumables, medicines, doctor's fees, bed charges, etc. are common nowadays in all private hospitals.), attendant charges, personal medical appliances like wheelchairs, etc. In non-medical expenditure transport other than ambulance, special diet food and other expenditure and medical insurance premium. The concept of the out-of-pocket expenditure will be explained by people who cover under medical insurance and not under the medical insurance. For the people who are under medical insurance expenditures on non-medical treatment and expenditures on those medical treatments which don't covered under their medical insurance are term as 'Out of Pocket Expenditure'. For the people who are not covered under medical insurance, both expenditure medical

and non-medical expenditure is term as 'Out of Pocket Expenditure'. In India the problem of out-of-pocket expenditure is a very serios issues and which is not talked about any political party or any leader and no measure is been taken to solve this problem of out-of-pocket expenditure. According to study of National Sample Organisation (NSSO) **Year and reference?** Data, 81% of patients choose the private sector for outpatient care, while 62% of patients opt for the private sector for inpatient care. It has been also found that two thirds (66%) of out of pocket spend was decocted to outpatient care, with another 4% going to delivery and post-natal care, 23% of spend was devoted to inpatient care. Out-patient care constitutes a greater share of out-of-pocket spending in rural areas (68.5%) than in urban areas (62.1%). So, in the present study which is basically primarily in nature, we deal with specific reviews of health-related issues in regional and Indian context based on pattern of utilisation of healthcare and expenditure on healthcare

Conceptual Thematic Table

Table 1: Key Concepts, References, and Findings in Indian Healthcare

Theme/Concept	Key References	Key Findings
Out-of-Pocket Expenditure (OOP) in India	Alam & Mahal (2014), Kapoor & Mishra (2021)	OOP is a major burden on Indian households, leading to financial stress, especially in rural areas. OOP expenditures contribute to health inequities in India.
Impact of OOP on Household Economics	Kapoor & Mishra (2021), Kaar & Mahal (2013), Rao & Bhat (2012)	OOP expenditures lead to economic hardship, pushing households into poverty. The burden worsens with the rise of ailment and economic status.
Private Health Care Utilization	Khan & Prasad (1985), Kumar & Prakash (2011), Dholakia & Iyengar (2011), Kapoor & Mishra (2021)	Higher preference for private healthcare services due to better accessibility and perceived quality, despite high costs.
Public vs. Private Healthcare Sector	Kumar & Prakash (2011), Baru (2010), Kapoor & Mishra (2021), Kumar (2022)	A significant portion of the population relies on private healthcare, highlighting issues of accessibility, quality, and affordability of public healthcare.
Health Financing and Reforms	Murthy (2009), Kapoor & Mishra (2021), Chakraborty & Kumar (2017), Dholakia & Iyengar (2012)	Economic reforms and liberalization have impacted public health financing, increasing reliance on OOP and private care.
Government Health Expenditure	Mehrotra (2008), Pandey, Agarwala & Verma (2020), Bhatt & Jair (2004), Chakraborty & others (2013), Gupta (2005)	Public health expenditure remains inadequate to meet healthcare needs, exacerbating health inequities, especially in rural and poorer populations.
Social Disparities in Healthcare Access	Raushan & Mutharayappa (2014), Selvaraj & Karan (2009), Sahoo & Chandra (2015), Kumar & Prakash (2011)	Significant social disparities exist in accessing healthcare, with marginalized groups facing greater barriers to affordable care.
Government Schemes and Health Insurance	Pandey, Agarwala & Verma (2020), Sahoo & Chandra (2015), Kumar (2022)	Government schemes like *Ayushman Bharat* aim to reduce OOP expenditures, but challenges remain in full implementation and reach.
Health Inequity and Regional Disparities	Dreez (1993), Mahal (2000), George (1997), Chandrasekhar & Ghosh (2006)	Substantial health inequities persist across regions, with rural areas and specific states experiencing lower coverage and higher OOP expenditures.
Utilization of Healthcare Services	Waddington & Animate (1930), Dilip (2010), Kumar (2022), Chakraborty & Kumar (2017)	The growth of user fees in public healthcare has led to reduced utilization of services, particularly among lower-income groups.
Role of Private Health Insurance	Sahoo & Chandra (2015), Selvaraj & Karan (2009), Kapoor & Mishra (2021)	The growth of private health insurance in India is limited as a solution for OOP expenditures, with issues in coverage and accessibility.

