Pattern of private expenditure on health and education across social groups in Uttar Pradesh and Madhya Pradesh

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ABSTRACT

This paper analyses the pattern and financial burden of expenditure on health and education services across social groups in two socially and economically most backward states of India. In recent years, the cost of education and health services have been rising sharply which is compelling households to expend larger part of their household budget on these services. This rising cost of these services severely affects the social and economic conditions of the most deprived social groups which further hamper the overall development of the economy and society. The efficient policy actions from government side is much needed to enlarge the effective and efficient social infrastructure in order to empower the most deprived and to enhance social development of the individual and nation as whole which further promotes inclusive economic development of the country.

Keywords: *Health, Education, catastrophic, out-of pocket expenditure*

Introduction

Education and health are important merit goods. The concept of merit goods was developed by Musgrave in 1959 to describe commodities that ought to be provided by state even if the members of society do not demand them. Thus, in broad sense, the merit goods are those goods whose consumption not only benefits their consumers but also non-consumers. The state should directly supply merit goods in the economy or alternatively it should subsidize their production and consumption. The market mechanism cannot provide merit goods efficiently to all the section of society because price determined by the market forces may exclude that section of society in the economy who has not sufficient purchasing power in hand. Thus, the large positive externalities created by merit goods on the society or economy make it necessary for the state to take the responsibility of supplying of merit goods in its jurisdiction. According to Schultz (1961), Expenditure on health and education is also a form of investment in human capital and this kind of investment increases the better job opportunities and productivity of workforce in the economy.

The expenditure on health and education plays an important role in the process of economic, social and human development of any economy because it creates efficient and productive workforce, responsible citizens and also helps in making political and social stability in the economy. Households in Indian economy have been expending a large share of their Monthly Per Capita Consumption Expenditure (MPCE) on health and education services. The Right of Children to Free and

Compulsory Education (RTE) Act, 2009, which came into effect on 1 April 2010, makes it necessary for state to provide free and compulsory education to all children under age 6-14 years, broadly it is known as Right to Education. But in case of providing better health care services to every individual in the economy, only a little progress so far has been achieved. After the introduction of economic reform on July 1991, the health and education services are largely being provided by private players at market determined high price and still the pace of privatization of health care and education services are high in the Indian economy.

In recent years, the cost of health care services has grown sharply and it has led high out of pocket (OOP) expenditure on health services. The *national health policy (draft) 2015* aims to significantly reduce out-of-pocket health expenditure due to high cost of health services and reduced the proportion of households experiencing catastrophic health expenditures and consequent impoverishment. The high out-of-pocket expenditure on health services are affecting more to the vulnerable sections of the economy, because high cost of health care services pushes a large number of persons into poverty and debt trap in India. The high cost of health services is financed by households past saving, selling productive assets and borrowing money from relatives and moneylenders (at a very high rate of interest). Out-of-pocket expenditure on health serves basically indicates the money amount paid by households at the point they receive health care services.

Many research works have shown that the rising OOP expenditure on health is taking a form of catastrophic out-of-pocket health expenditure. Catastrophic expenditure refers to any expenditure that threatens household's basic needs. According to Berki (1986), the catastrophic out-of-pocket health expenditure is that expenditure which consumes a large share of the household's budget and affects household's ability to maintain a decent living standard. According to national health policy (draft) 2015, "health care costs of a household exceeding 10% of its total monthly consumption expenditures or 40% of its non-food consumption expenditure is designated catastrophic health expenditure." The high cost of health services also affects the overall welfare of households because it cuts the expenditure on other basic human capability building inputs.

Thus, in an economy where financial protection against the disease and ill health is not proved by state, any health shocks affects households (especially marginalized households) deeply by two way; first, it consumes a large part of their budget and second, it push them into poverty and debt trap with jeopardizing future economic welfare. In India, NSSO provides data on the health expenditure in two component- Institutional and non-institutional health expenditure. The recall period for institutional health expenditure is 365-days and 30-days for non-institutional health expenditure. ***Institutional health expense*** refers to all expenses which are incurred for medical treatment undergone as an in-patient of a medical institution (such as a hospital or nursing home) or otherwise it is ***non-institutional health expenditure***. Institutional health expenses include Medicine, X-ray, ECG, pathological test, etc, doctor's/surgeon's fee, hospital & nursing home charges and other medical expenses, and non-institutional health expenses include Medicine, X-ray, ECG, pathological test, etc., doctor's/ surgeon's fee, family planning devices and other medical expenses.

Internationally, education (particularly elementary education) has been approved as a basic human needs and it must be provided free by state to its entire citizen. The Article 41 of directive principles of Indian constitution clearly said that education should be a right (right to education) and must be provided free to all by the state.

"The State shall, within the limits of its economic capacity and development make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want."(Article 41).

