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DISTRESSED HEALTHCARE FINANCING AMONG MIGRANT LABOURERS IN URBAN BENGALURU

Community Medicine

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ABSTRACT

Distressed healthcare financing (DHF) is defined as the out of pocket (OOP) healthcare payment financed through borrowings or sale of household assets.

Aim: To assess the mode of payment and its effect on the finances and healthcare seeking behavior among migrant labourers.

Methodology: A cross sectional study was conducted among 150 migrant labourers in urban Bengaluru, Karnataka; through an interviewer-administered questionnaire. Data was analyzed using SPSS version 23.0. Chi square test was used for associations.

Results: All the labourers paid for the excessive medical bills from savings (25%), borrowings (95%), selling jewellery (93%) and borrowing from relatives (7%). 82% of the participants were BPL card holders. The effect of DHF on buying of medicines was that 80% of the labourers either bought half the prescribed medicines or none at all.

Conclusion: Healthcare expenses are a huge burden on the migrant labourers of Bengaluru. There is a need for increasing awareness on the government healthcare financing schemes for BPL cardholders.

KEYWORDS

Distressed healthcare financing, labourers, out of pocket payments

INTRODUCTION:

The theme of World Health Day 2018 was "Universal health coverage: everyone, everywhere".[1] The concept of Universal Health Coverage arose out of a global concern for high levels of out of pocket expenditure for healthcare in many low and middle-income countries.[2] Universal health coverage means that all the people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[3] The way health systems are financed is a critical determinant for reaching universal coverage since they determine whether health services exist and are available and whether people can afford to use health services when they need them.[4] Health financing helps us to advance towards universal health coverage.[5] The four most frequently used modes of healthcare financing are Beveridge model, Bismark model, out of pocket payment[6] and National insurance model.[7] Out-of-pocket (OOP) healthcare payments financed through borrowings or sale of household assets are referred to as distressed healthcare financing.[8] Various countries finance their healthcare by OOP payment model. Namely, Burkina Faso, Chad, the Congo, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mali, Mauritania, Namibia, Senegal, Swaziland, Zambia and Zimbabwe[9], Myanmar, India and Nigeria.[10] A study by Duggal R et al. reveals that it is only in countries like India and a number of developing countries, which still rely mostly on OOP payments that the universal access to healthcare is elusive.[11] A study by Binnendijk E et al. among 5383 low income households in Orissa, examined health-related financing hardship in order to get a better insight on how poor households finance their OOP healthcare costs. The study found that poor households are subjected to financial hardship due to the indirect and longer-term OOP healthcare costs.[12] Despite substantial improvements in some health indicators in the past decade, India contributes disproportionately to the global burden of disease, as compared to other middle-income countries and India's regional neighbours.[13] The high dependence on OOP payments results in the households lacking financial protection, making them susceptible to impoverishment and catastrophic health expenditure.[14]

There is a scarcity of studies regarding distressed healthcare financing in India, especially on migrant labourers. The focus of this study is on the migrant labourers from neighborhood states who have settled in Bengaluru. A household member whose last usual place of residence (UPR) was different from the present place of enumeration was considered as a migrant member in a household. In this survey, usual place of residence (UPR) of a person was defined as a place (village/town) where the person had stayed continuously for a period of six months or more.

The study will seek answers on how the migrant labourers pay for their medical expenses and it also aims to assess the awareness of the participants on the government health insurance schemes, the healthcare financial burden they face and its effect on their health seeking behaviour.

Methodology:

A cross sectional survey was conducted among migrant labourers working in Bengaluru.

Migrant labourers more than 18 years of age who have consented to participate in the study were included in the study. A total of 150 labourers participated in the study. The estimated sample size was 113. The sample size was calculated by Single proportion-Absolute precision method. Expected proportion=0.25.[12] The duration of the study was 3 months from May to July 2018. It was a pretested interviewer administered questionnaire which consisted of items regarding: socio-demographic profile; medical and surgical history; mode of payment whether out of pocket/availing insurance policies; source of financing for out of pocket payment); awareness regarding the various government allowances for BPL card holders; awareness regarding the various government insurance policies, choice of system of healthcare due to financial burden. Ethical clearance was obtained from the Institutional Ethics Committee, Vydehi Institute of Medical Sciences and Research Centre, Bengaluru. Written informed consent was taken from the migrant labourers who met the inclusion criteria before interviewing them. They were interviewed at their site of work and in a language understood by them. The statistical analysis was done using SPSS version 23.0. Data is presented as tables and graphs and Chi-square test was done for associations, a p-value of less than 0.05 was considered as significant.

