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ijirset@gmail.com

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Assessing the Economic Implications of Household Health Expenditure in Dindigul District

Dr.P.Ravichandran, Dr.M.Anandan¹

Associate Professor and Head, Department of Economics, GTN- Arts College (Autonomous), Dindigul,
Tamil Nadu, India

Assistant Professor (on Contract), Department of Economics, The Gandhigram Rural Institute-DU, Dindigul,
Tamil Nadu, India

ABSTRACT: Health services exert a profound impact on the well-being of individuals and societies and constitute a crucial component of a nation's economy. Various countries have adopted National Health Accounts as a resource tracking tool to monitor the allocation of healthcare resources from diverse funding sources to the beneficiaries of these resources within a specified framework over a given time period. National health accounts offer insights into critical questions such as "who finances healthcare," "who receives it," and "for what purposes it is utilized." In the context of India, Out of Pocket Expenditure (OPE) plays a substantial role in total healthcare expenses, making it essential to track the scale and trends of both the public and private healthcare sectors. The current study aims to examine household health expenditure in Dindigul District, Tamil Nadu. This investigation integrates primary and secondary data, with primary data forming the core and secondary data providing supplementary evidence, particularly in the realm of environmental health. The objectives of this study encompass the following: To investigate the socio-economic characteristics of respondents in the study area. To scrutinize the healthcare system in India and the expenditure patterns within the healthcare sector. To evaluate the state of environmental health in the study area, including factors such as health, sanitation, availability of toilets, and access to clean drinking water. To propose strategies for enhancing environmental health conditions in the study area. This paper offers a comprehensive economic analysis of household health expenditure, focusing on Dindigul District and OPE in India. It sheds light on these aspects and empowers policymakers, researchers, program coordinators, and managers to leverage this information in their pursuit of creating a robust healthcare financial system, improving financial outcomes for households, and ultimately enhancing overall health outcomes.

KEYWORDS: Health, Household Expenditure, out of pocket expenditure and Household Health

I. INTRODUCTION

The Indian Constitution assigns the responsibility of healthcare provision to the state governments rather than the central federal government. Each state is mandated to prioritize "raising the level of nutrition, standard of living, and public health improvement" among its primary duties. The National Health Policy was initially approved by the Parliament of India in 1983, later updated in 2002, and most recently in 2017. The 2017 update primarily focuses on addressing the increasing burden of non-communicable diseases, the growth of a robust healthcare industry, unsustainable healthcare expenditure, and the expanding fiscal capacity due to rising economic growth. Government health policy in India has primarily encouraged private sector expansion alongside limited public health programs. In 2015, the World Bank reported that the total healthcare expenditure as a percentage of GDP was 3.89 percent. Out of this, government health expenditure constituted only 1 percent of the GDP, and out-of-pocket expenditure accounted for a substantial 65.06 percent of total health spending in 2015. India's public health expenditure did increase from 0.9 percent of GDP in 2015-16 to 1.1 percent of GDP in 2020-21. Despite this increase, the Economic Survey of 2020-21 noted that India ranks 179th out of 189 countries in terms of healthcare prioritization in the government budget. The National Health Policy of 2017 aims to raise public health expenditure to 2.5 percent of GDP by 2025, a significant increase from the recent range of 1.2 to 1.8 percent of GDP. However, this goal remains notably lower than other countries like Sri Lanka, China, Thailand, United Kingdom and USA, which invest more heavily in healthcare.

¹ Assistant Professor (on Contract), Department of Economics, The Gandhigram Rural Institute-DU, Dindigul, Email: anandanmku@gmail.com, Mobile: 99 408 75550.