"According to human development and human rights perspectives, education forms an essential component of human living and this should be provided universally to everyone without any

discrimination as an entitlement, and as a fundamental right."[1] The Right of Children to Free and Compulsory Education (RTE) Act, 2009, which came into effect in 1 April 2010, inserts article 21a in the constitution which makes it necessary for state to provide free and compulsory education to all children under age 6-14 years, and broadly it is known as Right to Education. Education plays an important role in process of development via promoting higher labour efficiency and productivity, reducing poverty and fertility level, making people more aware about their rights and duties and finally helping overall (social, economic, political and environmental) development of the economy.

Education, in India, is free only for children up to age 6-14 years. Much evidence shows that in recent year, households are spending a large proportion of their budget on educational service. The cost of education, with commercialization of education, is rising rapidly in economy and marginalized social groups of the economy are not in the position to afford the high cost of education beyond elementary level (up to elementary level education is free). Households are spending a large proportion of their budget on tuitions and other fees, other payment to school, other necessary expenditure on textbooks, stationary, uniform and transport etc. (Tilak, 1996). The high cost of education has two dimensions; first, it consumes larger part of households budget and leaves less amount of budget to spend on other human capability building inputs and second, it makes marginalized (purchasing powerless) sections unable to attain qualitative education beyond elementary level (also better quality elementary education). In India, NSSO provides data on educational expenditure by households. In this study, for both time periods 1999-00 and 2011-12, educational expenditure includes- expenses on books, journals, newspapers, periodicals, library charges, stationery, tuition and other fees (school, college etc.), private tutor/coaching centre, other educational expenses, and the recall period on education expenditure is 365-days in both rounds (55th and 68th) of NSSO.

About Study Area

The study area of the paper is Uttar Pradesh (UP) and Madhya Pradesh (MP) and according to IHDR 2011, in terms of ranking in HDI value, these two states had occupied the same rank in 2001 and 2011.According to IHDR 2011, Uttar Pradesh ranked 18th in the 1999-2000 and it also occupied same rank in the 2007-08, the performance of Madhya Pradesh in progress of human development was also almost similar, in the 1999-2000, M.P. occupied 20th rank and rank was same in the 2007-08. These two states are the economically most backward states in the India. Their performance in the progress of social indicators is worst in comparison of other states. These two states were the part of BIMARU states, a term coined by Ashish Bose.

Is private higher expenditure on education and health bad or good?

The education and health services are important merit goods which create larger positive externalities in society and many development economists have argued that these merit goods should be provided free by state to its all citizens. The development experience of developed countries shows that the all developed countries had made provision for free education and health services to its citizens in the form of universalizing education and health across country. In India, the provision of free education is limited up to elementary level (class I-VIII) and beyond the elementary level the education it is not free and existing public health sector is performing worst and it is highly underdeveloped. In India, since 1991 when economic reform was done, the cost of private educational and health services has been rising rapidly which creates high financial burden on the society especially the deprived section.

The cost of these merit goods are rising rapidly since 1991 because government has reduced

[1] Tilak, J. B G (2009): "Household expenditure on education and implications for Redefining the Poverty Line in India."

its role in providing these merit goods and private sectors (market forces) are taking leading role in providing health and education service at higher price which basically excludes resource poor or purchasing powerless section of society in the process of availing these services. The high cost of education and health services eats larger part of household's budget and leaves lesser amount to expend on other human capability building inputs. The high cost of these merit goods act as double edged sword because the high cost of these merit goods discouraged low income groups to pursue qualitative educational services and use better health services and it also push them into the vicious circle of poverty and debt. Thus, the high private expenditure on health and education by deprived and resource poor persons are economically and socially bad and it pushes them into poverty and debt trap.

Private expenditure on education across social groups in UP and MP

Education is an important dimension of human development and it has large capacity to produce positive externalities on the society. The development experience of developed countries has shown that at the initial stage of economic development of the economy, developed countries had made education free with universal coverage not only up to elementary level but also beyond the elementary level. Educational development is the pre-requisite of the economic development for any country and in India; educational development is not much satisfactory. Table 1.1 shows the per capita education expenditure in real terms at 2004-05 base year across the social groups in UP and MP in 1999-00 and 2011-12. From the table 1.1 it is clear that education expenditure in both states has increased across the social groups in all sectors (rural, urban and overall) during 1999-00 and 2011-12. In rural sector, the monthly per capita expenditure on education was highest in "Other" caste in both years in UP and MP. In UP, the expenditure on education by SCs social group was lowest ₹7.4 in 1999-00 and ₹21.6 in 2011-12 and in MP, expenditure on education by STs was lowest in both years (₹ 1.97 in 1999-00 and ₹6.22 in 2011-12). In urban sector the cost of education services are higher than rural sector. In 1999-00, the education expenditure of SCs (₹23.74) and OBCs (₹25.79) was lesser than rest of social groups and in 2011-12, again the expenditure of these social groups was lesser than rest of social groups. The main reason behind this is that, the level of income and education of these social groups has been low in UP in both years and also high cost of education services has prevented them to not expend much on and pursue education (at both-elementary and beyond elementary level). In MP, the education expenditure of STs (16.54) in 1999-00 was lowest, whereas in 2011-12, the education expenditure of SCs (43.91) was lowest in 2011-12.

