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Health Service Utilisation and Coping Mechanisms of Urban Slum Dwellers: A Case of Mumbai Slums

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Abstract

India spends about 6 per cent of its GDP on health, but public (Central, State and Local Governments combined) expenditure as a percentage of total health expenditure amounts to a meagre 20 percent of total expenditure on health which is among the lowest in the world. Households account for almost 70 per cent of the total health expenditure, (MOHFW, GOI). A number of studies have established that poor faces both high amount of direct and indirect cost of expenditure in case of falling sick. It is also agreed upon that large section of urban poor live in slum areas, in overcrowded house, unhygienic condition, drink contaminated water and go for open toiletries. Therefore they are at greater risk of falling sick and more prone to epidemics than their rural counterpart. Therefore the present paper has focused on the health seeking behavior of urban poor. A survey was conducted among 300 households of three slum areas of Mumbai. The objective was to understand how urban poor utilize health and health care services in case of falling sick. It also tried to find out the coping strategy adopted by urban slum dwellers to meet health expenditure.

Keywords: Health utilisation pattern • Coping mechanism • Out-of-pocket expenditure • Urban poor • Slum dwellers.

Introduction

Health service utilization and health seeking behaviour of a people depend on a number of factors ranging from perception of illness, severity of illness, need for health care, awareness and information about health services, physical, economic and social accessibility of health care services, quality of care, socio-economic structure and the biases of the health care provider. There have been several studies conducted focusing on utilization of health services in India. The studies were conducted in the communities focusing on utilization as part of larger studies that examined morbidity, event related preference for health care and expenditure incurred. Aspects with regard to the general preference for formal/informal, indigenous, private/public type of institutions and services have been studied at length [1]. Some of the study [2-4] was specifically urban based, focusing on how health services are utilised in urban settings.

Economic Burden of Illness

The financial burden of illness is a universal issue, cutting across socio-economic coordinates of households. However, health has often been perceived as a luxury good though it is not. The perception of illness in general and severity of illness in particular has been found to be affected by socio-economic characteristics such as income, age, sex, class and psychological characteristics like stress, co-morbidity condition adding to trauma, cognition abilities of an individual. Therefore, it means that the definition of ailment is not universal. For instance, a rich person may identify a relatively minor indisposition as ailment and go for treatment, while the poor might perceive an ailment only when it is work-disabling in nature. Their subsequent choice of service providers is often in conformity with their respective financial status. Thus, the resultant burden of illness is inherently asymmetrical as far as its nature and origins are concerned. It is the poor, who often continue to bear the burden of illness, even long after it has been cured.

It might be contended that the burden of illness are felt more by the urban poor vis-a-vis their rural counterpart [4,5]. Apart from the higher cost of living and an extremely competitive informal job market, the burden of disease among the urban poor is enhanced, also due to unhygienic living conditions, deplorable status of basic necessities like water and sanitation, increased exposure to accidents and poor environmental condition that increases the vulnerability to indispositions and hence the economic burden. High rate of growth of urban population and consequent increase in population residing in slums has led to over straining of infrastructure and deterioration in public health and wide inequalities in accessing services. Such hostile circumstances coupled with the lack of social network and fall back options, make them more vulnerable to catastrophic cost burden.

India spends about 6 per cent of its GDP on health, but public (Central, State and Local Governments combined) expenditure as a percentage of total health expenditure amounts to a meagre 20 percent of total expenditure on health which is among the lowest in the world. Households account for almost 70 per cent of the total health expenditure, (MOHFW, GOI). Even there imbursements in any

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form that is availed by households whose members are employed in the formal sector are a minority in India. Given that good health is the most basic of all necessities, such high levels of out-of-pocket spending by the households have certain adverse implications. While for some, access to health care is reduced considerably, others who opt for treatment face catastrophic burden of health care expenditures and are in danger of becoming impoverished.

Health utilization pattern in Mumbai

Mumbai is having a well-developed infrastructure and a vast supply of public and private health care services. The services range from the super specialty tertiary level care hospital to general practitioner [6-8]. The central government has its own dispensaries which are available only for their employees. Further there is employees State insurance Scheme catering to the organized sector employees. The various departments such as the ports, railways, defence etc have their own health care services and hospitals catering to their employees. For the general people the Bombay Municipal Corporation provides the major care in the public sector along with the state government. There are six teaching hospitals, fifteen peripheral hospitals, 26 maternity homes, 159 dispensaries and 76 health posts run by the BMC. In the private sector, the CEHET database records 1082 hospitals and nursing homes run by various agencies.

