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POVERTY, INSURANCE AND AVERAGE EXPENDITURE ON HEALTHCARE IN PUNJAB, NORTHERN STATE OF INDIA

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Abstract
Health insurance is the inadequate source of financing for individuals or households to improving health care utilization, decreasing health care expenditure and reducing the poverty.
The objective is to access the coverage of health insurance schemes among wealth quintiles of households in Punjab, Northern state of India.
The data is extracted from the unit level records of the 71st round of National Sample survey office (NSSO, 2014) for this study. A stratified two-stage sampling design was adopted during the study. For analysis purposes, data is extracted for Punjab state of north and whole states of India. Study covered the individuals who enrolled in any health schemes, monthly household consumption expenditure and Out of Pocket (OOP) expenditure incurred on pre-post natal care, delivery ailment, illness in 15 days and hospitalization in 365 days. Total 65932 households and 3,33,104 individuals covered for all states where 1529 households and 7797 individuals covered in Punjab. Chi-square test for trend used to find the significance of wealth quintile among insured households. The result reveals that only 15.1% population are covered by any health insurance schemes in India where Punjab (5.8%) reported enrolment respectively. Urban showed more enrolment in any health insurance in all states than rural area in Punjab. Richest quintile showed more enrolment in insurance and incurred excess of expenditure on health care expenditure. Since very less population are covered by health insurance schemes and much of expenditure incurred on health care. Study concluded that reducing high health care expenditure and poverty among households, government should maximize the coverage of health schemes in among all states of India.
Keywords: Health care expenditure, Insurance scheme, MPCE expenditure, Out of pocket expenditure (OOP), and Poverty

Introduction

According to the World Bank (2014), some 1.2 billion people worldwide were living in extreme poverty (defined as less than USD 1.25 per day) in 2010 and approximately twice as many were living on less than USD 2 per day, the average poverty line for developing countries [1]. Many of the world's 1.3 billion poor still do not have access to effective and affordable drugs, surgeries, and other interventions because of weaknesses in the financing and delivery of health care[2]. The World Health Organization (WHO) estimates that about 150 million people suffer financial catastrophe every year as a result of using and paying for health services, while another 100 million are pushed below the poverty line. In some countries, up to 11 per cent of the population can experience severe financial hardship every year and up to 5 per cent can be forced into poverty as a result of catastrophic health expenditure [3].Health systems in India or low-and middle-income countries (LMICs) are funded mainly through out-of-pocket (OOP) payments [4-7]. OOP payments are one of the most inequitable forms of health financing [8]; they act as a barrier to access, contribute

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towards household poverty, generate little revenue (less than 5% of total health care budget), and promote perverse incentives, bureaucracy and corruption [9-11]. In India, individuals and families on low incomes face significant barriers to accessing quality healthcare. Public health facilities suffer from poor management, low service quality, and weak finances. On the other hand, private health facilities are expensive, so that households typically have to borrow or sell assets to meet hospitalisation costs. Financial burden due to health care cost is continuing as a major issue all over the world. In this context, reducing 'out-of-pocket expenditure' through health insurance coverage is a major concern. So health insurance is emerging as an alternative of reducing the financial burden of the people. To offer financial protection against catastrophic health shocks to the poor, various government-sponsored health insurance schemes have been implemented in India since 2003. Various studies examine effect of Out-Of-Pocket (OOP) health expenditure on poverty to seen whether such expenditure push households deeper into poverty. Adversities related to out-of-pocket spending are apparent in the form of intensified poverty and ill fare in the country. In 1995-96 an estimated 2.2% of the Indian population fell into poverty because of out-of-pocket spending (Peters et al 2002) and it increased to around 3.2% in 1999-2000 [8]. A significant proportion of population may had to sold out their assets for hospitalization [12,13] and forgo treatment all together due to scarcity financial resources (NSSO, 60th Round, 2004). The overall expenditure on health in India is 4.1% of GDP [14] in which the government contribution is only 1% and 58 % still financed through OOP in 2012[15]