It's essential to distinguish health from healthcare, as the former is often wrongly perceived as a direct outcome of the latter. Health isn't merely the absence of disease; it represents freedom from illness and the capacity to fulfill one's potential. Health serves as the foundation for an individual's well-being. The health of populations is a pivotal concern in public policy discussions, influencing resource allocation, cultural perceptions of well-being, socioeconomic disparities, healthcare accessibility, quality and costs, and our understanding of health and illness. Healthcare encompasses not just medical treatment but also preventive care. It should not be limited to government-funded services but should also consider incentives and disincentives for self-care and privately financed healthcare. In India, where private out-of-pocket spending dominates healthcare financing, the impact is regressive. Healthcare is widely recognized as a public good and therefore, should not rely solely on market forces for regulation. Public health budgets are integral in reflecting government priorities and allocating resources to the healthcare sector, particularly in the social sector. Increasingly, there is pressure on governments to allocate more budget to the social sector, including healthcare, with suggestions to increase healthcare funding to 3 percent of GDP. This analysis explores the behavior of public health expenditures, with a particular focus on the states in India, as health is a state subject. It also examines the relationship between income and healthcare expenditure, providing insights into the determinants of healthcare spending and the connections between income, demand, and supply in the healthcare sector. This analysis is particularly relevant in the context of India's goal to increase public healthcare expenditure to 3 percent of GDP.

Statement of the Problems

The National Statistical Office (NSO), under the Ministry of Statistics and Programme Implementation, conducted a nationwide survey on household consumption expenditure during the 75th round, spanning from July 2017 to June 2018. The Consumer Expenditure Survey (CES) typically occurs at five-year intervals, with the last consumer expenditure survey taking place during the 68th round from July 2011 to June 2012. The NSS Consumer Expenditure Survey plays a crucial role in generating estimates of household Monthly Per Capita Consumer Expenditure (MPCE) and detailing the distribution of households and individuals across various MPCE categories. Its primary purpose is to gather information on expenditures related to both food and non-food goods and services consumed by households. The results of this survey are also instrumental in the process of rebasing the GDP and other macroeconomic indicators. According to the UN World Development Report 2020, India ranks at a disappointing 131st position on the Human Development Index (United Nations Development Programme, 2020) with a score of 0.645. India exhibits a higher infant mortality rate (under 5) than countries like Bangladesh and Nepal and its ratios of hospital beds and doctors per population are less favorable than several other nations in the region, including China, Sri Lanka, Thailand and Nepal. Notably, out-of-pocket expenditure accounts for over 65.0 percent of healthcare spending in India, a figure that starkly contrasts with countries such as China (32 percent), Sri Lanka (38 percent), Thailand (11 percent), and Nepal (60 percent) (OECD/WHO, 2018). This situation is mirrored in the severe shortage of healthcare professionals and public health infrastructure.

The public sector healthcare system in India encompasses primary health centers (PHCs), community health centers (CHCs), district-level secondary care hospitals, and tertiary-level care institutions. Owing to prolonged underinvestment in the healthcare sector, there is a significant deficit of CHCs, PHCs and sub centers (SCs) in India. The availability of hospital beds is limited with a ratio of 0.7 beds per 1,000 population (OECD/WHO, 2018), ranking India lower in comparison to other countries. Additionally, the doctor-to-population ratio stands at 0.8 doctors per 1,000 population, revealing an 81.5 percent deficit of specialists in CHCs across the country (Government of India, 2019). These factors contribute to a severely weakened public healthcare system that is often ineffective, inefficient, inequitable, and unresponsive to the population's healthcare needs, resulting in subpar service quality. As a consequence, India has witnessed the expansion of a thriving private healthcare sector and it remains one of the few countries that finance healthcare predominantly through substantial out-of-pocket payments, which are recognized as regressive. Many economists acknowledge the concerning trend of escalating out-of-pocket expenditures in recent years. Given the paramount role of health in the utilization of the workforce, the Planning Commission emphasized the importance of health programs in the pre-year plans. For planning purposes the health sector is subdivided into various categories, including water supply and sanitation, control of communicable diseases, medical education, training, and research, medical care (including hospitals), public health services, family planning, and indigenous systems of medicine. Improving the health status of the population has been a major focus of the country's social development programs, with a particular emphasis on enhancing access to and utilization of essential services like clean drinking water, housing, sanitation and more. Environmental health systems encompass primary and secondary care facilities staffed by medical and paramedical professionals, medical colleges, para-professional institutions, program managers overseeing ongoing initiatives and health management information systems.