Methodology

In the present study, utilization of health services implies all health care services and facilities. Utilization was defined as services taken from the health facilities referring any institution, BMC, private, tradition, charitable, subsidized, recognized and unrecognized in the event of falling sick. Treatment of sickness includes medical advice, examination, diagnosis, cure and care of illness. Non-treatment is when the sickness was reported during the recall period and where no action was taken to alleviate the symptoms. Self-medication and home remedy from any local health service provider were also included to cover the entire gamut of utilization of health care services by the households to understand the factors and aspects of health seeking behaviour. (Studies in urban areas show same trend in greater utilization of private facilities NCAER (1992) conducted study at India level indicated that for all states barring Himachal Pradesh, Assam, Orissa and Karnataka, the preference for private sector health provider is high. Even in a state like Kerala, which has a well-developed public health infrastructure, there is greater reliance on the private sector than the public sector. Public sector health service utilization ranges from 9% to 36% [9,10].

Outline of the study area

It is important to understand the geographical and demographic feature of the area under the study. The study comprises of a sample of 300 households selected at random from three slum parts of the area Kurla (L), Chembur (M) and Bhandup (S) in Mumbai city. The Brihann Mumbai Municipal Corporation (BMC) divides the city into 24 Wards(Table 1). The above-mentioned regions are among the top five wards of Mumbai's slum population. The data from the 2011 census shows that nearly 41.3% of the city's population lives in slums. Dharavi, which had the distinction of being largest slum of Asia, is a part of G north ward and its population is 5.82 lakh with nearly 60% slums [11-13]. Dharavi is no longer Asia's largest slum. It is now dwarfed by four other slum clusters of Mumbai and suburbs namely, Kurla-Ghatkopar (70%-80% slum population), Dindoshi (80% slum population), Bhandup (70% slum population), and Mankhurd-Govandi (95% slum population).

Area	% of Slum population to total population	% of Non-slum population
Bhandup (S)	86.83	14.17
Kurla (L)	84.68	15.32
Khar/Santacruz (HE)	78.79	21.21
Chembur (M)	77.55	22.45
Ghatkopar (W)	70.21	29.79
Greater Mumbai	54.7	45.95

Table 1: Wards of Mumbai slum and non-slum population with maximum slum population.

Source-Mumbai HDR (2009)

A mixed method approach using quantitative and qualitative techniques was adopted to make use of the advantages of each method and to enable triangulation. Data were collected at community level through a household survey and interviews with key informants. A simple random sampling was used with 300 households [14]. The care was taken to interview only those household which have faced illness in the past month. Using a pre-tested questionnaire, data was collected from the household members. Recall Period for illness reported data was taken as 1 month in case of common disease and 6 months for hospitalization treatment(Table 2). For interpretation of data, graph and simple diagrams have been used and for comparative and analytical study tabular presentation has been practiced.

Items	Kurla	Chembur	Bhandup	All
No. of household surveyed	140	90	70	300
No. of ailment cases (last one month)	101	61	50	212
No. of hospitalization cases(last six month)	39	29	20	88
Total	140	90	70	300

Table 2: Distribution of the selected sample.

The rationale behind the selection of these slum areas arises from the fact that as per BMC reports, four wards in the city K east (Andheri), L(Kurla), G south (Elphinston), E (Byculla and Chinchpoly) have been notified as high risk areas since 2010, where presence of slums, continuous construction activities and demographic conditions have led to high incidence of morbidity.

Objectives

The main objective of paper was to understand the health seeking behaviour of urban slum poor in case of falling sickness.

It also tried to find out that how poor people cope with burden of treatment and what were the various mode of resource mobilisation adopted in case of financial hardship.

Health seeking behaviour of sample areas

The analysis brings out a number of interesting findings that may help in improving policies meant for urban poor.

Use of medical services

The cases of seeking treatment is quite high as 94% of household accepted that they have taken the advice of health professionals, only 6% did not seek any treatment mainly due to cost factor or illness was not severe enough [15-19]. This shows increased awareness among the poor population regarding health benefit and need to have a proper diagnosis rather than to ignore the health condition. This finding is important as it implies that now health is not so widely considered as a luxury but as an investment for better working life.

