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LETTER TO THE EDITOR

Comment on: "Disease-Specific Out-of-Pocket Payments, Catastrophic Health Expenditure and Impoverishment Effects in India: An Analysis of National Health Survey Data"

Nafis Faizi[1] · **Yasir Alvi**[2]

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We read the paper on disease-specific out-of-pocket expenditure (OOPE), catastrophic health expenditure and impoverishment effects in India with great interest [1]. The paper confirms the pervasive presence of catastrophic expenditures across different diseases as well as types of healthcare, adding layers to the mounting evidence on healthcare expenditure in low-income and middle-income countries. The paper reflects the concern of the National Health Policy 2017 [2], and rightly identifies the two policy implications: (i) increasing access to health insurance and price regulations in the private sector and (ii) stringent implementation of health system financing policies. Given the disease-specific differences in access and provisioning of care, we now draw attention towards three additional policy-related issues of significance.

First, there are implications on India's path towards universal health coverage (UHC). Out-of-pocket expenditures were higher in hospitalisations (9.15%) as opposed to outpatient department (OPD) care (5.57%), whereas impoverishing effects were higher for OPD care (16.4% vs 14.1%) [1]. As India's National Health Protection Scheme or Pradhan Mantri Jan Arogya Yojana covers only hospitalisations, impoverishing effects from OPD care are likely to remain high unless the primary healthcare along with the continuum of care is also strengthened. Given the higher need for OPD care, the selective push and attention towards the insurance component alone is not a cost-effective approach within the limited public health spending [3]. Extant research reflects on this failure of Pradhan Mantri Jan Arogya Yojana in reducing OOPE, as has been the persistent trend with other state health insurance programmes in the past [4]. Excessive dependence on powerful private providers, provider capture and poorly regulated markets are the reasons behind such a failure [5]. Thus, strengthening of primary healthcare at all levels to reduce the heavy dependence on the private sector and its regulation is important along with the strengthening of health and wellness centres, which has seen a slower progress to date. Health and wellness centres are meant to provide comprehensive primary healthcare with an expanded range of services focussed on wellness, and the service provision is universal, free and close to the community.

Second, there are implications for diseases such as tuberculosis, which have a targeted provisioning of care through dedicated vertical health programmes. Aggregated analyses frequently undermine the differential impact that certain diseases have. Many diseases affect the poor and the vulnerable disproportionately and this does not manifest clearly in aggregate measures of financial expenditure. However, they are responsible for a vicious intergenerational cycle of poverty and vulnerability, as the non-affluents are typically more prone to neglected and infectious diseases, which leads to poverty due to catastrophic expenditure. Even in diseases such as tuberculosis and human immunodeficiency virus/acquired immune deficiency syndrome, which have vertical programmes providing free treatment and consultation, the catastrophic expenditure rate is significantly high [6, 7]. The current research could not measure the impact of indirect costs such as wage and productivity losses, which often constitute the bulk of expenses in vertical programmes [7]. While the current research vouches for customised disease-specific insurance packages at public facilities, we believe

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✉ Nafis Faizi
nafisfaizi@gmail.com

Yasir Alvi
yasiralvi13@gmail.com

[1] Department of Community Medicine, Jawaharlal Nehru Medical College & Hospital, Aligarh Muslim University (AMU), Aligarh, India

[2] Department of Community Medicine, Hamdard Institute of Medical Sciences and Research, New Delhi, India

that for vertical programmes, service-level integration can reduce OOPE by improving coverage and accessibility and lowering transportation costs, in addition to promoting local ownership and accountability [7]. While the current research observed the role of public and private providers through expenditure data, inclusion of social and economic conditions, which play a central role in determining household financial protection, unveils the differential impact of financial protection measures with greater clarity.

Third, there are pertinent reflections on the financial monitoring indicator of UHC. Public health experts argue that UHC's narrow indicator focus on financial protection for healthcare utilisation is insufficient to measure financial protection in the absence of measures to reduce indirect expenses [8, 9]. Whether the cause of catastrophic expenditure is healthcare utilisation expenditure or indirect losses or is due to the disease's disproportionate preponderance in the poor, its implications on treatment compliance and a cure hamper other goals of the health system, such as efficiency, equity and quality of healthcare. The UHC framework has the potential to incorporate strengthening of primary healthcare, as well as service-level integration, but their impact goes beyond the narrow indicator to improving other goals of the health system.

Given the enormous challenge of OOPE in India, this research is useful for policy makers and public health experts. Catastrophic expenditures are detrimental to India's future as they undermine health system goals, hinder our progress towards UHC and sustainable development goals (SDG), and lead to an intergeneration cycle of poverty.

Declarations

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