II. OBJECTIVES OF STUDY

The main objectives of the study are

- To study the socio-economic characteristics of the respondents in the study area viz. Krishnapuram village in Dindigul district;
- To analyze the healthcare system in India and the pattern of healthcare expenditure on health sector in India;
- To examine the status of environmental health of the respondents in terms of health, sanitation including toilets and drinking water in the study area; and
- To suggest ways and means to improve the environmental health conditions in the study area.

III. METHODOLOGY

This research study employs a combination of primary and secondary data. Primary data is collected through pre-tested interview schedules, specifically in Krishnapuram village, Dindigul district. The study encompasses various variables, including family size, educational attainment, income, expenditures, savings, debts, asset structure, housing conditions, toilet and sanitation facilities, healthcare accessibility, disease profiles, and household expenditures. In total, there are 150 households in the study area, with researchers directly visiting 30 households due to the constraints posed by the COVID-19 pandemic. The study also draws on secondary data sources, primarily collected from various issues of the Economic Survey from the Government of India. Additional secondary data are obtained from sources such as India State, National Health Accounts, the Reserve Bank of India (RBI) Database, World Bank Database, and Ministry of Health and Family Welfare. The RBI compiles comprehensive financial statements for state governments based on the states' budget documents and supplementary information. In contrast to the well-documented public health expenditures, information regarding private healthcare spending is limited. The study applies statistical methods to analyze the collected data in order to achieve the study's objectives.

Profile of the Study Area

As per the 2011 Census, Dindigul District had a total population of 2,161,267, and it exhibited a sex ratio of 998 females for every 1000 males, surpassing the national average of 929. Among the district's residents, 2,16,576 were children under the age of six, comprising 111,995 males and 104,621 females. Scheduled Tribes accounted for 20.95 percent of the population. The district's average literacy rate stood at 68.61 percent, which was slightly below the national average of 72.99 percent. Dindigul District was home to 560,773 households, and there were a total of 1,105,155 individuals engaged in various occupations. This workforce included 155,332 cultivators, 388,725 primary agriculture laborers, 25,253 involved in household industries, 393,707 other workers, 142,138 marginal workers, 10,073 marginal cultivators, 79,234 marginal agriculture laborers, 5,576 marginal workers in household industries, and 47,225 other marginal workers. Krishnapuram Village spans an area of 4 km², ranking as the fifth smallest village by land area in the sub-district. The village boasts a population density of 642 individuals. The nearest town to Krishnapuram is Ambilikai, and the village's post office is located in Oddaipatty with the pin code 624612. The district headquarters, Dindigul, is situated 45 km away. Krishnapuram Village is inhabited by 642 residents, comprising 324 males and 318 females. In terms of caste distribution, 75.0 percent belong to the general caste, while 25.0 percent are from the scheduled caste. Among the village's inhabitants, 9.0 percent are children under 6 years of age, with 42.0 percent being boys and 35.0 percent girls. The village consists of 160 households, with an average of 4 individuals in each family. Most of the houses serve as dwellings, and the primary sources of water supply are wells and bore wells.

Scope and Limitation of the Study

The primary objective of this study is to assess household health expenditures. Additionally, the research examines the relationship between health status and socio-economic variables, including factors such as caste, religion, community, family size, dietary habits, cooking practices and housing conditions. The findings of this study have the potential to assist policymakers in enhancing the overall health status of both rural and urban communities, benefiting not only the present generation but also future generations as they work towards achieving sustainable rural development. It's important to note that this study is focused exclusively on a specific hamlet, namely Krishnapuram village in Dindigul district, Tamil Nadu. The data and information were collected from selected respondents, with the acknowledgment of a potential recall bias as one of the study's limitations. Due to challenges posed by the COVID-19 pandemic, the researchers were able to directly contact only 30 households among the total number of households in the study area. Furthermore, it's crucial to highlight that the primary emphasis of this study is on household health expenditures and

the environmental conditions within the village. However, the study does not encompass a comprehensive examination of the broader environmental and health aspects due to constraints related to time, resources, and funding.