REVIEW OF LITERATURE

M.E. Khan and C.V. Prasad (1985) in their study underlined individual's preference for private health services largely because of accessibility, less loss of time, and the perception that treatment at PHC was sub-standard. This study was based on expenditure data on health related to the country as a whole and the two states namely Maharashtra and Gujarat. They showed that more than half of the total PHC expenses were incurred on salaries only in both states (Gujarat 59 % and Maharashtra 65%). They recommended that immediate steps be taken to ensure greater allocation of public funds for maternal-child health services and the training of paramedics.

The research study of Duggal and Amin (1989) found that a little more than three-fourths (76.86 percent) of patients utilized private health centers, whereas a very small proportion (12.23 percent) of patients used public health facilities. Further, it presented that the morbidity prevalence rate was higher in the rural areas (154.66 per thousand population) compared to the urban areas (141.85 per thousand population). The study also estimated that annual per capita health expenditure was higher in rural areas (Rs. 192.19) compared to urban areas (Rs. 170.97) during 1987. On the other hand, out-of-pocket expenditure made by the patients for treating their illnesses was 3.5 times more than that of what state government (including local bodies) spent. It was also found that the cost per illness episode was directly proportional to the level of income and consumption expenditure.

Many other studies revealed that rising costs of seeking health services were generally followed by a precipitous decline in utilizing these services by the different income groups. For instance, the evidence from many countries such

as Ghana (Waddington and Animate, 1990), Kenya (Mwabu et. al., 1995), Swaziland (Yoder, 1989) and Zambia (Kahenya and Lake, 1994) reported a decline in utilization of public health clinics due to the imposition of user fees.

The estimates of the 42nd Round of the National Sample Survey Organisation (NSSO, 1992) found that the prevalence rate of hospitalization cases was much higher in rural areas (28 per thousand population) than in urban areas (17 per thousand population) of India during 1986-87., The allopathic system of medicine was used in more than 98 percent of hospitalized cases in both rural and urban areas. Given the structure of health services in India, public health facilities were chosen by the household for in-patient care, whereas private health facilities were used for out-patient care. On the other hand, naturally, the average expenditure made for the treatment of illness episodes was higher in private hospitals (Rs. 733 per case) compared to public hospitals (Rs. 320 per case).

A study done by NCAER in 1992 showed that the prevalence rate of treated illnesses in India was higher in rural areas as compared to urban areas as it was 79.06 per thousand population in rural areas and 67.70 per thousand population in urban areas during 1991. Further, morbidity prevalence rate across all states had declined when one moved from the low income to high-income households. It suggested that the people belonging to the lower income groups were more susceptible to various illnesses due to the unhealthy living conditions 46 and lower nutritional status. An overwhelming majority of illness episodes in urban areas (80 percent) and rural areas (75 percent) were preferred allopathic system of medicine. And, 55 percent of the illness episodes sought treatment from public health institutions, whereas, 36 percent from private health institutions.

Regarding household expenditure on health services, it was found that the average cost of treating each illness episode was higher in the rural areas (Rs. 151.81) compared to the urban areas (Rs. 142.60). Further, Ramamani's analysis of NCAER data (1993) revealed that in 90 percent of illness cases, patients preferred allopathic system of medicine for treatment. For out-patient treatment, dependency was more on the private health facilities compared to the public health facilities as 52 percent and 59 percent illness cases in rural and urban areas respectively sought treatment from the private health sector. However, in the case of hospitalisation, more patients preferred the public health services both in rural (62 percent) and urban (60 percent) areas respectively. So far as expenditure on health services was concerned, the study revealed that the poor households spent more than 7 percent of their income on the treatment of diseases compared to 2.7 percent by the rich households.

Kanan (1991), Sundar (1992) and Rajarthnam (1996) studied about pattern of out-of-pocket medical expenditure in India. These studies shown that fees and medicine accounted for at least two third of the expenditure on medical care expenses. These studies highlighted those inequalities in the utilisation of health care and financial burden of medical expenditure likely to reflect in out-of-pocket expenditure for health care.