Today, India has most privatized health system in the world with 72% of health expenditure made in private sector that presently treats 78% of outpatients and 60% of inpatients [16]. Indian government has introduced many health insurance schemes for rural people during past years with affordable prices so that they can be covered by insurance without much burden on them. Insuring people can also leads to a better health access. Along with the government policies, several non-government organizations (NGO) also introduce many schemes for the people living below the poverty line [17]. Indian health system is mainly funded by out-of-pocket payments. It is estimated that more than 80% of population spend in health services from their personal expenses [18]. The components of the current health insurance are Employer mandated SHI (Social Health Insurance), Commercial /Voluntary health insurance and target oriented GFHI (Government Funded Health Insurance). A host of Health insurance schemes galore: ESIS (Employee State Insurance Scheme,1952), CGHS (Central Government Health Scheme,1954), Commercial health insurance provided by public and private owned companies, Yashasvini Cooperative farmers (2003, Karnataka) Rajiv Arogyashri Community Health Insurance (2007,AP), RSBY (Rashtriya Swasthya Bima Yojana, 2008), HP-RSBY plus (2010), VAS (Vajapayee Arogyasri Scheme, 2009, Karnataka), Rajasthan Bhamashah Swasthaya Bima Yojana, Apka Swasthya Bima Yojna (Delhi), CMK (Chief Minister Kalaigner, 2009,TN).

In 2005, National Rural Health Scheme (NRHM) was launched, and most recently the National Health Mission (NHM) launched in May 2013 to cover urban population and non-communicable diseases (NCDs), several initiatives implemented to cover women and children: Janani Suraksha Yojana (JSY) to reduce maternal mortality among pregnant women; Janani Shishu Suraksha Karyakarm (JSSK) to provide free to and fro transport, free drugs, free diagnostic, free blood, free diet to pregnant women who come for delivery in public health institutions and sick infants upto one year; Rashtriya Bal Swasthya Karyakram (RBSK) to screen diseases specific to childhood, developmental delays, disabilities, birth defects and deficiencies.

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The percentage share of consumer expenditure towards medical care has increased from 5.7 per cent to 6.9 per cent in the rural areas and from 5 per cent to 5.5 per cent in the urban areas between 2009–10 and 2011–12 (MoSPI 2013).Even though the per capita expenditure on medical care is higher in urban areas at Rs 146 as compared to Rs 95 in the rural areas, the burden on rural households is higher. Recent years, other states health insurance schemes initiated such as Sidda Sarkarada Nade Sevegala Kade Scheme for Schools (Karnataka), Free Treatment Scheme for Road Accident Victims (Delhi), Aawaz Health Insurance Scheme Launched (Kerala), Bhagat Puran Singh Sehat Bima Yojana (Punjab), Mukhyamantri Swasthya Suraksha Yojana (Chhattisgarh),Senior Citizen Health Insurance Scheme (Himachal Pradesh), Karunya Health Scheme (Kerala), Arogya Raksha Health Scheme in (AP), Mukhyamantri & Samajwadi Swastha Bima Yojana Health (Uttar Pradesh)[19].

Data And Methodology

Aim:To access the coverage of health insurance schemes among wealth quintiles of households in Punjab northern state of India.

Study design

Current study was based on secondary data analysis of a nationwide survey data collected by the National Sample Survey Organisation (NSSO), India.

Data source

The source of data was the representative nationwide survey data collected by the National Sample Survey Organization (NSSO) in its 71st round (2014) on 'Health' and 'Education'. NSSO is a national organisation under the Ministry of Statistics In India. The data was collected in all states of India from January 2014 to June 2014.