Table 1 Demographic and occupation characteristics of the Krishnapuram

S. No	Features	Details
1	District	Dindigul
2	Block	Oddanchatram
3	Village panchayat	Oddaipatty
4	Study village (hamlet)	Krishnapuram
5	Population	642
6	Sex Ratio	1010
7	Child Sex Ratio	Nil
8	Literacy Rate	72.12 %
9	Main Occupation	Farming

Source: computed from Secondary data

In terms of area and population Krishnapuram is smallest hamlet coming under Oddaipatti panchayat of Oddanchatram block in Dindigul district. The number of household in the Krishnapuram is 160 households with population of 642 of which 49.7 percent are male and 50.3 percent are female (Census, 2011). Average sex ratio is 1010 which is higher than Tamil Nadu state average of 996. The literacy rate of Krishnapuram village was 72.18 per cent compared to 80.09 per cent in Tamil Nadu. The main occupations are Agricultural labours, daily wage earners and construction workers. The main crops cultivated are vegetable such as Drumstick, Tomato, Onion and Brinjal and etc.

Table 2 Socio Economics Analysis of Household Health Expenditure in Krishnapuram Village of Dindigul District

Age of the respondents			
S. No	Age (in years)	No of Respondents	Percentage
1	<25	2	6.7
2	25-50	15	50
3	>50	13	43.3
Total		30	100
Communities			
S. No	Community	No of Respondents	Percentage
1	BC	13	43.3
2	MBC	17	56.7
Total		30	100
Gender of the Respondents			
S. No	Gender	No of Respondents	Percentage
1	Male	21	70
2	Female	9	30
Total		30	100
Size of the Households			
S. No	Size of house (in square feet)	No. of respondents	Percentage
1	<500	6	20
2	500-700	7	23.3
3	700-900	8	26.7

4	900-1100	4	13.3
5	1100>	5	16.7
Total		30	100
Types of Households			
S. No	Types of house	No of respondents	Percentage
1	Tiled	23	76.7
2	Concreted	7	23.3
Total		30	100
Educational Qualifications			
S. No	Educational Qualification	No of Respondents	Percentage
1	Illiterate	1	3.3
2	Primary	11	36.7
3	Higher school	11	36.7
4	Higher secondary	2	6.7
5	Diploma	1	3.3
6	Degree	4	13.3
Total		30	100
Occupations			
S. No	Occupation	No. of Responded	Percentage
1	Financier	5	16.7
2	Government employee	1	3.3
3	Agricultural coli	6	20
4	Agricultural	16	53.3
5	Private employee	2	6.7
Total		30	100
Economic Status			
S.No	Economic States	No of Respondents	Percentage
1	BPL	27	90
2	ABL	3	10
Total		30	100
Health Expenditure Preference to Visit Hospitals			
S. No	Source of Health	No of Respondents	Percentage
1	Government	5	16.7
2	Private	25	83.3
Total		30	100

Source: Computed from the primary data

Age: The Table 2 show that the age wise distribution of the respondents. Majority of the respondents 15 (50.0 per cent) belong the age group of 25 to 50, followed by above 50 years of age group (43.3 per cent) and the remaining 2 (6.7 per cent)of the respondents belong to the age group of 25-50 years who play a significant role in the economic improvement family in the study area.

Communities: The exhibit that caste wise distribution of respondents. Majority of the respondents (56.7 per cent) belong to MBC and followed by 43.3 per cent belong to BC communities. It is concluded that most of the respondents belong to MBC 17 (56.7 per cent)

Gender: The table 2 present the gender wise distribution of the respondents in the study area. It is observed that 21 (70 per cent) of the respondents are male ad 9 (30 per cent) of them are female. It is clear from the table that majority of the respondents are male in the study.

Size of the households: The table 2 pictures the size of the houses residence by the respondents. It observed form table that of very small houses constitute 26.7 per cent of the respondents whose house size is in between 700-900 square

feet, followed by 23.3 per cent of the respondents whose size of the houses are between 500-700 square feet, 20 percent of the them are living in the size of houses less than 500 square feet, and only 13.3 per cent are living 900-1100 square feet of houses. It is confirmed that majority of the houses are 700-900 square feet.

Types of houses are highlighted in the table 2 Of the total horses 76.7 per cent of the houses are tiled 23.3 per cent of the houses are concreted in the study area. Nature of housing and its type are very much essential to examine the status of the households followed by the facilities available, in the house which evident the economic and social status of households.