Source of treatment

Preference of the people regarding different service providers has its own policy implication(Table 3). It not only enriches our knowledge regarding the health seeking behaviour of the population, but also highlights the positive or negative aspects of different service providers.

Source of Treatment	No. of HH	% of HH
Traditional	15	5
Private doctor/clinic	148	49.32
BMC run hospital	72	24
Charitable Hospital	54	18
Over the counter purchase of drugs	11	3.6

Table 3: Preference of people for different source of health care provider.

Traditional home remedies like taking herbs and drink made of other natural extracts are the first course of treatment widely used by the households across the income and education group in case of common diseases. It is only when the condition deteriorated that professional help is sought. People assign high regard to government health professional as far as knowledge of medicine is concerned. But non-availability of drugs at public facilities was the most important weakness identified by respondents. After meeting a health worker at a public health facility people usually have to purchase the prescribed medicine from a private pharmacy. Long waiting times were also a problem mentioned by respondents(Figure 1). The household survey provided additional evidence about access barriers or factors influencing choice of treatment. The dominant factor cited as a reason for not seeking treatment was lack of money [20]. "Lack of money" might also include distance as an access barrier, since money is needed to pay to travel the long distances to health facilities (transport, food and lodging costs). Self-treatment with traditional medicine was one of the most common treatment strategies, and the household survey found it was used largely because it was low cost, effective and familiar to the family. When people had sought treatment at health stations and private clinics the reasons given were also predominantly pragmatic: they were relatively close, low cost or the only place to obtain the right sort of treatment.

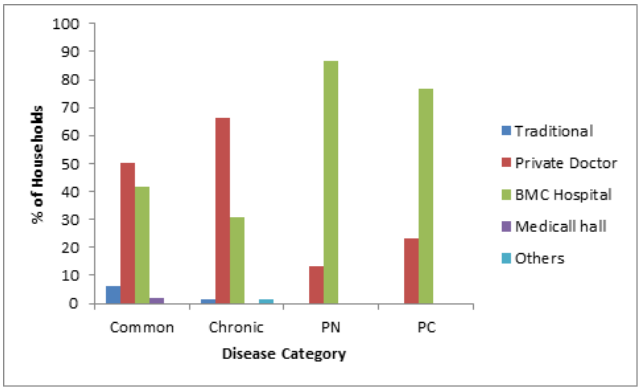

Figure 1: Percentage of household availing services as against disease categories.

*PN Pregnancy, Normal child Delivery, PC-Pregnancy, Caesarean child Delivery

The above diagram clearly show that people prefer private nearby doctor in case of common sickness, but the percentage rise sharply in case of chronic diseases(Figure 2), which in some cases require inpatient treatment [21]. Similarly for any treatment related to child delivery, households prefer to BMC run hospitals. The figure also establishes the fact that in case of common health problems, the first course of treatment for household is traditional medicines.

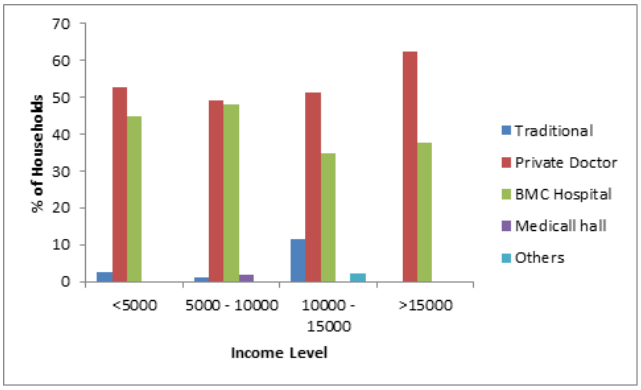

Figure 2: Percentage of households availing treatment against income level.

The finding is somehow strange, because in health economic literature, health expenditure is considered positively related to per capita income. In other words, as income increases, people spent more on expensive treatment which is normally provided by the private sector in case of developing countries [22]. The figure shows that the lower income group had used more the services of private doctors than their next income group households(Table 4). But this behavior is unique in case of Mumbai slum as the higher preference

for private doctor is mainly due to nearby and easy accessibility and availability of doctors rather than the cost factors.

Reasons	No. of HH	% of HH
Good services provided	23	7.6
Affordable services	117	39
Near	88	29.3
Any others	72	24

Table 4: Reasons for seeking particular source of treatment.

