ABSTRACT

Realizing the importance of health as a driver of economic prosperity, developing countries are striving to spend a higher percentage of their GDP on healthcare. However, governments of developing countries like India are facing a major challenge in allocating higher percentage of their scarce resources towards the health sector due to increasing competitive sectoral demands in liberalized environments. As a result, increasing inequality in health outcomes across socio-economic groups is observed in many developing countries including India. The prevalence of disparities in health outcomes across socio-economic groups is also a result of disparities in healthcare utilization. The disparity in utilization is mostly due to the fear of unforeseen high out-of-pocket (OOP) expenditure on healthcare services. Often households accept to trade off future welfare of all its members against access to healthcare for one of them by inefficient coping mechanisms such as incurring debts, selling off productive assets, or sacrificing investment in future productivity, for example - by curtailing children's education. Such coping mechanisms can trigger a vicious circle of impoverishment and indebtedness. Due to the fear of high healthcare cost and its impoverishing impact, poor people depend more on traditional healers, self-medication and advice of pharmacists or, could avoid treatment. Costly health care also deters people from using health services thereby generating long-lasting or deteriorated health problems. Such instances are more pronounced more among socio-economically backward groups. Therefore, providing health security to the low income and vulnerable households is crucial to achieve equity in healthcare. Consequently, in recent years, health security is increasingly being recognized as an integral part of poverty reduction strategies where, provision of health insurance (HI here after) as a means to curb the risks to health has been given importance. The provision of health insurance is looked upon as a better option vis-à-vis fee –for-service, since it meets the requirements of timely access to healthcare facilities and prevents unexpected household expenditure.

Various policy documents of the Indian Central and State governments reflect a strong political intent to provide health insurance as a health security measure to the vulnerable sections of society. In recent years, it is seen that both government and non-government initiated health insurance programs have evolved to offer formal health security in the form of health insurance.

The surge in provision of health insurance is based on the theoretical argument that provision of health insurance leads to timely access to healthcare, circumvents self-care and
no care, increase in utilization of healthcare and avoids catastrophic health expenditure irrespective of socio-economic barriers. As a result, it brings efficiency and equity in the health sector. However, the high level expert group report (HLEG, 2011) on “Universal health coverage for India” has stated that health insurance as a system has not been able to provide enough financial protection but has rather led to increased vulnerability due to over and unnecessary utilization of services (the problem of moral hazard), higher share of riskier groups in a pool (presence of adverse selection), provision of selective and incomplete coverage and higher preference to expensive private facilities. The above assertion contradicts and poses uncertainty on the role of health insurance in financial protection. Hence, there is a need for thorough and careful empirical investigation into the issue since a few attempt have been made to study into this matter Keeping in view the above context, this thesis attempts to study (a) the healthcare utilization behaviour of households and its financial implications, (b) the factors determining household healthcare utilization behaviour and the impact of health insurance (c) the factors determining out-of-pocket financial burden and the impact of health insurance, and (d) financial risk protection provided by targeted government health insurance schemes to low income households.

To examine the above objectives, both secondary and primary data has been used. For the first three objectives, data from both NSS 60th Round (2004-05) on “Morbidity, Health Care and Condition of the Aged”, and Indian Human Development Survey (IHDS, 2004-05) have been used as secondary data. The NSS 60th round data has been used to derive a broad picture on healthcare utilization, health expenditure burden and its source of financing. The information regarding households’ health insurance status, its impact on healthcare utilization and reduction in health expenditure has been analyzed using IHDS (2004-05) data. Although the data is relatively old, this is the only secondary data available till date in public domain which provide information on individual/household health insurance status. The last objective of the study, which examines the impact of governmental health insurance on healthcare utilization by low income households, financial protection, and dependence on inefficient financial coping mechanisms, has utilized the findings of a detailed primary survey since the available secondary data does not provide information on recent government health insurance schemes. The primary survey is based on case-control study design where, non-beneficiaries and beneficiaries of Rastriya Swasthya BimaYojna (RSBY) scheme are considered as control (89 households) and treatment groups (98 households) respectively. The survey followed a multistage sampling method where, Cuttack district in Odisha state is selected in the first stage followed by two blocks (one urban and other as rural) in the second
stage. Two villages and two wards have been selected from rural and urban blocks respectively in third stage. From each village and ward, an equal number of households of both beneficiaries and non-beneficiaries have been selected for interview purposes in the last stage. A structured interview schedule has been employed to obtain the required quantitative data, whereas for some qualitative information, several in-depth and group discussions have been carried out.