Educational Status: The table 2 examine educational status of the respondents in the study area. It is observed from the table 2 that followed by 3.3 per cent are illiterates, 11(36.7 per cent) of the respondents have completed primary education and 36.7 per cent respondents have completed high school and 6.7 per cent respondents have completed HSC education and 3.3 per cent respondents have completed diploma. It's clear that majority of the respondents have studied up to primary school education in the study area.

Occupations: The table 2 states the distribution of respondents according to the occupation of 30 respondents of the total 53.3 per cent are agricultural labours, 20 per cent are agricultural coli, 16.7 per cent are financier and 6.7 per cent private employee and 3.3 per cent government employee

Economic Status: The table 2 show the poverty statues of the respondents in the study area. It is observed from the table that (90 per cent) of the respondents are living below poverty line and 10 per cent of them are living above poverty line. It is clear from the table that majority of the respondents are BPL in the study area.

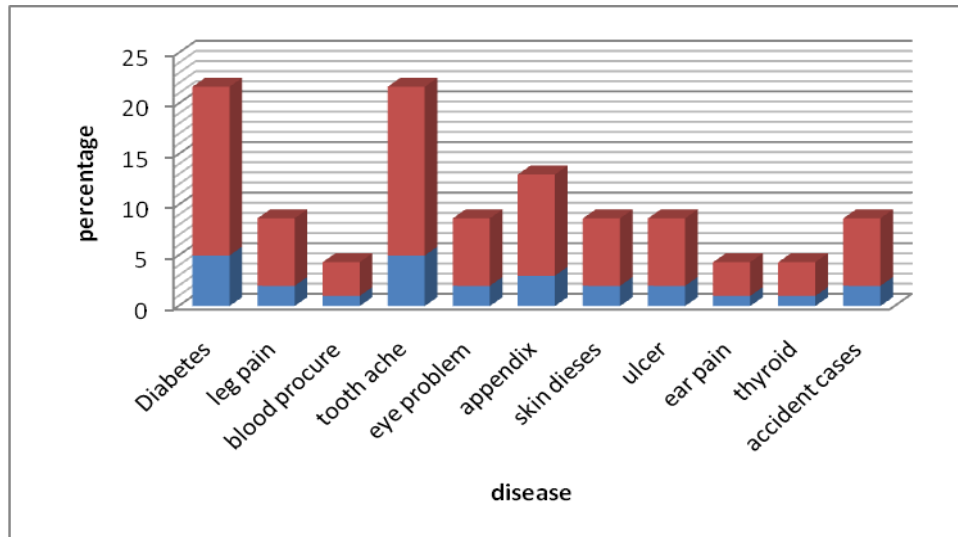
Health Checkup preferences: The table 2 show that the source of health of respondents. Majority of the respondents 83.3 percent use private hospital and only 16.7 per cent of the respondents are use government hospital. However major reasons for vist private hospital centre hospital Infrastructure facilities are good and another major reasons government hospital not nearest place available.

Table 3 Distribution of the Respondents According to the Disease Pattern

S. No	Disease	No of Respondents	Percentage
1	Diabetes	5	16.7
2	leg pain	2	6.7
3	blood procure	1	3.3
4	tooth ache	5	16.7
5	eye problem	2	6.7
6	Appendix	3	10
7	skin dieses	2	6.7
8	Ulcer	2	6.7
9	ear pain	1	3.3
10	Thyroid	1	3.3
11	accident cases	2	6.7

Source: computed from the primary data

Figure 1 Distribution of the Respondents According to the Disease Pattern



Source: Derived from table 3

It is observed from the table 3 and figure 1 furnished the details about disease patterns households of the population of 30 respondents. The table shows that a large number of populations infected by Diabetes and tooth ache (16.7 per cent) followed by skin dieses, Ulcer, eye problem, leg pain and accident cases (6.7 percent) and Thyroid, ear pain and blood procure (3.3 percent) population. It is found that, most of the population infected by Diabetes population in the village. Household health expenditures are the expenditures incurred by households on health care and includes out of pocket expenditures and prepayments. OPE are the payments made directly by individuals at the point of service where the entire cost of the health good or service is not covered under any financial protection scheme. When an individual/household has to bear the expenditures for health care out of pocket, most of the times expenditures tend to be high in relation to their income thereby leading to low living standards (reduction in expenditure on basic necessities like food and clothing). OPE becomes a burden for the poor especially when they have to spend huge amounts from their disposable income.