Thus, the overall (R+U) pattern of education expenditure across the social groups also indicates that the deprived classes of economy are expending much less on education services in both states in both years. Though, the amount of expenditure on education has increased across the social groups in both states during 1999-00 and 2011-12. During this time period, the compound annual growth rate of per capita education expenditure on average was 4.34% in UP and by 8.66% in MP. In UP, it was highest of Others (6.26%) and lowest of SCs (4.44%). In MP, the compound annual growth rate of education expenditure was highest of STs (11.67%) and lowest of SCs (5.48%). The pattern of percentage of real MPCE (Monthly Per Capita Consumption Expenditure) also clearly shows that S Cs and OBCs social groups in UP were spent least percentage of their real MPCE on education services. The percentage of real MPCE on education was 1.77% in 1999-00 and 3.14% in 2011-12 of SCs and it was 2.30% in 1999-00 and 4.25% in 2011-12 of OBCs in UP. The percentage of real MPCE on education services of Other has been high in both years (5.14% in 1999-00 and 11.28% in 2011-12). In MP, the similar situation also exist, the derived section (STs and SCs) of economy has been spending lesser amount on education services in comparison to their advanced counterpart in economy. The STs and SCs are the most deprived sections of the economy in

MP and they are still economically and educationally most backward. And, due to low level of education and income, they are unable to spend more on educational services. In 1999-00, STs and SCs had spent 0.72% and 2.17% of their real MPCE on educational services respectively and in 2011-12; it was 2.51% of STs and 3.09% of SCs, respectively. In both years, the percentage of real MPCE and also absolute amount of expenditure on education was higher of the "Other" social group in MP.

Thus, it is clear from above analysis that the deprived section of economy in both states are spending lesser amount on educational services due to low level of income, ignorance about the importance of education (Illiteracy) and high cost of educational services. Though, the per capita monthly expenditure on education has increased across social groups in both states, but the compound annual growth rate of the per capita monthly expenditure on education has been high across social groups in MP than UP. There is nothing like "free" education in India, because households are spending a sizeable amount on educational services. The all section-rich and poor (marginalized SCs, STs and OBCs) are spending a larger part of their household budget on the educational services (Tilak, 2002).The high costs of education discourage derived social groups (low income group) to pursue high education and it also make households poor because it consumes a large part of their income. Due to these reasons, the Suresh Tendulkar committee on poverty line had included education expenditure in poverty line.

Table 1.1: Pattern of monthly per capita private expenditure on Education across the social groups in 1999-00 and 2011-12 (figures of 1999-00 and 2011-12 are adjusted from CPI deflator with base year 2004-05)

	RURAL SECTOR				**URBAN SECTOR**				**OVERALL (R+U)**			
	UP		**MP**		**UP**		**MP**		**UP**		**MP**	
Social groups/year	**1999-00**	**2011-12**	**1999-00**	**2011-12**	**1999-00**	**2011-12**	**1999-00**	**2011-12**	**1999-00**	**2011-12**	**1999-00**	**2011-12**
ST	8.35	30.86	1.97	6.22	75.55	93.3	16.54	81.47	17.28	29.92	3.4	12.78
SC	7.4	21.6	3.91	8.81	23.74	34.7	21.38	43.91	9.91	16.69	8.6	16.31
OBC	10.12	28.45	6.31	18.94	25.79	38.95	27.22	62.69	12.95	22.68	11.69	31.5
OTHER	16.76	43.06	10.21	32.17	53.91	116.46	43.04	154.14	29.27	60.67	24.81	89.6
ALL	11.23	29.09	5.62	15.18	40.26	66.34	32.6	91.31	17.53	29.2	12.89	34.93

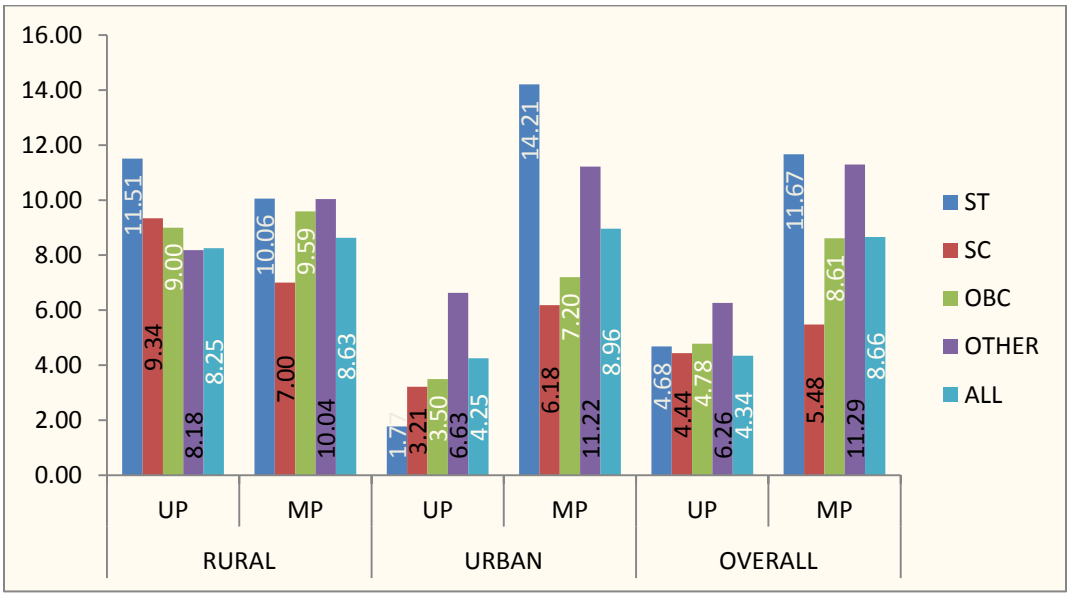
Source: Computed from NSSO 55th and 68th round, unit level data