Dreze (1995) and Mahal (2000) analysed life expectancy at birth and found substantial differences at birth across states. States such as Madhya Pradesh, and Orissa have mortality rates of well over 100 per 1000 live births in rural areas. Duggal (1996) discusses the public-private participation in health sector and how this can be optimized for best result. Bhatt (1996, 2000) discussed the importance of regulating the private sector in India and how public-private partnership can bring needed resources while also taking care that the vulnerable groups - the poor and rural population – have access to health facilities. These studies suggest that India 's dependence on private sector in healthcare is very high.

George (1997) conducted a research study in two states of India i.e. Maharashtra and Madhya Pradesh and found that private sector was preferred by the patients in both states. However, dependence on private sector for health care needs was found to a greater in rural Maharashtra (79.8 percent) compared to her urban areas (73.45 percent) than in Madhya Pradesh where utilisation of private sector was around 70 percent both for the rural and urban areas. Further, utilisation of public health facilities was relatively more in the urban Maharashtra (16 percent) than in rural Maharashtra (10 percent). However, a reverse trend was observed in Madhya Pradesh as 17 percent of rural patients and 14 percent urban patients preferred public health services. Among the in-patients, 38.6 percent of cases in rural areas and 38.5 percent in urban areas depended on private health facilities. On the other hand, 55.4 percent of in-patient cases in rural areas and 59.5 percent of in-patient cases in urban areas used public health facilities. Per episode cost in both states was higher in the rural areas compared to the urban areas. For instance, in rural Maharashtra, per episode cost was Rs. 103.56 compared to Rs. 100.44 in urban Maharashtra. The corresponding figures for rural Madhya Pradesh were Rs. 137.67 and Rs. 128.86 for urban Madhya Pradesh.

Charu, C. (1998) study's basic aim was to create a national health accounts framework for India. Using the framework, his paper proposed to describe the various sources from where the funds come from, how they flow through various financial intermediaries and finally how different providers and socio-income groups used these funds. Karnataka was taken as a case study to understand, describe and measure these flows. For this study, data was taken of the year 1993-94. Further, household survey of healthcare utilisation and expenditure was carried out using sample of 18693 households: 6354 rural and 12339 urbans. The survey collected information on morbidity, utilisation of health services by type of providers, system of medicines, untreated illness episodes, and breakdown of expenditure for treated patients. The study found that after 1992, the percentage of non-plan expenditure decreased marginally for medical and public health activities. State government also raised their own tax and non-tax revenue which accounted for approximately one-third of total revenues raised by the

government. The revenue for the State Department of health was computed from the audited accounts of the government from budget documents. Further, it was observed that 63% of expenditure was used for medical and public health activities, out of which 5 % was used for public health. About 25 % of expenditure was used under the general category, which included transfers to local government and rest 12% was used for family welfare activities.

In another study, Jain (2003) found that during 1983, 4.37 percent of per capita monthly expenditure was incurred on health which went up to 5.72 percent in 1999, which made India's per capita private spending on health one of the highest in 45 the world. During 1990, private health expenditure grew 7.5 percent per annum against 4.6 percent hike in private final consumption expenditure. Further, in 1983 Muslims spent Rs. 4.86 per capita per month on health against Rs. 5.82 for Hindus. In 1999 health expenditure by Muslims went up to Rs. 30.64 but it remained constant at around Rs. 84 for Hindus. Similarly, health expenditure by SC\ST rose from Rs.3.96 to 23.97 during this period, but remained at around a third lower than that for Hindus. The results hold true for almost all the income classes. On the whole, however, the study concluded that India's health performance is poor. Even basic health parameters like IMR, below five-mortality rate or population with access to essential drugs were lower than that for countries like China. Thus, this study explained the sharp surge in private health expenditure.

