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Health Expenditure Pattern among Migrant Slum Dwellers in Ludhiana (Punjab), India

Paramita Sengupta[1], Dharmesh Lal[2]
[1]Professor in Community Medicine, Christian Medical College, Ludhiana, Punjab India
[2]Senior Programme Manager, PHFI, Gurgaon, Haryana India

***Corresponding author**
Dr. Paramita Sengupta

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Abstract: Over 30 percent of Indians live in urban areas, and the proportion is projected to grow to 40 percent, or about 590 million people, by 2030. In Punjab, 73 out of 143 towns have reported slums. Ludhiana, Punjab's most populated and rapidly growing metropolitan city had a population of 1,618,879, approximately, 15 per cent of which lived in slums. In India the out of pocket (OOP) health expenditure has been estimated as high as 89.2% pushing 40 million into poverty each year. This study will help the policy makers and health managers to come out with the mix of strategies like universalizing the health insurance and to conduct further operational research to gear up the health system as well to reduce the OOP. Health insurance was available to only 6.41% of the respondents while 60 % of the respondents are meeting their treatment needs from their own savings and 22% are borrowing to meet the expenditures. Overt reliance on private health care has to be regulated, to reduce OOP expenditure amongst the migrants. Effective universal health insurance can help in preventing the migrants in falling into the medical poverty trap.
Keywords: Migrants, OOP expenditure, Universal health Insurance, Urban slums.

INTRODUCTION

Over 30 percent of Indians live in urban areas, and the proportion is projected to grow to 40 percent, or about 590 million people, by 2030 [1]. As per Census 2011, as many as 2613 towns of India have reported the presence of about 33510 slums of which 13761 were notified and 19749 were non- notified[2].

In Punjab, 73 out of 143 towns have reported slums, with a total slum population being to the tune of 14, 60,518, while Ludhiana, Punjab's most populated and rapidly growing metropolitan city had a population of 1,618,879, approximately, 15 per cent of which lived in slums in a total of 91 slum settlements in Ludhiana, 50 of which were "notified" slums (population of 198,895 in 41,101 households) and 41 "non-notified" (population of 59,223 in 12,953 households). The total slum population in Ludhiana was 258,118 in 54,054 households [3].

Non-notified slums have been less likely to receive support from government schemes aimed at reducing urban disparities. Ill-health reduces the income earning potential and increases expenditure on medication, thereby causing asset depletion, increasing debt and worsening poverty. The government of India spends significantly less on health than other countries in the region, and the budget allocation for urban health is especially low.

In India the out of pocket (OOP) health expenditure has been estimated as high as 89.2% [4] which is big barrier in the way of India's quest to achieve Universal Health Coverage (UHC) [5,6]. As a result of high OOP payments, 40 million Indians are pushed into poverty each year. Every year major chunk of OOP (70%) is spent on medicines alone, driving approximately 3.5%-6.2% of India's population below the poverty line (BPL)[7,8] So the challenge in India is to reduce the OOP with applications of mix of strategies through change in public health planning as advocated in National Health Policy 2017 also. Accessibility and affordability of the health services become extremely difficult especially for the poor and marginalized who are in maximum need of such services [9,10].

Literature on health expenditure pattern among the poor migrant population in Indian context is extremely scarce affecting the focused need based health services to (these populations) achieve the UHC.

This study is part of a national task force project entitled "Migration, poverty and access to healthcare: a study on people's access and health system's responsiveness in fast growing smaller cities", and aimed to study the sources of health expenditures incurred for meeting the treatment needs, and to formulate the recommendations for reducing the out of pocket expenditure among the migrants of Ludhiana. This study will help the policy makers and health managers to come out with the mix of strategies like universalizing the health insurance and to conduct further operational research to gear up the health system as well to reduce the OOP.

The analysis included 3,947 respondents of whom 2,575 (72.5%) were males. Mean age of respondents was 28.5 years (non- notified slums) to 27.15 years (notified slums). Most (76.21%) of respondents were residents of non-notified slums. The mean monthly income was more in the migrants staying in the notified slums. (Table deleted).

Maximum respondents had expenditure in the range of Rs 501- 1000, while only 4 respondents were not incurring any expenditure. Health insurance was available to only 6.41% of the respondents. Almost 60 % of the respondents were meeting their treatment needs from their own savings and 22% were borrowing to meet the expenditures. Approximately 8% of the respondents were insulated from OOP due to having health insurance (6.41%) and 1.10% getting the services free of cost.

Table-1: Details of expenditure on illness of the participants (for illnesses without hospitalisation) n=359

Variable	Total
Total number of households surveyed	3947
Total number of family members in these households	14,603
Number of family members hospitalised over the past one year	82
Number of participants hospitalised over the past one year	23
Number of family members suffered from any illness over the past 6 months	648
No. of participants reported illness over the past 6 months	359
No. of participants reported spending of money for treatment	355
Distribution of participants based on the amount they spent during a recent episode (self)	
No expenditure	4
Rs. 1-200	50
Rs. 201-400	25
Rs. 501-1000	107
Rs.1001-1500	26
Rs. 1501-2000	33
Rs. 2001-2500	18
Rs. 2501-3000	24
Above Rs. 3000	72
Distribution of participants based on the way they arranged money for treatment (self)	
From own income	3 (0.81 %)
From savings	214 (59.6%)
From Health insurance	23 (6.41%)
Sold items like furniture and jewellery	19 (5.30%)
Contributed by relatives/friends	17 (4.71%)
Borrowed	79 (22.0%)
Services are free of cost	4 (1.10%)

This study shows that private health care is most commonly sought by the migrants of Ludhiana, which leads to massive out of the pocket expenditures. Only 1.10 % who availed free government care was insulated from OOP shock. Although healthcare expenditure constitutes almost 5% of gross domestic product (GDP), contribution of Government is only 0.9% of GDP [11]. In 2004–05, OOP payments in India accounted for approximately two thirds of total health expenditure and less than 10% of households had health insurance for at least one member [12]. Sengupta *et al.* found that newer migrant households lacked voter cards and rations cards, presence of which would have increased their access to a range of benefits [3].

CONCLUSION

The overt reliance on private health care has to be regulated, to reduce OOP expenditure amongst the migrants. The goal of universal health coverage is to ensure that all people obtain the health services they need without risk of financial ruin or impoverishment.[13] Effective universal health insurance can go a long way in reducing the OOP with availability of free medicines and diagnostics in the public health facilities. Health

financing also can help in preventing the migrants in falling into the medical poverty trap.

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