Table 1.2 Percentage of real MPCE* on educational services

1999-00							2011-12					
	Uttar Pradesh			Madhya Pradesh			Uttar Pradesh			Madhya Pradesh		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
ST	1.77	6.55	3.01	0.58	2.58	0.72	4.29	9.6	5.55	1.3	8.59	2.51
SC	1.55	2.07	1.77	1.16	3.19	2.17	3.87	6.5	3.14	1.94	4.67	3.09
OBC	2.22	2.24	2.3	1.74	4.1	2.9	4.35	6.8	4.25	4.1	6.68	6
OTHER	3.77	4.66	5.14	2.91	6.53	6.04	5.09	10	11.28	6.91	16.33	17.41
ALL	2.44	3.45	3.19	1.74	5.02	3.14	4.41	8.4	5.36	3.24	9.65	6.77

Source: Computed from NSSO 55th and 68th round
Note: * MPCE refers to Monthly Per capita Consumption Expenditure

Figure 1.1: Annual growth rate in monthly per capita educational expenditure (1999-00 and 2011-12).



Source: Calculated from NSSO 55th and 68th round, unit level data

Pattern of private expenditure on health across social groups in UP and MP

Health is an important factor that affects both economic and human development of economy. In India, the share of out-of-pocket expenditure in total expenditure by households on health services is 70% (GOI, 2005). The World Health Report (2000) identified that the fundamental objective of health care system is to provide financial protection against the cost of ill health. Ill health affects households in two ways; first, it aggravates out-of-pocket expenditure on health and second, it undermines income generation which further jeopardizes the economic welfare of households. Households are facing high monetary burden of health services in developing country like India, where health system is not well functioning and well developed. In recent years, the costs of health services have been rising

rapidly in India, and high cost of health services are taking a form of catastrophic out-of-pocket expenditure on health services (because Indian health care system is not universal and well developed). The underdevelopment of health care system in India puts high economic pressure on households to make catastrophic out-of-pocket expenditure on health services. The high level of out-of-pocket expenditure on health care services affects vulnerable sections of the society more severely because they are economically (resource) poor and high cost of health services push them into poverty and debt trap. The table 1.3 shows the pattern of institutional and non-institutional health expenditure across the social groups in UP and MP. In rural sector, the monthly per capita institutional health expenditure has increased across social groups in UP and MP except in STs in MP during 1999-00. In both UP and MP, the monthly per capita institutional health expenditure of "Other" social groups has increased rapidly than of rest of social groups during 1999-00 and 2011-12. In 2011-12, the monthly per capita institutional heath expenditure was 9.93 of STs, 11.89 of SCs, 21.2 of OBCs and 37.72 of Others in UP whereas in MP, it was lowest in STs (3.08) and highest in Other (28.77) social groups. It is clear from the table that the institutional health expenditure was low among the deprived sections of economy in both states in both years. The monthly per capita non-institutional health expenditure is much high in comparison to institutional health expenditure across social groups in both states in both years. In rural sector, all social groups are spending much of their income on non-institutional health services in both states. The non-institutional health expenditure has increased across the social groups except in Others in UP (in other, it fell from 47.18 in 1999-00 to 42.06 in 2011-12) during 1999-00 and 2011-12. One possible reason behind this is that introduction of National Health Insurance Scheme in 2007, which covers institutional health expenses. Due to this scheme, the persons from "Other" social group prefer to incur institutional health expenses. In MP, monthly per capita non-institutional health expenditure has increased sharply across social groups. The non-institutional health expenditure of STs has increased by 10.93% annually, from 12.12 in 1999-00 to 42.07 in 2011-12 (which is highest). But, the annual growth in non-institutional health expenditure across the social groups has been much high in MP than UP. In 2011-12, monthly per capita non-health expenditure was 49.7 of OBCs, 42.07 of STs, 44.34 of Others and 40.94 of SCs in MP.

In rural area, the percentage of real MPCE on institutional health expenses has increased and on non-institutional health expenses has decreased across the social groups in UP whereas in MP, the percentage of real MPCE on both institutional and non-institutional health expenses has decreased across the social groups during 1999-00 and 2011-12. In UP, persons from marginalized social groups were spending lesser percentage of their real MPCE on institutional health. Although, the percentage of real MPCE on institutional health services has increased across the social groups in rural UP during 1999-00 and 2011-12. In 2011-12, the percentage of real MPCE on institutional health services was 1.38% of STs, 2.11% of SCs, 3.26% of OBCs and 4.50% of others in UP, which indicated the deprived section of society are spending lesser percentage of their income on institutional health services.