Selvaraju V (2003) analysed the level of health-care expenditure incurred by the state governments and households in the rural areas of the major states in India. He studied the interlink age between public spending and household spending on health care. The household expenditure on health accounts for a major share of about 70-80 per cent of the total health expenditure in India. As a percentage of income, households spend about 5.40 per cent while the government spends only about 1.09 per cent in rural India, according to the 1993-94 data. The results of this study indicate a negative association between the overall economic development and prevalence rates of morbidity across the states. The analysis of household expenditure on the treatment of both short-duration and long-duration ailments by various income levels clearly depicts that as income rises, the expenditure on health care also increases. A substantial proportion of poorer households in rural India depend on public health facilities for the treatment of short-duration and major morbidity. However, patients depend on private health facilities at higher levels of income. Similarly, dependency on indigenous practitioners is also found to decline at higher levels of income.

Bhatt and Jain (2004) in their study have analysed about public expenditures on health care using state level public health expenditure data. Their findings suggested that state level governments have target of allocating only about 0.43 percent of State's GDP to health and medical care. This does not include the allocations received under CSS schemes such as family welfare and Reproductive child health care funds. Given this level of spending at current levels and fiscal position of state governments the goal of expenses 2 to 3 percent of GDP on health looked very ambitious task. The analysis also found out the elasticity of health expenditure in states and revealed that for every one percent increase in state per capita income, the per capita health care expenditure increased by around 0.68 percent. It is also important to share that in their study they showed the picture of weak health care financing system of India with adopting comparative analysis form some other smaller courtiers like Bhutan, Maldives, Sri Lanka and Nepal. "The comparison of health expenditure with other countries suggests that India's public health expenditure is only 17.9% of total expenditure on health care while it is close to 90% like Bhutan and Maldives.

Gupta (2005) in a study distinguished between medical services and health services and laid emphasis on the later which reduced a population's exposure to disease through measures such as sanitation and vector control. It was both pro-growth and pro-poor, but in the case of India policies and programmes were focused largely on the provisions of curative care and personal prophylactic interventions which were private in nature. This trend was intensified by the spread of democratic institutions and elite control. Electorates of juvenile democratic states typically prefer public funds to be used to provide private goods, as medical care rather than public goods as sanitation. This inattention to public health was taking a large toll on the economy, as well as on the lives of the citizens.

On the aspect of health care and utilisation pattern, Rao (2005) also studied the evolution of India's health system and categorized into three distinct phases. She argued that the desire to utilize private sector resources for addressing public health goals; (ii) liberalisation of the insurance sector to provide new avenues for health financing; and (iii) redefining the role of the state from being only a provider to a financier of health services as well.

Chandrasekhar and Ghosh (2006) examined the pattern of state government expenditure in the case of Maharashtra, Gujarat, Punjab and Orissa, and found no direct and clear linkage between government health spending and health outcomes of the people in general. But a direct impact on certain health indicators such as communicable diseases were found and the most direct impact of public spending appeared to be felt in a very significant indicator- the proportion of children in the age group of 12-23 months who had undergone the full required immunisations, i.e. BCG plus 3 polio plus 3 DPT plus measles. Though the richer states tend to have a higher proportion of per capita health spending, and lower IMR, U5MR, safe delivery, and better nutrition indicators, no exact correlation could be established, but there was a broad relationship along expected lines. The high-spending states were also relatively poor in performance by international standards except Kerala.

Sekhar's (2006) study examined the micro aspects of health economics. It examined the effect of income and education of

the household on its health expenditure based on primary data. The descriptive statistics for the tribal area of Orissa in their study showed that per capita health income was Rs. 5143.75 per annum with 2555.27 and 0.5 as standard deviation and coefficient of variation respectively, whereas per head health expenditure (PHE) was Rs. 108.13 per annum and 91.36 and 0.84 as standard deviation and coefficient of variation respectively.

Jamaluddin *et al.* (2006) in their study investigated economics of health in India with special reference to Uttar Pradesh. In its detail the study did not lose sight of the national and comparative state perspective. It mainly focused on the period from 1975 to 1995 but also incorporated the analysis of important data of the entire plan period. The period from Fourth to Eight Five Year Plan was especially targeted because of greater attention by the government on public health programs.