RESULTS:

This questionnaire based study included 150 migrant labourers >18 years of age from neighborhood states who have settled temporarily in Bengaluru. This study comprised of 71 males and 79 females. The labourers were from various occupations like-construction site workers (32%), vegetable/flower vendors (14%), carpenters (5%), housemaids (40%) and others-dyeing, painting industry workers (9%). Majority of the participants were illiterate (41%). Most of them belonged to nuclear families and 82% of the labourers were BPL card holders.

The labourers were enquired about the mode of payment It was seen that all the labourers adopted one or the other method of distressed financing. Most of them used more than one method. A multiple response analysis showed that borrowing with interest or without interest (95%) and sale of jewellery (93%) were the ones that were most practiced [Figure 1].

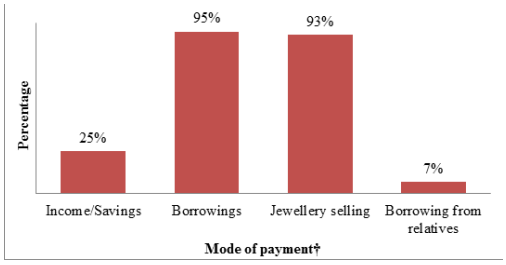

Figure 1: Source of money for out of pocket payment for healthcare among labourers

†multiple response analysis

The mode of payment and its relationship with education, occupation and family type was deduced.

The relationship between mode of payment and education showed that all the illiterate migrant labourers paid for their medical expenses mostly by borrowings with or without interest and sale of jewellery. Comparatively fewer illiterate labourers paid by borrowings from relatives or from their savings. None of the labourers belonging to the middle school category opted to pay by borrowing from relatives. All of the undergraduates paid by borrowings with/without interest and about 80% of them paid by sale of jewellery. None of them opted to pay by borrowing from relatives [Table 1].

Table 1: Association between mode of payment and education

Mode of Payment*		Income/ Savings	Borrowings	Sale of Jewellery	Borrowing from relatives
		Yes	Yes	Yes	Yes
		No. (%)	No. (%)	No. (%)	No. (%)
Education	Illiterate	14(23)	62(100)	60(97)	6(10)
	Primary school	7(24)	28(97)	28(97)	2(7)
	Middle school	3(30)	9(90)	8(80)	0(0)
	High school	7(26)	25(93)	27(100)	2(7)
	Higher Secondary	5(42)	9(75)	9(75)	1(8)
	Undergraduate	1(10)	10(100)	8(80)	0(0)
	p-value	0.652	0.006	0.006	0.985

**the above table contains numbers and percentages of the response 'yes' only*

The relationship between mode of payment and occupation showed that all the carpenter migrants paid by sale of jewellery and/or borrowings with/without interest. Compared to other occupations migrants of the others group had a higher percentage opting for payment by income/savings [Table 2].

Table 2: Association between mode of payment and occupation

Mode of Payment*		Income/ Savings	Borrowings	Sale of Jewellery	Borrowing from relatives
		Yes	Yes	Yes	Yes
		No. (%)	No. (%)	No. (%)	No. (%)
Occupation	Construction site worker	12(25)	47(98)	45(94)	5(10)
	Vegetable/flower Vendors	6(29)	20(95)	21(100)	2(10)
	Carpenter	2(29)	7(100)	7(100)	1(14)
	Housemaids	11(18)	57(95)	56(93)	3(5)
	Others	6(43)	12(86)	11(79)	0(0)
	p-value	0.366	0.376	0.206	0.494

**the above table contains numbers and percentages of the response 'yes' only*

The relationship between mode of payment and family type did not reveal any significant results.

All the labourers (100%) did not opt for any government schemes - namely Rashtriya Swasthya Bima Yojna.

With respect to choice of healthcare among the different migrant labourers-99% (148) opted for allopathy, 1% (2) homeopathy. Only 1% (2) of the individuals felt that homeopathy was better both financially as well as in terms of treatment. The effect of financial distressed healthcare financing among the migrant labourers was that 80% of the migrant labourers bought either half the prescription or did not buy any medicines and 20% of them bought all the prescribed medicines.