In case of the percentage of real MPCE on non-institutional health services, it has decreased across the social groups in rural UP but still the marginalized sections of economy are spending more on non-institutional health services than institutional health services in rural UP. In 2011-12, the percentage of real MPCE on non-institutional health services was 6.68% of SCs, 6.37% of OBCs, 4.97% of Others and 4.43% of STs in rural UP which clearly indicates that the deprived sections are spending larger percentage of their real MPCE on non-institutional health services than institutional health services. In case of rural MP, the percentage of real MPCE on institutional health services has decreased across the social groups except Others during 1999-0 and 2011-12. And, in case of the percentage of real MPCE on non-institutional health services it has increased across the social groups in rural MP. In 2011-12, percentage of real MPCE on non-institutional health services was 10.80% of

OBCs, 9.50% of Others, 9.07% of STs and 8.86% of SCs, which is much higher than the percentage in 1999-00. This clearly indicates that the health care system in rural MP is not well developed and existing health care system is performing poorly. This has resulted in high out-of-pocket expenditure on non-institutional health services by deprived social group which push them in poverty and debt trap. The poorer households are spending a large part of their total budget on health care services (Joglekar, 2008). In both states, the deprived sections of the economy finance their expenditure on health services (both institutional and non-institutional) by past saving of household, selling productive assets and borrowing from money lenders at high rate of interest and this approach of financing healthcare expenses push them into debt trap and vicious cycle of poverty (Damme, et al., 2004 and Sinha, 2014).

In urban sector, the monthly per capita institutional health expenditure has increased across social groups except in STs, and in case of non-institutional health expenditure it has decreased across social groups except in STs in Uttar Pradesh. The maximum increment in the monthly per capita institutional health expenditure has take place in Others, it rose by 10.33% annually (from 9.36 in 1999-00 to 30.45 in 2011-12) and minimum increment has take place in OBCs, it rose by 1.68% annually (from 9.05 in 1999-00 to 11.06 in 2011-12). In case of the monthly per capita non-institutional health expenditure, highest fall has been taken place in SCs, it fell by -3.81% annually (from 37.83 in 1999-00 to 26.22 in 2011-12) and lowest fall has been observed in OBCs, in OBCs social group it fell by -0.45% annually (from 32.23 in 1999-00 to 30.54 in 2011-12). Thus, it is clear that in urban Uttar Pradesh, the pattern of health expenditure is changing from non-institutional to institutional health services across social groups because the monthly per capita non-institutional health expenditure has been decreasing across the social groups and the monthly per capita institutional health expenditure has been rising across the social groups. The main reason behind this change is that the health care facility is urban UP is well developed and also well functioning that is why people from all major social groups are preferring to avail institutional health care services. In urban MP, the monthly per capita institutional health expenditure has decreased across the social groups except Others (in Other it rose by 5.87% annually, from 11.54 in 1999-00 to 22.87 in 2011-12) and the monthly per capita non-institutional health expenditure has increased across the social groups except in STs during 1999-00 and 2011-12. The rising non-institutional health expenditure indicates that public health care system is not well developed and existing health care facilities are performing poorly.

As far as percentage of real MPCE on institutional and non-institutional health expenditure in urban areas is concerned, in UP, percentage of real MPCE on institutional health expenditure has increased across the social groups except for ST (in STs it fell from 0.50% in 1999-00 to 0.3% in 2011-12). The percentage of real MPCE on institutional health expenditure has increased from 0.43% in 1999-00 to 2.0% in 2011-12 in SCs, from 0.78% to 1.9% in OBCs and from 0.78% to 2.6% in Others. In case of non-institutional health expenditure, the percentage of real MPCE has increased sharply across social groups except in Others (in case of other, it fell from 4.31% in 1999-00 to 3.8% in 2011-12). It means the marginalized social groups in urban UP are spending a large part of their budget on health services and this catastrophic out-of-pocket health expenditure leaves lesser part of budget to spend on other human capability building inputs. In MP, the percentage of real MPCE on institutional health expenditure has decreased across social groups except in Others (in Others, it rose from 1.82% in 1999-00 to 2.44% in 2011-12). In case of non-institutional health expenditure, the percentage of real MPCE has decreased sharply in STs (from 11.55% to 5.94%) and also decreased in OBCs (from 5.17% to 4.675), and in case of Others and SCs it increased during 1999-00 and 2011-12. Thus, in both states the deprived sections of economy are spending a large part of their income on health care services, despite having less income and lack of financial and physical assets.