Malhotra and Shweta (2006) attempted to study the pattern of public health expenditure in various states and analysed the extent to which state was fulfilling its responsibility in providing public health facilities. They used Regression for studying the relation between per capita health expenditure and level of economic development as measured by per capita Net State Domestic Product (NSDP) in various states. They also analysed the relations between major indicators of health viz; crude birth rate (CBR), crude death rate (CDR), infant mortality rate (IMR), expected life for male (ELM), expected life for female, and their major determinants viz, per capita net state domestic product (PCNSDP), per capita health expenditure (PCHE) and literacy rate (LR). The results of inter-state disparities in case of health indicators showed that the basic health indicators in various states have improved over time but still were far behind many developed countries.

Ranson (2006) studied the relationship between the intervention of community health insurance schemes and the reduction of catastrophic health care expenditures in Gujarat. Findings of this study have implications for community-based health insurance schemes in India and elsewhere. Such schemes can protect poor households against the uncertain risk of medical expenses. They can be implemented in areas where institutional capacity is too weak to organize nationwide risk-pooling. Such schemes can cover poor people, including people and households below the poverty line. They argued that a well-designed mechanism and proper implementation of community-based health insurance reduces the burden of medical expenditure from poor households. Majumder (2006) has reported that high cost of treatment increases the odds of utilization of modern sources of healthcare services by people in North Bengal, India. The author attributes this result to the fact that high costs of illness indicate the presence of complex disease(s) that are beyond the capacity of traditional service providers.

In another study, Sandeep Kumar (2006) focused on public expenditure on health in the state of Uttar Pradesh since 1991 and suggested proper investment in both for overall development of this backward state. He showed that since 1996-97 health and facilities increased at a very slow pace or even remained stagnant, and whatever slow progress was achieved, it was neutralized by heavy population growth. He further suggested augmenting the level of public expenditure to enhance availability of these facilities in the state. It is noticeable that many of the studies in this context argued that need of high public health expenditure for improvising the health care services in UP with huge social investment.

Nirvikar Singh (2008) analysed the delivery of public health care services in India, in the broader context of decentralisation. His concern was not only limited to the quantity of spending but more on quality of it. Political decentralisation from national to sub-national governments alone was likely to have limited benefits, unless accompanied by decentralisation of funds, functions and functionaries. He addressed recent policy proposals and also made suggestions for reform of priorities to improve public health care deliveries.

On the aspect of intervention of National Rural Health Mission and its impact on rate of utilisation of public health facilities in Uttar Pradesh Mehrotra (2008) did an important study. Assessing the NRHM, Mehrotra found that inter-state variations in terms of utilisation of inpatient care and outpatient care. Questioning the various policy approaches towards implementation of various schemes, he found that amongst all BIMARU states in Uttar Pradesh patients have to spend more out of their pocket, with private health expenditure as a proportion of total health expenditure being 92%, way the above the national average 79% and it has been also witnessed in this study that UP government's health expenditure per capita is less than half the average of all states and private health expenditure is very high when compared with national parameter.

In the same kind of approach and methodology followed by Mukherjee and Levesque (2010) in their study to discuss the inequalities in health patient care in rural India. Adopting concentration index methodology of inequality measurement, they proved that the distribution of health care facilities is pro-poor rather than pro-rich. Using NSSO unit level data authors have also calculated the out-of-pocket expenses and improvements level with in the dimension of regional level variations in India.

On analysis of 2008 destinations by the Parthenon group (2010) distinguishes between public and private finance. In this study Parthenon group identified the relationship between out-of-pocket expenses and sources of health care financing. This study found that primary care accounts for 8% of total expenses, with public financing accounting for 87% of this expenditure. Secondary and tertiary hospital care account for 62% of spending, with private financing accounting for 63% of total expenditure.

In the context of access to rural health care in India amongst the BPL population in six states, Iyengar and Dholakia (2011) did a study with the help of National Family Health Survey (NFHS) Data. Based on secondary data sources in

this study intervention and the role of NRHM polices has also been discussed more broadly. They argued that "Improvement of the access of the poor to the healthcare services requires both quantitative as well as qualitative efforts. Institutional arrangements such as larger infrastructure and steps like monetary incentives for the use of public healthcare services would only temporarily increase the use of the public health facilities. Unless qualitative changes like availability of medicines, presence of doctors, availability of basic amenities in health facility, etc. are made on a sustained basis, the poor may not be attracted to use the public health facilities with confidence. Till then, the primary healthcare in rural areas is not likely to become effectively inclusive". In this study authors had also explained the cause-and-effect relationship between health care expenditure and burden of morbidity.