Methodology

A stratified two-stage sampling design was adopted during the study. First stage sampling, census villages in the rural areas and urban frame survey blocks in the urban sector selected followed by second stage sampling of households. Survey covered total of 4577 villages and 3720 urban blocks were surveyed from which 36,480 and 29,452 households were sampled in rural and urban areas respectively. Survey covered 65,932 households and 333,104 persons were interviewed all over 36 states of India

Data Analysis

Data was analysed using SPSS version 21.0 for analysis (SPSS Inc. SPSS Statistics for Windows, Version 21.0. Chicago).The study population was divided into quintile groups based on monthly per capita consumption expenditure (MPCE). Wealth quintiles is calculated for all households, arranged in an ascending order as per their monthly per capita consumption expenditures, was further divided into five equal parts. This segregated the households into five groups, ranging from the bottom 20% of the sample with lowest consumption expenditure, to the top 20% households of the sample with highest consumption expenditure. Average values and proportion for pre natal, post natal care, delivery ailments, illness in 15 days and hospitalization in 365 days were compared across each of the five MPCE quintiles. Chi-square test for trend was used to test linear trends across quintiles.

Result

Household and individuals covered

Study covered 36 states and union territories of India. Study covered household and individuals in all states of India were 65932 households and 3,3,104 where study covered where in Punjab1529 households and 7797 individuals covered in 2014.

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Monthly average consumption expenditure (Rs.):
Delhi (Rs.17,538), Chandigarh (Rs.16,102), Punjab (Rs.12,228), Haryana (Rs.11,620) reported maximum monthly average consumption expenditure where as Bihar (Rs. 6647), Chhattisgarh (Rs.6488), Arunachal Pradesh (Rs.6319) and Odisha (Rs.5631) reported minimum average consumption monthly expenditure and remaining states showed average expenditure between Rs. 11,380 and Rs.6942 respectively.

Monthly per capita expenditure (Rs.):
Delhi (Rs.4207), Chandigarh (Rs.3903), Kerala (Rs.2798), Punjab (Rs.2642), Puducherry (Rs.2579) reported maximum monthly per capita consumption expenditure where as Manipur (Rs.1462), Jharkhand (Rs.1440), Chhattisgarh (Rs.1307), Odisha (Rs.1307) and Bihar (Rs. 1290) reported minimum per capita monthly expenditure and remaining states showed average expenditure between Rs.1479 and Rs.2578 respectively (Fig.1).

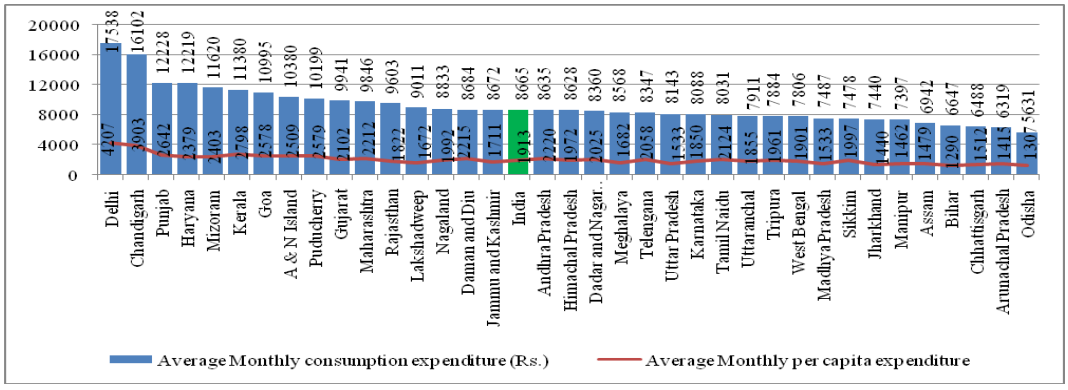

Figure 1: Average Monthly consumption expenditure and Monthly per capita expenditure in states of India-NSSO,2014

Average medical insurance premium:
Average premium was reported Rs.4621 for all over study. Sikkim report Rs. 504 minimum insurance premium where as Maharashtra Rs.9963 report maximum average premium (Fig.2). Majority of states have five households size where Lakshadweep report maximum seven household size in study (Fig.2)