The data supports the general perception that for a poor population, affordable services are the main criteria while selecting a particular source of health care providers. The second consideration is the easy and nearby availability of health care professionals. This is mainly to save time and transport cost. Any others include traditional medicine, polite health workers, and prompt attention.

The mode of health care expenditure

Out of pocket expenditure emerged as the primary source of financing health care service expenditure. As much as 95% household have spent from their personal income and a meagre one i.e., 5% (15 cases) have used the insurance or employees health fund. These cases were of those people working in railways and health department of the government as technician, peon and other low paid jobs. Two of the cases also reported to avail the benefit of Rajiv Gandhi Jivandayani ArogyaYojana Card.

Coping mechanism adopted by slum poor

In order to understand the household behavior regarding different methods resorted to deal with the health cost expenditure; data was collected on coping mechanism(Table 5). Coping mechanism can be defined as the actions, ways and strategies that aim to manage the costs of an event or process, such as illness, that threatens the welfare of one or more members of the households [23]. Household's asset portfolios and the social and financial resources available to people in the wider community influences the capacity to cope with illness cost. The study has identified the following range of mechanism that were used to manage illness cost.

Types	No of HH	% of HH
Claims on relatives	33	11
Dissaving	70	13
Sale of asset	32	10.6
Delay in payment on consumptionand other items	148	49.3
Not seeking full treatment	17	5.6
Shift to other providers	10	3.3

Table 5: Number and percentage of household.

Opting for different coping mechanism

Using the sample household survey data, the above table summarizes the strategies that people adopted when they lacked money to pay for treatment. A high percentage of households (49 %) opted for delay in payment for ration, electricity and water bill, school and tuition fees of children or cutting the expenditure on entertainment and other consumption items. This is followed by dissaving, which mean that due to health expenditure, household could not save even the meager amount to pay the earlier borrowing or to spend on any other items than the basic consumption needs. This can be termed as the sacrifices or opportunity costs of health expenditure. Most of the respondents stated that the money was intended for other basic necessities such as food, clothing, education and fuel. Borrowing with no interest from better-off households or neighbors or relatives and employee was also a common strategy. Gifts from family or neighbors were also a common strategy used. In case of hospitalization requiring high medical bill, households had also to sell jewelries or any other assets to get money. In some cases, the asset can be the source of livelihood also.

Coping mechanism and economic status of the household

Taking monthly income of household as a representation of economic status, an effort was made to understand whether there is any relation between economic status and choice for particular source of coping strategy(Figure 3).

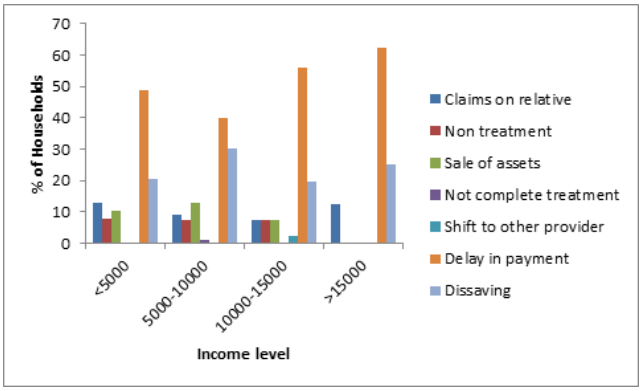

Figure 3: Coping strategy as against income level.

The lowest income group households generally depend on their relatives in case of sickness. The proportion of non-treatment in income group is also comparatively more compared to other income groups. But as the income level increases, delay in payment for basic needs goods becomes the common coping strategy across the group. Households have been found to change the treatment from one health service providers to others, but here appears a thin line of difference between as whether the reason to shift the provider was non-satisfaction from the services providers or the money factors. Dissaving implying depletion of savings also emerged as the common coping strategy across the income group. However, for the lowest income group, mainly those who are earning less than 5000 Rupees a month and who can barely meet its basic consumption expenditure, the question of saving does not arise.

Resource mobilization to meet health needs

The analysis shows how a particular household facing medical needs mobilizes the funds to pay for availing health services. It was found that urban poor mainly count on their wage income to meet their health service demands(Table 6). This is important as it reflects that being a wage earner or employed in informal sector, these households don't have any health insurance coverage, already their ability to generate income is less and therefore paying out of the pocket for health services may seriously affect the households' basic consumption needs(Figure 4).