IV. SUMMARY OF MAJOR FINDINGS

- Krishnapuram village is home to 160 individuals, with a total population of 642. The sex ratio stands at 65 percent, comprising 324 males and 318 females. The literacy rate in the village is 72 percent.
- The primary occupation of the residents is agriculture, with a focus on cultivating vegetables such as onions, tomatoes, and brinjals.
- In terms of age distribution, the majority (50 percent) of respondents fall within the age group of 25-50 years.
- A significant proportion (56.7 percent) of the respondents belong to the Most Backward Classes (MBC) category.
- Gender-wise, 70 percent of the respondents are male, while females constitute 30 percent of the population.
- Literate respondents make up 36.7 percent of the population, with 36.7 percent having completed primary education, and there are no illiterate individuals.
- Occupation-wise, the majority of respondents (53.3 percent) are engaged in agricultural work, while 16 percent work in the financial sector.
- Housing size data reveals that most respondents (26.7 percent) reside in houses ranging between 700-900 sq. ft.
- Regarding housing facilities, 76 percent of the houses have toilet facilities.
- A significant portion, 90 percent, of the respondents fall under the Below Poverty Line (BPL) category, while the remaining 10 percent belong to the Above Poverty Line (APL) category.
- In terms of healthcare, the majority of the 30 respondents (83.3 percent) have utilized services from private hospitals.

- Health issues prevalent among the respondents include diabetes (16.7 percent), toothaches (16.7 percent), and appendicitis (10 percent).

V. SUGGESTION AND RECOMMENDATION

Here are some recommendations and suggestions to enhance health expenditure and healthcare status in Tamil Nadu and India:

Reducing Reliance on Out-of-Pocket Payments: To safeguard the household health expenditure, especially for low income households, it is crucial to reduce the reliance on out-of-pocket payments within the healthcare system. This can be achieved by implementing policies that offer greater financial risk protection. While increasing the availability of health services is essential for improving health in economically disadvantaged regions, it can also lead to higher healthcare costs for households. Therefore, it's imperative to prioritize risk protection policies under such circumstances. Household health expenditure is influenced by various factors such as income, the type of illness, age, gender, healthcare facility, and quality of care. Increasing public spending on healthcare and expanding access to health insurance can significantly alleviate the burden of household health expenditure.

Enhancing Public Health Spending: To address the issue of insufficient public spending, it is evident that both national and state governments need to increase the overall healthcare budget. Additionally, allocations for health insurance schemes for the underprivileged, such as the Rashtriya Swasthya Bima Yojana (RSBY), Pradhan Mantri Jan Arogya Yojana (PMJAY) and Chief Minister Comprehensive Health Insurance Scheme (CMCHIS) should be augmented to extend coverage to more beneficiaries.

Promoting Private Sector Involvement: Regulatory reforms, including raising the limit of Foreign Direct Investment (FDI), are necessary to encourage private sector participation in expanding financial access to healthcare.

Tax Incentives for Health Insurance: Providing tax incentives to employers and families who opt for health insurance can stimulate growth in the healthcare sector and encourage more individuals to invest in health coverage.

Establishing a Comprehensive Public-Private Partnership (PPP) Framework: It is essential to create a robust framework for public-private partnerships to bridge the demand-supply gap in healthcare. This collaboration can improve healthcare accessibility and affordability.

Supporting Modern Healthcare Technologies: The government should concentrate on enhancing the profitability of the private sector, particularly in the domain of modern healthcare technologies, by providing tax incentives and promoting their development.

Investing in Preventive Healthcare: Promote preventive healthcare measures through public awareness campaigns and incentives for regular check-ups and vaccinations. Preventing illnesses can reduce the overall burden on the healthcare system.

Strengthening Primary Healthcare: Focus on strengthening the primary healthcare infrastructure to ensure that individuals receive timely and appropriate care at the community level. This can reduce the need for expensive secondary and tertiary care.