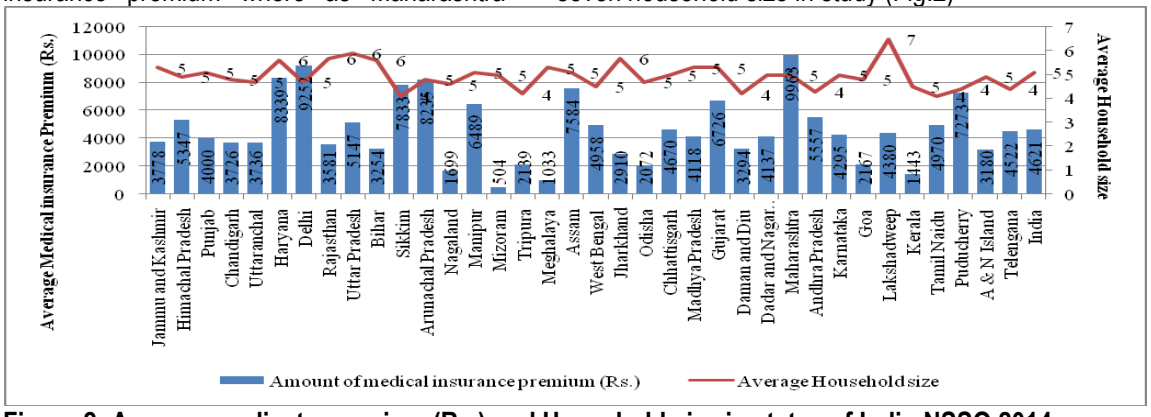

Figure 2: Average medicate premium (Rs.) and Household size in states of India-NSSO,2014

Coverage of Insurance in Punjab and India:

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Result revealed that 15.1 % population is covered by any health insurance in all states of India where in 5.8% population were covered in Punjab state. Rural (8.2%) population is covered more as compared to urban (3.6%) in Punjab where urban (17.3%) population covered more as compared to rural (13.4%) in all states. Males (5.9%) showed more enrolment as females (5.8%) in Punjab where females (15.2%) showed more enrolment in all states as compared to males (15%). More enrolment were reported for more age persons in Punjab and all states of India (Table 1). Postgraduate and above education showed more enrolment in insurance in Punjab (14.4%) and India (23.6%). Hind (7%) and Sikhism (5.4%) households showed more enrolment in insurance in Punjab where as Hindu (15.1%), Christianity (31.7%) and other (Jainism, Buddhism/ Zoroastrianism& Other) showed 46.9% enrolment in all states of India. Highest end of income that is richest quintile showed more enrolment of insurance in Punjab and all states of India (Table 1)

Table 1: Insurance coverage among household in Punjab and India: A study of NSSO-2014

		Punjab	India
Insurance	Overall Insured	5.8	15.1
Area	Urban	3.6	17.3
	Rural	8.2	13.4
Gender	Male	5.9	15.0
	Female	5.6	15.2
Age	0-4	4.1	10.1
	5-15	5.4	13.1
	15-29	5.0	14.7
	30-44	6.8	16.5
	45-59	6.8	19.2
	60-69	8.4	18.2
	70 and above	5.0	17.1
Education of individuals	illiterate	3.5	12.6
	upto Primary	4.6	14.7
	upto Matric	5.5	15.3
	upto higher secondary/ Other certificate/Diploma	7.7	17.3
	upto Post graduation and above	14.4	23.6
Religion of households	Hinduism	7.0	15.2
	Islam	0	9.4
	Christianity	0	31.7

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	Sikhism	5.4	6.9
	Jainism/ Buddhism/ Zoroastrianism/ Other	0	46.9
Social Group of Households	Scheduled Tride	0	21.9
	Scheduled Caste	3.8	13.9
	Other Backward classes	6.0	14.5
	Other	7.3	13.6
Wealth Quintile	Poorest	1.9	13.2
	Poor	4.0	12.2
	Medium	3.9	13.8
	Rich	5.8	14.1
	Richest	7.5	20.0