In both sectors (rural plus urban), the monthly per capita institutional health expenditure

has increased across the social groups in UP and it rose by 9.58% annually in Others (from 8.96 to 26.87), by 5.60% annually in SCs (from 4.25 to 8.17), by 5.26% annually in STs (from 3.83 to 6.06) and lowest increment have taken place in STs. In case of monthly per capita non-institutional health expenditure, it decreased across the social groups during 1999-00 and 2011-12 but still the absolute amount of expenditure is much higher on non-institutional health services than institutional one. In UP, each social group has been spending a larger part of its budget on non-institutional health services. In 2011-12, monthly per capita non-institutional health expenditure was 33.7 of Others, 27.64 of OBCs, 27.37 of STs and 23.34 of SCs and this amount is much higher than expenditure on institutional health services by each social groups in state. In MP, during 1999-00 and 2011-12, the monthly per capita real institutional health services has decreased across the social groups except in Others (in Others, it rose by 5.77% annually, from 13.5 to 26.48) and maximum reduction in the monthly per capita real institutional health services has been observed for STs, in which it fell by -2.23% annually, from 4.21 to 3.21). In case of monthly per capita non-institutional real health expenditure, it has increased across the social groups and highest increment has taken place in STs, in which it rose by 7.39% annually (from 18.88 to 44.41). In MP also, the monthly per capita real expenditure on non-institutional health expenditure is much higher than on institutional health expenditure in each social group.

Thus, we can say that the cost of health care services in both economically and socially backward states has been rising sharply and people from each social group are spending a big part of their household budget on health care services. In Indian context, the private sector is emerging as giant player in providing health care services at high price. The backwardness and malfunctioning of public health care system is aggravating the plight of deprived sections of the economy, because due to lack of financial protection against health shocks and lack of better performing public health care system, people are incurring high cost on the treatment of health related problems. The catastrophic out-of-pocket health expenditure has been affecting the deprived section of society more severely than their richer counterpart.

The share of non-institutional health expenditure in total health expenditure is much more than 70% in both the states and the non-institutional health expense does not include any government supported health insurance schemes. The high cost of health care services (which is reflected through high out-of-pocket health expenses on both institutional and non-institutional health services) puts more financial burden on the marginalized social groups and pushes them into vicious cycle of poverty and debt trap (Narayanan et al. 2000, Amakom and Ezenekwe, 2012 and Kumar et al., 2014). The poor may be driven into vicious cycle of poverty after paying high cost for health care. "A severe ill health that afflicts the breadwinner of the family may completely impoverish the family especially those who sell their labour on daily basis to provide food for their families. Even the non-poor may be impoverished by large random out-of-pocket payment arising from unanticipated ill health."[2] The high cost of health services can be reduced by providing financial protection against health shocks through health insurance schemes and by strengthening public health care system.

[2] Amakom, U. and Ezenekwe U. (2012): "Implication of household catastrophic out-of-pocket health spending in Nigeria." Journal of Research in Economics and International Finance, Vol 1(5) pp. 136-140.

Table 1.3 Pattern of private expenditure on health across the social groups in 1999-00 and 2011-12 (figures of 1999-00 and 2011-12 are adjusted from CPI deflator).

	RURAL Uttar Pradesh				**RURAL Madhya Pradesh**			
Years	**1999-00**		**2011-12**		**1999-00**		**2011-12**	
	In health*	**Non-In health****	**In health***	**Non-In health****	**In health***	**Non-In health****	**In health***	**Non-In health****
ST	3.3	26.57	9.93	31.69	3.69	12.12	3.08	42.07
SC	3.93	34.75	11.89	38.38	5.54	26.05	6.57	40.94
OBC	6.52	32.74	21.2	40.98	6.5	24.06	7.78	49.7
OTHER	8.28	47.18	37.72	42.06	13.02	21.75	28.77	44.34
ALL	6.31	37.13	17.85	40.35	6.94	20.8	8.91	45.25

	URBAN Uttar Pradesh				**URBAN Madhya Pradesh**			
	1999-00		**2011-12**		**1999-00**		**2011-12**	
	In health*	**Non-In health****	**In health***	**Non-In health****	**In health***	**Non-In health****	**In health***	**Non-In health****
	6.17	30.52	3.02	70.41	4.11	76.31	3.6	55.93
ST	4.86	37.83	10.71	26.22	9.68	23.47	6.93	45.17
SC	9.05	32.23	11.06	30.54	14.1	34.46	8.47	43.8
OBC	9.36	50.09	30.45	44.14	11.54	37.78	22.87	65.15
OTHER	8.55	42.28	10.9	35.08	11.66	37.23	12.58	51.88
ALL								
	OVERALL Uttar Pradesh				**OVERLL Madhya Pradesh**			
	1999-00		**2011-12**		**1999-00**		**2011-12**	
	In health*	**Non-In health****	**In health***	**Non-In health****	**In health***	**Non-In health****	**In health***	**Non-In health****
ST	3.83	28.43	6.06	27.37	4.21	18.88	3.21	44.41
SC	4.25	36.93	8.17	25.34	7.16	28.27	6.8	42.8
OBC	7.23	34.3	13.37	27.64	8.93	29.09	8.14	49.14
OTHER	8.96	50	26.87	33.7	13.5	30.29	26.48	54.76
ALL	7.06	39.91	14.84	28.35	8.86	27.12	10.04	47.96

*Stands for **Institutional health expenditure** and** stands for **Non-institutional health expenditure**.

