Research Article

Descriptive study of the need and gap in enrollment within the existing health insurance structure in slums of city Ahmedabad

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ABSTRACT

Background: The central and state governments have launched new medical insurance schemes, all with different features, to extend coverage to workers in the informal sector, particularly those who are poor. The primary objective all health-care schemes are to provide and improve the access of BPL families to quality medical and surgical care for the treatment of identified disease involving hospitalization, surgeries, and therapies through an empanelled network of health-care providers. **Objective:** To study the medical expenditure in slum population and to see the people perception, knowledge and willingness for different health insurance schemes. **Materials and Methods:** A cross-sectional study was conducted from September 2015 until September 2016. Interview in the form of semi-structured questionnaire was used. The questionnaire was pretested infield practice area of BJ Medical College, Ahmedabad, Gujarat, and was prepared in Gujarati. **Results:** Most of the families has an average income of Rs. 6000 to 10,000 with mean income of Rs. 8520 with average family size of 5.7.33.9% households has to suffer from catastrophic health expenditures, 53.6% households have no insurance or assurance cover. People want to participate in insurance schemes that are designed according to their need but want government platform for it. **Conclusion:** Health insurance alone is not a remedial measure. Demand for health has to be generated within communities, pooling of resources can be done and let the people manage their own health need according to their priority.

KEYWORDS: Health Insurance; Health Expenditure; Urban Slums; Health Care Schemes

INTRODUCTION

"Health for all," the declaration of Alma-Ata, signed by nearly all member states of the World Health Organization and UNICEF was to occur by the year 2000, some of its words "the existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries…." The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.[1]

About 40% of household NCD treatment expenditure are financed by household borrowing and sales of assets, and 45% of spending is on medicines.[2] The studies also show that hospitalization is a huge burden when it comes to annual income levels of individuals, and a single hospital stay can eat up to 40-50% of the per capita annual income in a public health-care facility and about 80-90% in a private health-care facility.[3] Similar fact is also highlighted in the report health and growth about people across the world selling productive assets and being forced into long-term poverty due to health-care costs.[4]

Thus, creating huge challenge to government in financing health care, the challenge lies in the ability to create accessible and affordable health-care system that have scale

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(reach), permanence (multigenerational), and are supported by sustainable financing mechanisms. WHO has also cited that users need to be given financial protection against the cost of seeking care.[4]

If we went back in history in India in 1912, health insurance was introduced when the first insurance act was passed in 1948 the central government introduced the employees state insurance scheme for blue-collar workers employed in the private sector, and in 1954, the central government health scheme for central government employees and for their families and thus followed by many state government accordingly for their employees. So organized sector was always has some cushion of protection from out of pocket health expenditures but for non-organized sector and for poorest among poor the concept of universal health coverage (UHC) that was envisaged in 12-year plan still appear to be a distant dream. Furthermore, there is huge inequity in the utilization of funds and delivery of health-care system. For instance, funds favor the better-off states and urban people and the delivery of health-care systems favors the organized sector workers, neglecting the ones in the unorganized sector.[5]

Since 2003, the central and some governments have launched new medical insurance schemes, all with different features, to extend coverage to workers in the informal sector, particularly those who are poor. The largest is central government's Rashtriya Swasthya Bima Yojana (RSBY) launched in 2008 and specific to state are Yeshasvini scheme in Karnataka launched in 2003, Kudumbashree in Kerala launched in 2006, and Arogyasri in AP in 2007.[6-9] In Gujarat, Mukhyamantri Amrutum (MA) Yojana has been launched and its primary objective is to provide and improve the access of BPL families to quality medical and surgical care for the treatment of identified disease involving hospitalization, surgeries, and therapies through an empanelled network of health-care providers.[10]

Insurance Regulatory Development Authority Act 2000 has provided bigger opportunities for public as well as private industry for better utilization of health-care facilities. Despite this, there has not been much progress in the coverage of our population within the health insurance system; only around 3% coverage has been reported.[11] With this background information, this study was conducted to study the medical expenditure in slum population and to see the people perception, knowledge and willingness for different health insurance schemes.

MATERIALS AND METHODS

A cross-sectional study was conducted from September 2015 until September 2016. Interview in the form of semi-structured questionnaire was used. Questionnaire was pretested infield practice area of BJ Medical College, Ahmedabad, Gujarat, and was prepared in Gujarati. Study protocol was approved by Institutional Ethics Committee.

Selection of the study site was according to zone wise distribution of city Ahmedabad and ward was selected with the help of local informer or concerned UHC MO of houses comprising poorest among poor. This study has included the family with permanent settlement, residing more than 5 years in the study area. One house or family was considered as one study unit.

Sample size was calculated using n master 2.0 software based on proportion, with a precision of 5% and desired confidence interval taken as 95% and test applied was confidence interval estimating single proportion. Sample size calculated was 369. 369 families were divided into six regions of Ahmedabad city. Slum was listed in each region and from randomly selected slums families were covered from each region. First, family in each slum was selected randomly and the study was done until completed. To minimize the recall bias only the major expenditure in health hospitalized or nonhospitalized during the last 1 year was asked.