Coverage of health insurance schemes in Punjab and India

Government funded insurance Scheme i.e CGHS, RSBY, Arogyasri, ESIS), Employer support health showed enrolment in Punjab and India as 66.5% and 81.7%, Employer support health protection mean other government showed enrolment 22.4% in Punjab and 8.4% in India. Arrange by households with insurance companies showed enrolments 9.8% in Punjab and 8.4% in India. Rural individuals showed more enrolment in government funded insurance scheme as compared to urban individuals where as in employer support health protection, urban individuals showed more enrolment in government funded insurance scheme as compared to rural individuals (Fig.3).

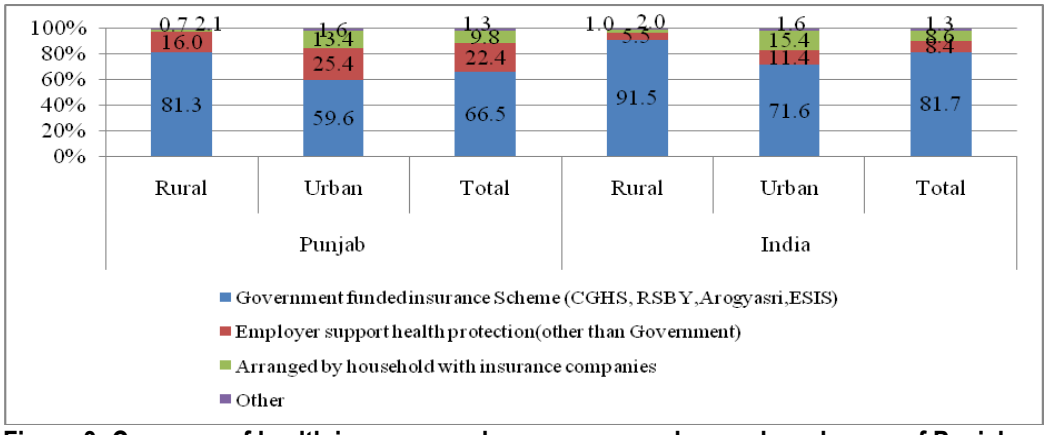

Figure 3: Coverage of health insurance schemes among urban and rural areas of Punjab and India, NSSO-2014

Female showed more coverage in government funded scheme & other as compared to males whereas males showed more coverage of enrolment in employer supported health schemes & arranged by households schemes (Fig 4)

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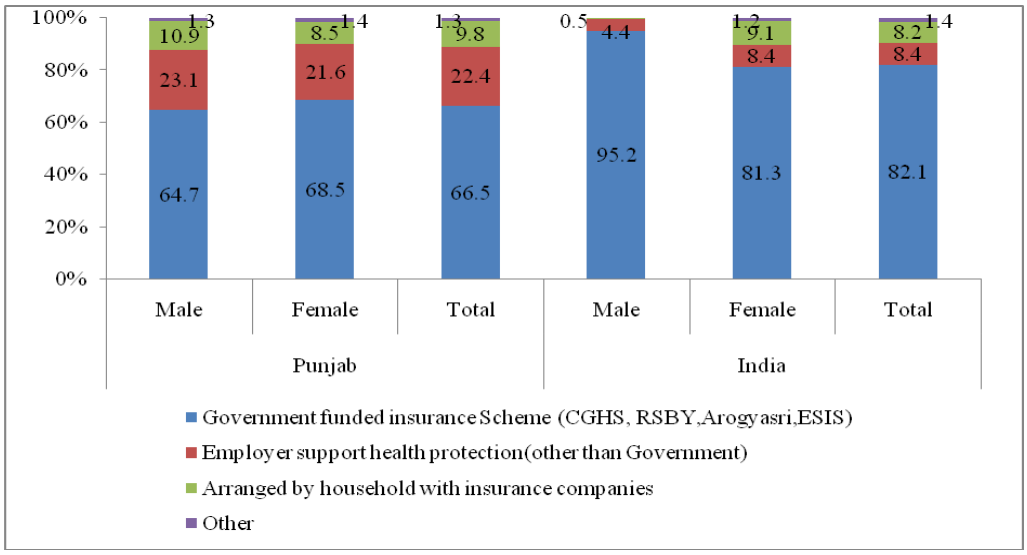