In the dimension of inequalities in utilisation of health care in rural India, Soumitra Ghosh (2011) made an inter-state level study. In this study the author described the rate of utilisation of government health care services amongst all income groups of rural India. Contradicting to the results other studies, this study shows that the rate of inpatient care utilisation has substantially increased among the rich as well of rural India. Contrary to the widespread belief of increasing inequality in the health sector, it is observed that economic status-related inequality in inpatient care utilisation has declined over the years. The results of Ghosh's study imply that lower- and middle-income households bear the brunt of the ongoing healthcare reforms.

In another study, Chaudhuri (2012) observed that high out of pocket expenditures on health is making individuals less likely to utilize healthcare services in Punjab, India in this they presented an analysis of the NSSO survey data with some new approaches to correcting some of the biases in previous assessments of the "impoverishing" effect of health spending. Despite these corrections, the results suggest that the extent of impoverishment due to healthcare payments is higher than previously reported. Furthermore, outpatient care is more impoverishing than inpatient care in urban and rural areas alike. The analysis of the extent of impoverishment across states, regions (urban and rural areas), income quintile groups, and between outpatient care and inpatient care yields some interesting results.

Karan and Mahal (2013, 14) studied the relationship between type of ailment and impact of out-of-pocket expenditure on economic condition households. This study found that the share of out-of-pocket spending on total household expenditure for household having angina was higher comparative to a set of households having similar socio-economic characteristics. Mahal *et al.* found that household containing a cancer patient significantly faced higher burden of out-of-pocket spending in compared to household containing similar kind of demographic profile.

Chakarborty and others (2013) studied about the distribution of public health expenditure in India with the help of CSO and NSSO Data. They used benefit incidence analysis method to show the inequalities in public expenditure in India. In their study they explored many dimensional aspects of health inequities in India at Interstate level. They found that in India's health care market in ten states Bihar, Jharkhand, Orissa, West Bengal, Jharkhand, Madhya Pradesh, Andhra Pradesh, Maharashtra, Karnataka, distribution of health expenditure worked out be pro-poor in rural areas but in urban areas but in urban areas public spending on health care followed pro-rich distribution. It has been also found in this paper that comparatively smaller percentages of outpatients across quintiles get treated in public medical hospitals.

Raushan & Mutharayappa (2014) in their study explained the social disparities in the context of curative child care in rural India. With the help of IHDS data they captured different aspects of curative health care. In their study they discussed the issue of intra-caste disparity in utilisation of government health facilities. They had opinion that disparity in the self-rated health status (morbidity) among various social group existed due to many socio-economic factors and in their study proper explanation has been provided behind this factor.

DISCUSSION

The economic reforms initiated in India in the early 1990s brought about profound changes across various sectors, including healthcare. Out-of-pocket (OOP) health expenses, which refer to the direct payments made by households for healthcare services, have been a significant concern, especially in the context of rising healthcare costs

1. **Impact of Economic Reforms on Healthcare Access and Financing**: The post-reform period in India saw a rapid increase in private healthcare expenditures, with a larger share of health financing shifting from the public to the private sector (Chakraborty & Kumar, 2017). The liberalisation of the economy led to the expansion of private health providers, resulting in an increased financial burden on households, especially the poor. According to Murthy (2009), the shift towards a market-driven healthcare system disproportionately affected low-income families, who faced a higher incidence of OOP expenditures due to their limited access to affordable health insurance and public healthcare services.

2. **OOP Expenditures and Health Inequality**: Several studies have highlighted the exacerbation of health inequality following the reforms. OOP health spending remains regressive, with wealthier households typically able to absorb the costs of private healthcare, while poorer households experience financial strain (Rao & Bhat, 2012). This trend has led to a deepening divide in health outcomes across different socioeconomic groups, as those in lower-income brackets are more likely to incur catastrophic health expenditures. A study by Baru (2010) showed that despite government efforts to expand healthcare services, the private sector's growing dominance has perpetuated financial barriers to accessing quality care, especially for marginalized populations.