RESULTS

Average income of household per month was minimum of Rs. 1000 to maximum of Rs. 37200 with a mean of 8520 and SD of 4764.358, average family size was 5.7 and expenditure on health on 1 year recall basis has average expenditure per month is Rs. 100 to Rs. 300 (Table 1). 33.9 % of household has to borrow money for treatment or has catastrophic health expenditure which was calculated according to WHO proposal when it is > or= 40% of capacity to pay.[12] Noncommunicable disease was a major contributor of morbidity that was 30.3% in comparison to communicable disease which was 20.3%. Correlation analysis done shows a positive correlation when socioeconomic class was compared with health expenditure (Table 2) as we move from SE Class 1 to 5 people are earning less and at the same time are also having more expenditure on health probably due to increase in various risk factors. Expenditure on education is also showing positive correlation but it is not a very strong one, probably education of children is compromised due to expenditure on health issues.

So to protect the vulnerable population from health expenditure government, private and some NGO'S has launched certain schemes like RSBY. BH (BPL health card), MA Yojana a health Assurance schemes and SEWA a women help group, but the penetration is really poor. 58.0% of household has no insurance or assurance cover, 33% of household do not even know about insurance but after persuasion almost 68% of households willingly opt to contribute if government want to launch some scheme such as Community based health insurance. 82% of household has no idea that who make

this health card and where it is made most of them were dependent on enrollment drive from government authorities. Almost 90% of households in possession of RSBY card was not updated, they were not aware that it is supposed to be renewed every year. 63% of respondents told that they knew about MA card when some of their relative got admitted in hospital (Table 3).

Almost 90% of beneficiaries responded with positive feedback when question was asked regarding use of health card in hospital.

DISCUSSION

The majority of families belongs to socioeconomic Class 3 and 4 according to Park classification,[13] with mean income per family is 8520 and most of them are daily wages workers or skilled workers like auto rickshaw driver or painter for household, a minor ailment like fever for 2 days can severely disturb the financial system of household, 79% of slum dwellers in Surat city lost their daily wages when sick.[14]

Table 1: Correlation between average monthly household income and health expenditure

Correlation	Average monthly household income	Health expenditure
Average monthly household income		
Pearson correlation	1	−0.219**
Significant (two-tailed)		0.000
n	369	369
Health expenditure		
Pearson correlation	−0.219**	1
Significant (two-tailed)	0.000	
n	369	369

**Correlation is significant at the 0.01 level (two-tailed)

Table 2: Correlation between socioeconomic class and health expenditure

Correlation	Socioeconomic class	Health expenditure
Socioeconomic class		
Pearson correlation	1	−0.172**
Significant (two-tailed)		0.001
n	369	369
Health expenditure		
Pearson correlation	−0.172**	1
Significant (two-tailed)	0.001	
n	369	369

**Correlation is significant at the 0.01 level (two-tailed)

Which is than compromised by less purchase of food item leading to under nutrition or education as only three households had family member graduate and huge number of families with school dropout from Class 6,7, and onward. People have borrowed money from neighbors, relatives, friends to pay the catastrophic health expenditure, selling of asset like jewelries was not encountered. Among the studied population proportion of people with enrollment and awareness is poor. In Gujarat as on date 31:03:16, total target families enrolled under RSBY:4396654, enrolled families 1876628, hospitals empanelled; 1,566 (private;1083, public 483) in Ahmedabad as on date 30:06:2016 total target families 412563, enrolled families 112320 number of hospitalization 1835 hospital empanelled 104.[15]

There was no strategy by enrollment agencies to enroll potential beneficiaries. Most of the households studied are daily wage workers and it was not affordable to miss daily work or wages. Social exclusion for enrollment was not studied in this study, but one area predominantly of tribal population showed very poor enrollment.[16]

There is poor understanding of empanelled hospitals and card has to be renewed every year is not properly translated across the household, so hence will defeat the very purpose of protecting families in need of hour.

Even in slums people are bothered by problems of infertility and skin disease which is also a very costly affair, as medicines and treatment intervention are very costly. Hence, schemes that cover OPD and medicines charges are much in demand. Hence, there is always some scope for schemes which are molded according to the need of slum dwellers and can action like some successful model running in India[17] or formation of Mahila Arogya Samitis as envisaged in draft of NUHM.[18] In spite of card possession, its non-utilization rate is very high as people do not know when to use it and people are also bothered by various other morbid condition in day to day life, which is taking a major chunk of daily earning of semiskilled and laborers. Although the development in our country during

Table 3: Inclusion in health care schemes

Religion	Insurance (assurance) schemes *n* (%)						
	RSBY	MA	LIC	BH	Other*	Not insured	Total
Hindu	18 (6.7)	16 (6.0)	4 (1.5)	32 (12.0)	54 (20.2)	143 (53.6)	267 (100.0)
Muslim	11 (10.8)	3 (2.9)	0 (0)	4 (3.9)	31 (30.4)	71 (69.6)	102 (100.0)
Total	29 (7.9)	19 (5.1)	4 (1.1)	36 (9.8)	85 (23.0)	214 (58.0)	369 (100.0)

*Other insurance schemes such as ESIS, CGHS, ICICI and RELIANCE, etc., RSBY: Rashtriya Swasthya Bima Yojana

the last decade look impressive, it is quite uneven especially among the poorest of poor and in other vulnerable section of society. The aim was to provide a sustainable comprehensive and holistic framework for development through eradication of poverty and deprivation, improvement of economics, protection of health and environment and promotion of good governance and peace in all communities and countries around the world.

CONCLUSION

The living condition, poor sanitation measures, and substance abuse all provide a congenial environment for disease promotion in slum dwellers. Preventive measures if taken can reduce certain disease condition to minimum level and thus help people to protect their hard earned money. Health insurance alone is not a remedial measure. Demand for health has to be generated within communities, pooling of resources can be done and let the people manage their own health need according to their priority.

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