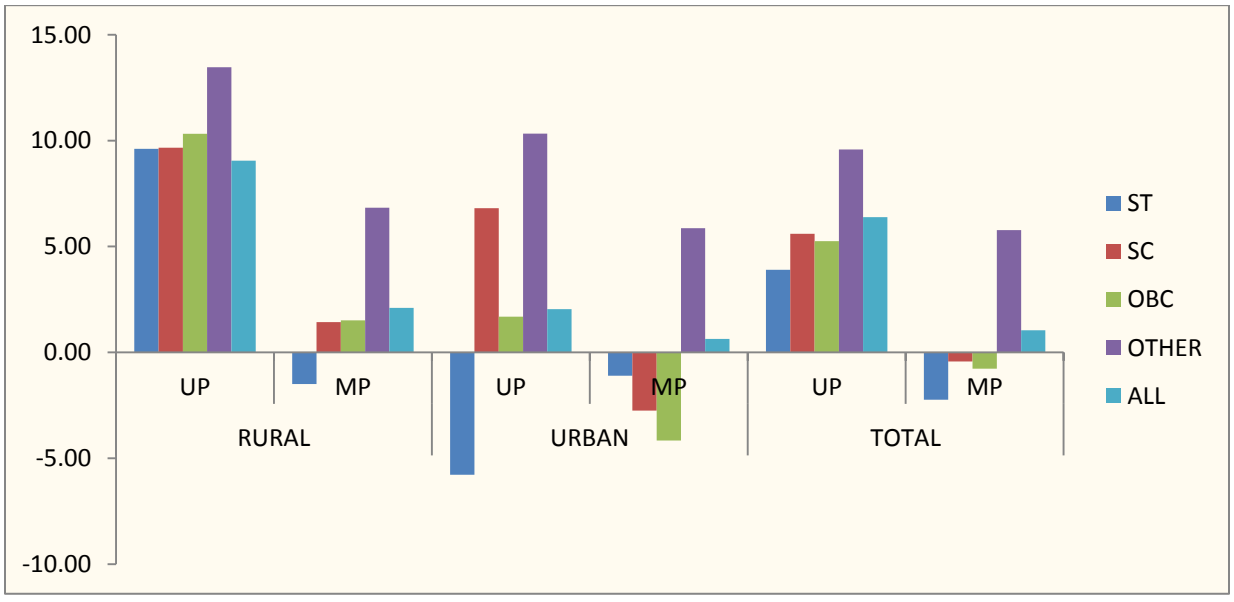
Source: Calculated from NSSO 55th and 68th round, Unit level data.

Table 1.4 Percentage of real MPCE on institutional and non-institutional health services

Percenatge of Real MPCE on institutional health services							Percenatge of Real MPCE on non-institutional health services					
1999-00												
	Uttar Pradesh			Madhya Pradesh			Uttar Pradesh			Madhya Pradesh		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
ST	0.67	0.52	0.71	1.16	0.61	0.97	5.99	2.67	4.96	3.49	11.55	4.59
SC	0.89	0.43	0.71	1.74	1.52	1.69	7.76	3.28	6.56	7.56	3.50	6.76
OBC	1.55	0.78	1.24	1.74	2.13	2.17	7.32	2.76	6.03	6.98	5.17	7.00
OTHER	1.77	0.78	1.60	3.78	1.82	3.14	10.42	4.31	8.87	6.40	5.78	7.25
ALL	1.33	0.78	1.24	2.03	1.82	2.17	8.20	3.62	7.09	6.10	5.62	6.52
2011-12												
	Uttar Pradesh			Madhya Pradesh			Uttar Pradesh			Madhya Pradesh		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
ST	1.38	0.3	1.11	0.65	0.42	0.58	4.43	7.2	4.99	9.07	5.94	8.51
SC	2.11	2.0	1.48	1.51	0.74	1.35	6.68	4.8	4.62	8.86	4.77	8.32
OBC	3.26	1.9	2.40	1.73	0.85	1.55	6.37	5.4	5.18	10.80	4.67	9.48
OTHER	4.50	2.6	4.99	6.26	2.44	5.03	4.97	3.8	6.28	9.50	6.89	10.64
ALL	3.19	2.3	2.77	1.94	1.38	1.93	6.08	4.5	5.18	9.72	5.51	9.28