Figure 4: Coverage of health insurance schemes among males and females of Punjab and India, NSSO-2014

Significant pattern of Health insurance: Significant trends were observed among health insurance schemes for wealth quintile from Poor to richest in all northern states except Chandigarh showed non significant trend among wealth quintiles (Table 2).

Table 2: Association between Health insurance scheme and Wealth quintiles in northern state of India: A study of NSSO-2014

A	Wealth	Government	Employer	Arranged	Others	Not	Chi-	p
Punjab	Poorest	1.9	0.0	0.0	0.0	98.1	29.8	0.00**
	Poor	3.0	0.8	0.0	0.1	96.0		
	Moderate	2.9	0.6	0.3	0.0	96.1		
	Wealthy	3.9	1.8	0.0	0.1	94.2		
	Wealthiest	4.7	1.5	1.3	0.1	92.5		
	Total	3.8	1.3	0.6	0.1	94.2		
India	Poorest	12.4	0.6	0.1	0.1	86.8	700.5	0.00**
	Poor	11.1	0.7	0.1	0.1	87.8		
	Moderate	12.5	0.9	0.3	0.1	86.2		
	Wealthy	12.2	1.2	0.7	0.3	85.6		
	Wealthiest	13.1	2.4	4.2	0.3	80.0		
	Total	12.3	1.3	1.3	0.2	84.9		

Significance for WQ trend is calculated by using chi-square value, ** Significant at 0.01 level of significance

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Out-of –pocket expenditure (OOP):

Richest quintile showed more average expenditure (INR) on pre natal care (Rs.6728), Post Natal care (Rs.3156), Delivery ailment (Rs.26650), Illness in 15 day (Rs.1133) and Hospitalization (Rs.35084) respective. (Table3) Significant expenditure trends was observed for both end of income distribution i.e poorest and richest in Punjab as well as for overall for Pre-Natal care, Post–Natal care, Delivery ailment, illness in 15 days and hospitalization in 365 days in case of insured and non insured individuals.

For Pre natal care: It is found average expenditure for poor (Rs. 6500) and Richest (Rs. 14864) in case Punjab and poor (Rs.1697) and Richest (Rs. 4453) in case of India. For Post natal care: It is found average expenditure for poor (Rs.1000) and Richest (Rs.11045) in case Punjab and poor (Rs.1180) and Richest (Rs. 2121) in case of India. For Delivery ailment care: It is found average expenditure for poor (Rs.2250) and Richest (Rs.35700) in case Punjab and poor (Rs.3559) and Richest (Rs. 26650) in case of India. For illness in 15 days care: It is found average expenditure for poor (Rs.800) and Richest (Rs.1299) in case Punjab and poor (Rs. 700) and Richest (Rs.1133) in case of India. For hospitalization in 365 days care: It is found average expenditure for poor (Rs.39175) and Richest (Rs.37909) in case Punjab and poor (Rs. 7662) and Richest (Rs. 35084) in case of India.

Discussion

With increasing public expenditures under state government health insurance programmes and NHM seems to had helped in reducing the OOP expenditures from 72 % in 2004 (MoHW 2009) to 58 % in 2012 [20]. In spite of the decreasing share of OOP expenditures in total health expenditures, still lot of families incur catastrophic health expenditures and push towards below poverty line due to direct healthcare payment. In fact, the percentage share of consumer expenditure towards medical care has increased from 5.7 per cent to 6.9 per cent in the rural areas and from 5 per cent to 5.5 per cent in the urban areas between 2009–10 and 2011–12 [21].