Types	No. of HH	% of HH
Routine wage/salary	129	43
Borrowed from relatives	83	27.3
Borrowed from employee	35	11.6
Sale of asset	12	4
Borrowed on interest	18	6
Saving	24	8

Table 6: Number and percentage of household using the different source of resource mobilization.

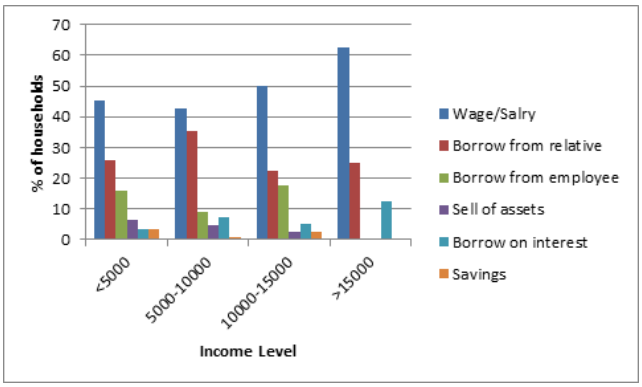

Figure 4: Source of resource mobilization by different income groups.

For urban slum dwellers, across the income group, the common source of fund mobilization to meet health expenditure is their regular income. As in most cases, these households don't have any alternative source of income. That is the reason, indirect cost of income loss due to falling ill should be emphasized more in any health policy reforms aimed at urban poor. Borrow from relatives is the second most important source of resource raising, but on which terms the help comes is not clear. It was vaguely responded in some cases that nobody helps in free. Other source covered in the questionnaire namely saving and sale or mortgaging assets do not emerge as significant, mainly may be due to the reasons that the urban poor do not have enough income generating assets and surplus income to save.

Discussion

The cases of seeking treatment is quite high as 94% of household accepted that they have taken the advice of health professionals as against 6% who did not seek any treatment mainly due to cost factor or illness was not severe enough. This shows increased awareness among the poor population regarding health problems and also the realization of a proper diagnosis at early stages rather than to ignore the health condition. This finding is important as it implies that now health is not so widely considered as a luxury but as an investment for better working life. Good health status implies regular working days which mean more income to family. But if this finding is related with the actual rate of continuing treatment or forgoing the institutional care by replacing it with traditional means due to some economic constraints, the cost and access factor regarding health care becomes important. Thus, household are denied of proper health care not because they are not aware of health benefit but because they cannot afford it.

Awareness about the government policy and schemes are critical. Most of the respondents agree that even if few of people in their locality are aware about the program, they can well spread the knowledge. According to some of the respondents, following are common problems faced, while seeking to health care services,

Most of the times health workers at hospital do not provide adequate information.

They do not inform them regarding health cost coverage schemes.

The medicine provided at the BMC run hospitals are of low cost but also of less value in terms of benefits (which may be a bias, as some of the respondents were happy with the treatment got in public hospitals) Non-availability of drugs, hence, people have to depend on private sellers for antibiotic and other branded medicines, which prove to be costly and burdensome.

During the course of survey, it was observed that the people attach more importance to education than health. Health cost is something that may incur or not, but education is something that is needed even to understand health and wellbeing. Therefore any health programs must be accompanied with educational attainment on which the success of preventive care depends. Reliance on relatives and friends is the most sought after coping strategy for these people. They are under permanent debt trap. People also resort to intra house labor substitution and not happy with this state of affair as they lose their daily wages. This labor substitution occurs in the form of working without cash or kind for the person from whom the loan has been taken. A high level of opportunity cost is attached with intra-household-labor substitution. The households seeking treatment incur costs that force them to cut spending on other basic needs or to adopt coping strategies that put them into debt or deplete their assets. The poorest were, in particular, less likely to seek treatment and were less able to cope with cost burdens because they could not obtain loans and had no assets to sell.

There is growing interest in the impact on households of the costs of illness and of health service utilization. At the same time, it is also being increasingly recognized that these costs can lead to household impoverishment and create increasing pressure on the demand for health care facilities in the urban slums.

Conclusion

Therefore the main objective of the study was to study how illness perception and treatment seeking behavior are influenced. The health infrastructure of the country is not adequate and accessible equally to

all sections of population. Urban poor which forms a large percentage of informal worker live in vulnerable situation, therefore more prone to sickness and consequently face catastrophic burden of health care cost. The role of government in primary health care in terms of free and cheap service is non-substitutable as far as poor people are concerned. But there exists a wide gap between quality needed and quality provided.

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