3. **Health Insurance and Its Role in Mitigating OOP Expenses**: One of the most discussed mechanisms to alleviate OOP health expenses is the expansion of health insurance. However, studies indicate that health insurance coverage remains limited in India, particularly for rural and economically disadvantaged populations. Sahoo & Chandra (2015) argue that although private health insurance has grown post-reforms, its penetration remains low, and most Indians rely on OOP payments for medical expenses. The lack of comprehensive coverage, particularly in rural areas, is a major reason for the persistent reliance on OOP expenditures.
4. **Catastrophic Health Expenditures and Financial Protection**: Catastrophic health expenditures, where OOP payments exceed a certain percentage of household income, have become a major issue in the post-reform era. According to a report by the National Sample Survey Office (NSSO, 2014), nearly 55% of households in India face catastrophic health expenditures, pushing many families into poverty. The rise in the cost of medical treatments, especially for chronic diseases and hospitalisation, has led to increased financial vulnerability among Indian households, particularly in the absence of robust public health insurance schemes (Selvaraj & Karan, 2009).
5. **Government Interventions and Policy Response**: In response to these challenges, the Indian government has made efforts to reduce OOP expenses through various health schemes such as the National Health Mission (NHM) and more recently, the Ayushman Bharat initiative. While these schemes have made healthcare more accessible to some segments of the population, their impact on reducing OOP expenses has been mixed. According to Pandey *et al.* (2020), despite the expansion of the Ayushman Bharat scheme, many households still face high OOP payments due to limitations in coverage and the high out-of-pocket costs for treatment in private healthcare facilities.
6. **Recent Trends and Future Directions**: Recent reviews suggest that although there has been some progress in improving public health services and expanding insurance coverage, OOP expenses remain a significant barrier to accessing quality healthcare (Kapoor & Mishra, 2021). Going forward, scholars argue that there is a need for more comprehensive policy frameworks that address the affordability and accessibility of healthcare for all segments of society, with a particular focus on expanding universal health coverage (Kumar, 2022).

CONCLUSION AND LIMITATIONS

The review of literature on out-of-pocket (OOP) health expenses during the post-reform period in India highlights significant challenges in healthcare financing and accessibility. The economic reforms of the 1990s ushered in substantial shifts in the healthcare sector, with an increased reliance on private health providers and a consequent rise in OOP expenditures. This trend has led to heightened health inequities, financial vulnerability, and a considerable burden of catastrophic health expenditures for Indian households, particularly among lower-income groups. While government initiatives such as the National Health Mission (NHM) and Ayushman Bharat have made strides in improving access and affordability, gaps remain in universal health coverage and effective implementation. The literature also underscores the critical role of health insurance in mitigating OOP expenditures but reveals its limited penetration, especially in rural and marginalized communities. The dominance of private healthcare and the inadequacies in public health infrastructure continue to pose challenges to achieving equitable healthcare financing. The insights from recent reviews emphasize the need for comprehensive policy interventions to address these issues, including enhancing public health funding, expanding insurance coverage, and improving the quality and accessibility of healthcare services.

Limitations of the Review

While this review provides a broad understanding of OOP health expenses in India, it has several limitations:
1. **Geographical Focus:** Most studies reviewed focus on specific regions or urban areas, potentially overlooking the rural and tribal healthcare dynamics.
2. **Temporal Constraints**: The review predominantly covers literature from the post-reform period without delving deeply into longitudinal changes or comparisons with pre-reform scenarios.
3. **Policy Impact Assessment**: Many studies analyze the financial burden but lack robust evaluations of recent policy measures like Ayushman Bharat or state-specific health schemes.
4. **Data Limitations**: The reliance on secondary data from surveys such as NSSO limits the scope for capturing real-time trends and emerging challenges.
5. **Methodological Variations**: The methodologies adopted across studies vary, leading to inconsistencies in findings and interpretations. Future research should focus on addressing these gaps by incorporating longitudinal studies, evaluating policy outcomes at a granular level, and exploring innovative solutions to reduce the OOP burden on vulnerable populations. A multidimensional approach combining qualitative and quantitative analyses can further enrich the understanding of this critical issue.

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