The major findings of the thesis are; (i) there exists socio-economic inequality in healthcare utilization and healthcare burden, (ii) in general, health insurance increases the utilization of health services, decreases the degree of OOP spending, and decreases the probability of catastrophic spending and impoverishment. (iii) the impact of RSBY on utilization and financial risk protection is futile.

Socially and economically disadvantaged sections of society, in general, have a lower utilization of healthcare although their healthcare burden is higher than the well-off sections of society. With insurance, the number of days spent in hospital (a measure of utilization) increases than without insurance, which is found to be statistically significant. Similarly, with insurance, the likelihood of preference for private over public health facilities increases than without insurance. These changes in utilization behaviors due to the presence of health insurance indicate the possible presence of moral hazard. While underutilization of healthcare is a major concern in India, the presence of moral hazard from the consumers’ is not a serious problem as compared to that from producers since it leads to huge out of pocket OOP financial burden for households. Since the presence of insurance leads to increase in utilization, the recent emphasis on provisioning health insurance by the government to achieve universal health coverage (UHC) is a welcome move.

However, evidence of increased utilization of healthcare due to presence of health insurance is not found in the case of RSBY scheme. The findings of this study show that the scheme has been ineffective in achieving two main objectives- increasing utilization of healthcare and, providing financial risk protection against cost of illness. The main reason for the ineffectiveness is lack of effective awareness among the beneficiaries about the scheme. Most of the beneficiaries were ignorant about the usage of the smart card provided to them under the scheme. They don’t know when, where and how to use that card. We also observed flaws in the implementation of the scheme. Various stakeholders at different levels like; government nodal agency, health insurance company and healthcare providers have not done their act right at different levels of implementation to make the scheme successful. On the
other hand, from beneficiaries’ point of view, the sense of ownership and responsibility is also missing since they have not to pay any premium for availing the insurance. However, while asked about their willingness to pay for a scheme that is based on their needs (some form of outpatient care to be included in the scheme), a significant proportion of beneficiaries were willing to pay (varies from Rs. 10-150 per month) for it. This implies that they are ready to contribute a premium if they are provided the right package that meets their needs and expectations.

In addition to the above, it is also found from the analysis that the probability of experiencing catastrophic expenditure and impoverishment increases almost equally because of both outpatient and inpatient expenditure. However, most of the health insurance schemes in India, either government or privately provided are inpatient oriented, thereby excluding a large part of OOP expenditure. The perception of beneficiaries towards the scheme was overtly negative. They treat the RSBY scheme just like any other government scheme with little value. It is also found that not only poor but also higher income households face the problem of higher healthcare burden (catastrophic expenditure). Hence, universalization of health insurance is essential. Moreover, under this scheme, the risk pool is constituted by the BPL population which has a low least ability to pay. If the same scheme is extended to other populations of the society and some premium is charged, the pools will become bigger and more financially sustainable as in the case of general private sector-led health insurance. Since the RSBY scheme is for the BPL families only, many non-BPL households who genuinely need the scheme are deprived from benefitting from the scheme. Hence, the scheme should be universalized and a nominal premium charged for a comprehensive health insurance package that caters to their needs. In addition, it is also well known that the selection of BPL families is flawed and hence, needy beneficiaries are left out of such schemes’ ambit.

In conclusion, since awareness among the people from low income groups regarding health insurance is overtly low, they should be educated about the benefits of it. Government health insurance programmes like RSBY will succeed if the government upgrades the existing health facilities and regulates the private sector with an effective regulatory mechanism. Unless people will choose private over public sector healthcare providers, pay higher medical costs and face impoverishment. Moreover, along with awareness, there is a need for redesigning and effective implementation of the RSBY scheme so as to enhance its acceptance and effectiveness.