At the two ends of income distribution—those in the poorest quintile and those in 4th and 5th quintiles, there is some form of health security, but for those above the poverty line in 3rd quintile, there is almost no financial risk protection. Most studies showed that in the 2nd and 3rd quintiles, the maximum population falls below the poverty line due to OOP payments on health care [22-23].

Average expenditure for illness in 15 day for 5th quintiles in case of insured individual we Rs. 1299 in case Punjab and Rs. 1133 in case of India where in case of non insures individual we have Rs.1100 in Punjab and Rs. 1095 in all states (Table 3). Most of studies showed a maximum proportion of peoples (mostly hovering just above the poverty line) fall below poverty line due to health expenditures on outpatient care and expenditure on medicine & drugs. In urban areas, the peak is at 2nd quintile with almost 12 percent of urban households fall BPL due to healthcare expenditure and again over 8 per cent are due to expenditures on out-patient treatment and drugs [23]. Those who are in 2nd and 3rd quintile are more likely to fall below the poverty line due to large expenditures on drugs and out-patient care. Mainly, worker in the informal sectors fall in the 2nd, 3rd or 4th quintile. They do have sufficient coverage from health insurance and always rely on government provided policies for in-patient care almost all rely on OOP payments for out-patient treatment and drugs.

Our study revealed that 5th quintile showed more average on hospitalization, pre-post natal care and delivery ailment in Punjab and all states of India (Table 3). Only 5 percent of households have health insurance at the national level surveys [24-25] where in 21% in Punjab and 29% in all states of India [26]. In Punjab, the State health insurance scheme predominates (62% of households), distantly

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followed by the Central Government Health Scheme (CGHS) and the Employees' State Insurance Scheme (ESIS)[26]. Study revealed that 81.7% enrolment in government funded schemes is more than earlier survey [24-26]. Also, both end of income distribution poorest and richest income quintile showed that enrolment 93.6% and 65.5% in government funded scheme more than previous survey [24-25]. Private providers will have to make sure that at least 75% of outpatient care and 50% of in-patient services are offered to citizens under the national health package [27]. The private health insurances are basically for people who can afford. They charge hefty premiums and give limited coverage primarily just to in-patients. The biggest disadvantage is that they do not cover outpatient charges and fees though the majority of health expense is on OPD only (60% of the total expenditure). Thus instead of giving comprehensive health coverage they provide mainly for accidents and sudden hospitalizations.

Conclusion

The study revealed that despite of health insurance schemes coverage, the majority of health care expenditure incurred. It is concluded that the reducing high health care expenditure through insurance scheme need to take major intension and therefore, we need keep on eye to maximize the coverage under different categories of health insurance and reducing the poverty in northern state of India.

Authors' contributions

SKR was responsible for preparation of study proposal, analysis and interpretation of data and preparation of the first draft of the manuscript. GSG and RS were involved in writing, editing and giving final touch to manuscript. All the authors read and approved the final manuscript.

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None.

Competing interests

The authors declare that they have no competing interests.

Availability of data and materials

The source of data is a representative nationwide survey data collected by

The National Sample Survey Organization (NSSO) is conducted after 10 years and data collected is representative nationwide. Data is available on public domain and can be procured from NSSO by paying a nominal charge.

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Table 3: Average out-of-pocket expenditure (Rs.) between insured and non insured for poverty levels of households in Punjab and India-NSSO,2014