DISCUSSION:

Our study on distressed healthcare financing among 150 migrant labourers in urban Bengaluru revealed that all the migrant labourers paid for their medical expenses by any one of the OOP payment methods. It can be inferred that education, occupation and family type had no role to play when the labourers had to pay for their medical expenses. All of them opted for one or the other distressed modes of financing. Most of the labourers paid for their medical expenses by borrowings with or without interest. Second most opted choice was by sale of jewellery. Also a pattern was observed where people financed their expenses by sale of jewellery and/or by borrowings with or without interest. Some of them seemed to pay for their medical expenses from their savings or by borrowing from relatives. Under a self-financed healthcare system, the majority of the low income earners would either have a tendency to avoid using health facilities or under-spend in healthcare probably because they have to trade-off healthcare expenditures with other basic needs like food, shelter and schooling.[16] None of the labourers availed the advantages provided for the BPL cardholders (free surgeries and medications) or were aware of any government schemes for healthcare financing. This was a major concern seen in the study group as they had poor knowledge and negative attitude towards the government providing any help. One of the government scheme available is the Rashtriya Swasthya Bima Yojna (RSBY). Every BPL family holding a valid ration card may enroll to avail the insurance benefits as extended by the RSBY scheme.[17] Financial protection has been the mainstay of any government insurance scheme. For RSBY too, providing "cashless" hospitalization services and reducing catastrophic expenditure for hospitalization has been the most important objective. A systematic review on the impact of publicly financed health insurance schemes found that though utilization increased with coverage, there was no impact on reduction of OOP expenditure.[2] Also, none of them opted for any insurance policies to aid their healthcare financing. The labourers felt that it was a time consuming process and the premium itself was equal to the amount required for their day to day living. In a study done by Minal R. Patel et al. a similar observation was made that maintenance of insurance eligibility is a component of financial burden perceived by individuals and is consistent with findings from international settings. In addition, the stress of managing insurance premiums and the stress of uncovered expenses add on to the burden.[18] Almost all the migrant labourers opted for allopathy medicine for treatment and 1% of them opted for homeopathic medicine. Similar observation was made in the NSSO survey and it was found that there was a higher inclination towards allopathy treatment (around 90%) in both rural and urban areas. Only 5 to 7% usage of other type of treatment including AYUSH has been reported both in rural and urban areas.[19]

Health expenditures were a major financial burden for many persons in low and middle-income countries, where individuals often lack health insurance.[20] In our study also it entails a huge financial burden on the migrant labourers of Bengaluru. This burden seemed to reflect on their purchase of medicines as most of them either bought half the prescribed medicines or none at all and only a few of them bought all the medicines as prescribed. Similar observation was made in a study done by Selvaraj S et al which suggested that expenditure on medicines is a major cause of catastrophe and impoverishment at the household level. It also demonstrated that purchase of medicines was the single largest component of the total OOP payments by households, and the study also recommended that government intervention in providing medicines free of cost in public healthcare facilities would have the potential to considerably reduce medicine-related spending and total OOP payments of households and thereby a reduction in OOP-induced poverty.[21] A study by Singh T et al observed that healthcare expenditure places households under considerable financial strain in rural areas of Punjab in India. Improvements of public hospitals may increase their utilization and decrease the financial burden.[22] Since a relatively larger proportion of population seeks outpatient care in private facilities, which is often multiple times expensive than public health facilities, they observed a disproportionately higher burden of medicine-related OOP payment for outpatient care.[21] Fu W et al. in their 'research in health policy making in China' state that health expenditure financing

mechanism safeguards people's access to healthcare services, and the percentage of OOP payment is an important indicator of people's health financial burden and health financing equity in the population.[23] This makes it all the more important to address the financial needs of the people in terms of healthcare, as health is a basic right of human beings and is the basis of national development and prosperity.[23] A fact that we are concerned about is that the state health scheme-Karnataka Arogya Bhagya Scheme is not applicable for migrant labourers.

The limitations of the study were that it was conducted among a small population of migrant labourers. They may not be entirely representative of all the migrant labourers. Other labourers in general or other below poverty line groups were not included. Further research can be done with other marginalized groups with a larger sample size. A survey can also be conducted post awareness to understand the knowledge, attitude and practice of the participants towards the government schemes and insurance policies. The study demonstrated that healthcare expenses are a burden on the migrant labourers of Bengaluru. There is a need to include benefits for migrant labourers in the national and state health care schemes irrespective of the state to which they belong.