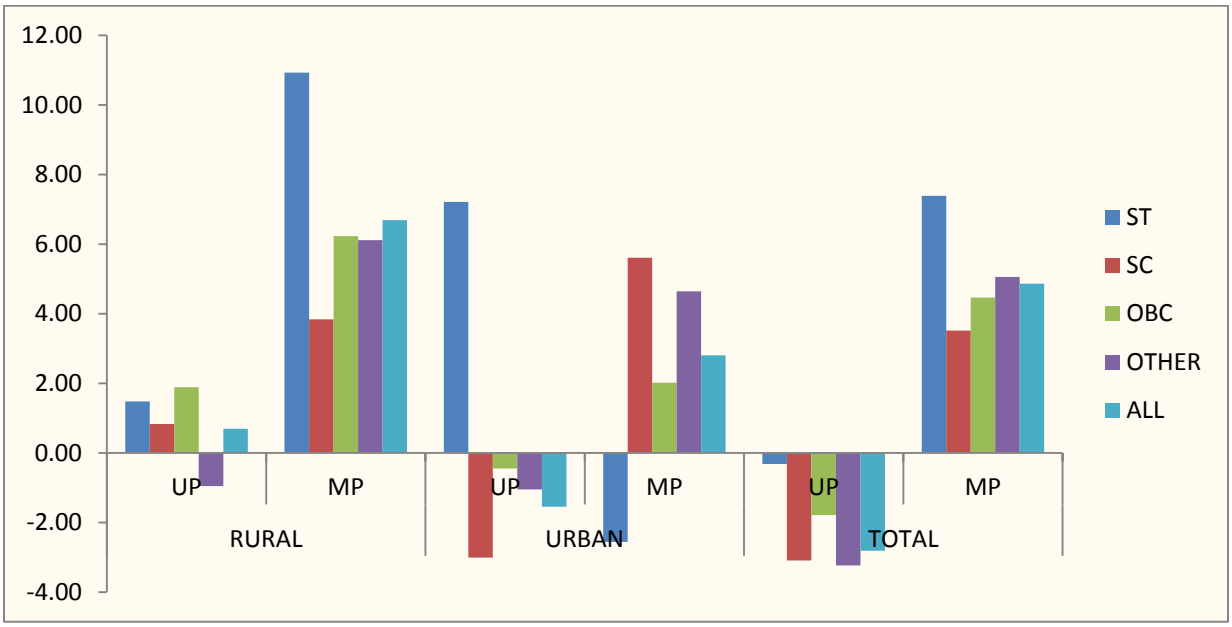
Source: Calculated from NSSO 55th and 68th round, unit level data

Figure 1.3a: Annual growth rate in monthly per capita **institutional health expenditure** (1999-00 and 2011-12).



Source: Calculated from NSSO 55th and 68th round, unit level data

Figure 1.3b: Annual growth rate in monthly per capita **non- institutional health expenditure** (1999-00 and 2011-12).



Source: Calculated from NSSO 55th and 68th round, unit level data

Concluding Remarks

As many economists have suggested that the education and health care services should be provided by states without any cost to all the citizens of the country. Form the above analysis it is clear that still the expenditure on educational services in UP and MP are high because education is free only up to elementary level (from class I to VIII). The cost of education beyond the elementary level is rising sharply and high cost of education discouraged household (especially marginalized social groups) to pursue education. Due to this, persons from deprived social groups are avoiding costly education and compelled to enter into labour force for surviving themselves and their family. The educational and economic backwardness of deprived social groups puts severe constraints on the household's ability to invest on educational services which generally opens better job opportunities for the households. High cost of educational services consumes larger part of household's budget and leaves less budget for expenditure on other basic needs.

The pattern of health expenditure (institutional and non-institutional) also clearly indicates that the monthly per capita health expenditure has increased across the social groups during 1999-00 and 2011-12. The rising costs of health services have aggravated the catastrophic out-of-pocket health expenditure. The monthly per capita non-institutional health expenditure is much more than institutional health expenditure across all the social groups. It is because, the institutional health expenditures are more costly than non-institutional health services and to a lesser extent; it is covered by some government supported health insurance schemes. But, the rapidly rising non-institutional health expenditure puts more financial burden on the households and consumes a bigger part of the household's budget. The high cost of health services (both institutional and non-

institutional) are affecting every sections of the economy but the deprived social groups are being affected more severely by high cost of health services. The malfunctioning public health care system and lack of financial protection against any health shocks have accelerated the vulnerability of marginalized sections of economy in both states. The high cost of health services, which is reflected through catastrophic out-of-pocket health expenditure, is also responsible for high incidence of poverty and indebtedness of deprived social groups in both states. Because the poor persons finance their health expenditure by past saving, selling productive assets, borrowing from relatives and moneylenders at high rate of interest and most of the poor do not settle their debt which push them into debt trap and vicious cycle of poverty.

Policy Implication

The cost of educational services should be checked by government and the government should make education free up to higher secondary level and also technical and skill formation curriculum should be included in syllabus. The quality aspect of educational services of public supported institutions and schools should be enlarged by strong monitoring on absentee teachers and maintaining good teacher-student ratio. The high out-of-pocket health expenditure can be reduced by (1) raising the public investment in creating a vibrant and well-functioning public health care sector which provide equal health services to all section of society that is universalizing health care system, (2) universalizing formal and publicly financed health insurance coverage and (3) controlling drugs prices and ensuring greater availability of drugs at public health care centre (institutions). These policy measures will help in both raising status of human development and breaking vicious cycle of poverty and debt trap of marginalized social groups.

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