		Punjab						India					
		Poor Mean (SE)	Poorest Mean (SE)	Moderate Mean (SE)	Rich Mean (SE)	Richest Mean (SE)	Overall Mean (SE)	Poor Mean (SE)	Poorest Mean (SE)	Moderate Mean (SE)	Rich Mean (SE)	Richest Mean (SE)	Overall Mean (SE)
Monthly Expenditure (INR)	Average Exp	3258 (85)	5449 (35)	7571 (31)	10406 (57)	20723 (324)	12228 (200)	3133 (7)	5154 (4)	7019 (6)	9662 (10)	18359 (74)	8665 (26)
	Per capita Exp	1369 (85)	1562 (55)	1842 (58)	2331 (54)	4013 (96)	2642 (47)	1091 (5)	1308 (6)	1564 (7)	1987 (9)	3615 (22)	1913 (6)
Pre Natal care expenditure (INR)	Insured	-	6500 (3500)	7500 (2500)	11500 (8500)	14864 (5256)	12618 (3539)	1697 (145)	2435 (170)	4001 (211)	5078 (564)	6728 (305)	4553 (166)
	Non Insured	2329 (482)	3212 (504)	3406 (506)	6411 (954)	6289 (518)	5148 (335)	1726 (57)	2248 (65)	2739 (67)	3303 (74)	5370 (250)	3169 (61)
	Total	2329 (482)	3318 (500)	3530 (501)	6521 (946)	6906 (628)	5474 (362)	1723 (53)	2268 (61)	2918 (65)	3556 (103)	5636 (210)	3369 (58)
Post Natal expenditure (INR)	Insured	-	1000 (-)	2500 (500)	3500 (1500)	11045 (6694)	8406 (4647)	1180 (108)	1443 (103)	1499 (87)	2076 (130)	3156 (214)	2121 (82)
	Non Insured	2591 (905)	2084 (443)	2159 (388)	2586 (341)	3207 (476)	2675 (228)	1217 (43)	1475 (48)	1648 (59)	2094 (71)	2741 (91)	1888 (31)
	Total	2591 (905)	2063 (434)	2172 (374)	2609 (333)	3861 (715)	2956 (317)	1213 (40)	1471 (44)	1627 (52)	2091 (63)	2826 (85)	1922 (29)
Delivery	Insured		2250	1900	82533	35700	36053	3559	6773	8319	12478	26650	14557

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Ailment expenditure (INR)			(1750)	1400)	(71410)	(17269)	(15875)	(382)	(553)	(518)	(817)	(2348)	(826)
	Non Insured	8731 (2540)	8507 (1433)	7705 (1544)	12940 (1454)	20304 (2434)	14043 (1117)	4526 (229)	6162 (223)	8076 (287)	10418 (285)	18309 (568)	10074 (172)
	Total	8731 (2540)	8275 (1389)	7486 (1494)	15761 (3192)	21470 (2596)	15187 (1356)	4414 (208)	6232 (207)	8112 (256)	10738 (272)	20003 (659)	10756 (193)
Illness Expenditure in 15 days (INR)	Insured	800 (700)	782 (259)	772 (292)	569 (126)	1299 (293)	1024 (173)	700 (183)	567 (35)	590 (31)	677 (31)	1133 (100)	809 (41)
	Non Insured	740 (96)	523 (51)	787 (110)	752 (65)	1100 (91)	868 (45)	710 (31)	772 (34)	750 (22)	846 (26)	1095 (31)	864 (13)
	Total	743 (94)	542 (51)	786 (105)	738 (61)	1124 (87)	882 (44)	708 (41)	736 (29)	717 (18)	809 (21)	1105 (35)	853 (14)
Hospitalization expenditure in 365 days (INR)	Insured	39175 (10825)	6558 (2906)	7283 (3930)	46333 (14097)	37909 (8447)	34861 (6049)	7662 (426)	12044 (847)	13383 (815)	17639 (737)	35084 (1274)	20543 (503)
	Non Insured	21719 (6954)	17375 (2217)	16361 (2344)	22602 (1803)	38884 (7176)	27036 (2855)	9371 (246)	11414 (278)	13413 (311)	17057 (599)	29902 (719)	16942 (232)
	Total	22366 (6715)	16608 (2081)	16101 (2281)	24454 (2012)	38781 (6481)	27645 (2674)	9107 (218)	11506 (268)	13408 (293)	17162 (509)	31189 (627)	17607 (211)