Telemedicine and E-Health: Invest in telemedicine and e-health solutions to provide healthcare access to remote and underserved areas, reducing the need for costly travel and improving healthcare efficiency.

Health Education Programs: Implement comprehensive health education programs in schools and communities to promote healthy lifestyles and awareness about healthcare resources.

Streamlining Healthcare Regulations: Simplify and streamline healthcare regulations to reduce administrative burdens on healthcare providers and facilitate efficient service delivery.

Healthcare Quality Assurance: Establish mechanisms for monitoring and ensuring the quality of healthcare services to prevent unnecessary expenditures on substandard care.

Research and Innovation: Encourage research and innovation in healthcare, fostering the development of cost-effective treatment options and technologies.

Regional Disparities: Address regional disparities in healthcare access by investing in healthcare infrastructure and services in underserved areas.

Public-Private Collaboration for Medical Training: Encourage public-private collaboration in medical education and training to produce a larger pool of skilled healthcare professionals.

Health Information Systems: Implement comprehensive health information systems to collect and analyze data for informed decision making, resource allocation, and monitoring healthcare outcomes.

Supporting Vulnerable Populations: Develop targeted programs and financial assistance for vulnerable populations, including the elderly, disabled, and those with chronic illnesses, to ensure they have access to necessary healthcare services.

Disaster Preparedness: Invest in disaster preparedness and response systems to mitigate the financial burden of healthcare during emergencies and natural disasters.

Holistic Healthcare: Promote holistic and integrative healthcare approaches that address both physical and mental health, reducing the overall healthcare burden.

Environmental Health: Address environmental factors that affect public health, such as pollution and access to clean water, to prevent health issues and reduce healthcare costs.

By implementing these recommendations, Government of Tamil Nadu (GoT) and Government of India (GoI) can take significant steps toward improving healthcare accessibility, reducing the financial burden on households, and enhancing the overall healthcare system.

VI. CONCLUSION

This paper delves into the intricate landscape of public health expenditure in India, with a specific focus on Krishnapuram village in Dindigul district, Tamil Nadu. It underscores the crucial importance of efficient and equitable allocation of resources within the healthcare sector, emphasizing the constitutional assignment of healthcare responsibility to state governments. The study brings to light the existing inefficiencies and inequities within India's public health expenditure system, with a significant portion of healthcare costs being borne by households through out-of-pocket payments. Despite incremental increases in public health spending as a percentage of GDP, India remains challenged in prioritizing healthcare within its budgetary framework. Notably, the National Health Policy of 2017 sets an ambitious target of increasing public health expenditure to 2.5 percent of GDP by 2025, though this goal remains lower compared to several other nations. The paper effectively distinguishes between "health" and "healthcare," with a poignant reminder that the well-being of individuals extends far beyond access to medical treatment, encompassing overall health, freedom from illness, and the capacity to achieve one's full potential.

The study highlights the socioeconomic factors that underpin healthcare spending patterns, disease profiles, and household health expenditure preferences. Among these findings, the preference for private healthcare services is prominent, reflecting both the growth of the private healthcare sector and the considerable out-of-pocket expenses incurred by households. Common health issues, such as diabetes and toothaches, underscore the broader challenges in healthcare accessibility and affordability. Moreover, the study offers a comprehensive set of recommendations and suggestions to address the prevailing issues in public health expenditure. These encompass reducing reliance on out-of-pocket payments, enhancing public health spending, promoting private sector involvement, and fostering innovation in healthcare delivery. It also underscores the importance of supporting vulnerable populations, improving healthcare infrastructure, and encouraging public-private partnerships. In essence, this research paper provides a holistic analysis of the intricacies of public health expenditure in India, offering a roadmap for more efficient, equitable, and accessible

healthcare services. It underscores the urgency of addressing these challenges, particularly in a global landscape where health crises, such as the COVID-19 pandemic, have underscored the critical need for robust healthcare systems. The research serves as a reminder that the allocation of resources to healthcare is not merely a budgetary concern but a commitment to the well-being and prosperity of the nation's citizens, extending beyond the absence of disease to the fulfillment of human potential.

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