REFERENCES:

1) Campaign essentials for World Health Day 2018. Available from: http://www.who.int/campaigns/ world- health-day/2018/campaign-essentials/en/ [Last accessed on 2018 Aug 10].
2) Nandi S, Schneider H, Dixit P, Prinja S. Hospital utilization and out of pocket expenditure in public and private sectors under the universal government health insurance scheme in Chhattisgarh State, India: Lessons for universal health coverage. PLoS One. 2017; 12(11).
3) Universal health coverage and health financing. Available from: http://www.who.int/health_financing/universal_coverage_definition/en/ [Last accessed on 2018 Aug 10].
4) Health financing strategies for universal coverage. Available from: http://www. who.int/health_financing/strategy/en/ [Last accessed on 2018 Aug 10].
5) Health systems financing. Available from: http://www.who.int/healthsystems/ topics/financing/ en/ [Last accessed on 2018 Aug 10].
6) Dixon A. Funding and delivering healthcare. In: Guest C, Ricciari W, Kawachi I, Lang I, editors. Oxford Handbook of Public Health Practice. 3rd ed. United Kingdom: Oxford University Press; 2015. pp. 346-7.
7) Canada: The National Health Insurance System. Kjs5903. 2016 Jan 16. Available from https://sites.psu.edu/smithcivicblog/2016/01/16/canada-the-national-health-insurance-system/ [Last accessed on 2018 Aug 10].
8) Duggal R. Poverty & health: criticality of public financing. Indian J Med Res. 2007 Oct; 126(4):309-17.
9) Leive A, Xu K. Coping with out-of-pocket health payments: empirical evidence from 15 African countries. Available from: http://www.who.int/bulletin/volumes/86/1 1/07-049403/en/ [Last accessed on 2018 Aug 10].
10) Hamilton D. Health Care: Out-of-Pocket. 2009 Nov 4. Available from: https://fsutorch.com/2009/11/04/health-care-out-of-pocket/ [Last accessed on 2018 Aug 10].
11) Patel V, Parikh R, Nandraj S, Balasubramaniam P, Narayan K, Paul VK, et al. Assuring health coverage for all in India. Lancet. 2015 Dec 12; 386(10011):2422-35.
12) Binnendijk E, Koren R, Dror DM. Hardship financing of healthcare among rural poor in Orissa, India. BMC Health Serv Res. 2012 Jan; 12-23.
13) Joe W. Distressed financing of household out-of-pocket health care payments in India: incidence and correlates. Health Policy Plan. 2015 Jul; 728-41.
14) Silva AD, Ranasinghe T, Abeykoon P. Universal health coverage and the health Sustainable Development Goal: achievements and challenges for Sri Lanka. WHO South-east journal of public health. 2016; 5(2):82-88.
15) Household migration. Migration in India 2007-2008 NSS 64th ROUND (July 2007 – June 2008) National Sample Survey Office Ministry of Statistics & Programme Implementation Government of India June 2010. Available at URL: http://mospi.nic.in/sites/default/files/publication_reports/533_final.pdf [Last accessed on 2018 Aug 10].
16) Fonta W, Ichoku EH. The Distributional Impact of Healthcare Financing in Nigeria: A Case Study of Enugu State. PEP working paper serie. 2018 Jul 11. Available from: https://ssrn.com/abstract=3173203 or http://dx.doi.org/10.2139/ssrn.3173203 [Last accessed on 2018 Aug 10].
17) Sujatha. Rashtriya Swasthya Bima Yojana (RSBY). 2016 Aug 28. Available from: https:// www.mapsofindia.com/my-india/government/rashtriya-swasthya-bima-yojana-rsby [Last accessed on 2018 Aug 10].
18) Patel MR, Nelson BW, Deen EI, Caldwell CH. Beyond co-pays and out-of-pocket costs: perceptions of health-related financial burden in managing asthma among African American women. J Asthma. 2014 Dec; 51(10):1083–1088.
19) Singh M. 90% of Indians prefer allopathy over AYUSH. TNN. 2015 Jul 8. Available from: https://timesofindia.indiatimes.com/india/90-of-Indians-prefer -allopathy-over-AYUSH/articleshow/47981441.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst [Last accessed on 2018 Aug 10].
20) Pandey KR, Meltzer DO. Financial Burden and Impoverishment Due to Cardiovascular Medications in Low and Middle Income Countries: An Illustration from India. PLoS One. 2016 May 9; 11(5).
21) Selvaraj S, Farooqui HH, Karan A. Quantifying the financial burden of households' out-of-pocket payments on medicines in India: a repeated cross-sectional analysis of National Sample Survey data, 1994-2014. BMJ Open. 2018 May 31; 8(5).
22) Singh T, Bhatnagar N, Singh G, Kaur M, Kaur S, Thaware P, et al. Health-care utilization and expenditure patterns in the rural areas of Punjab, India. J Family Med Prim Care. 2018 Jan-Feb; 7(1):39-44.
23) Fu W, Zhao S, Zhang Y, Chai P, Goss J. Research in health policy making in China: out-of-pocket payments in Healthy China 2030. BMJ. 2018 Feb; 360: k234.