CHAPTER-7
SUMMARY OF FINDINGS AND SOME IMPLICATIONS

7.1 Introduction:

The principal objectives of this study are to examine the impact of health insurance on healthcare utilisation and financial risk protection. The study made use of both secondary and primary data and employed statistical tables as well as econometric techniques for analysis purposes. In this chapter, the major findings of the study have been provided in various subsections of section-7.2. Subsection-7.2.1 presents a situational analysis of health financing in India and the relevance of health insurance while the role of health insurance on healthcare utilisation has been analysed in subsection-7.2.2. In subsection-7.2.3, the impact of health insurance on financial risk protection has been examined. Considering RSBY scheme as a case study, its effectiveness in providing financial protection and reducing the dependence on informal and inefficient sources of financing has been examined in subsection-7.2.4.

7.2 Major Findings:
7.2.1 Health Financing in India: The Role of Health Insurance

In Chapter-3 a situational analysis of various health financing mechanisms with special reference to health insurance has been carried out. In India, healthcare of citizens is primarily the responsibility of State governments and the budgets allocations of each state include allocations to health sector programmes. Besides this, to fund the health sector, state governments also receive support from central government through central sponsored programmes (considering the concurrent list). In general, the sources of health financing mechanism existing at central level are equivalent to state also. The only difference is that centre provides financial assistance to the state while the other way round does not happen.

There are mainly five sources of Health financing available in India. These are (i) the tax-based public sector that comprises local, State and Central Governments, in addition to numerous autonomous public sector bodies; (ii) the private sector including the not-for-profit sector, that organizes and finances, directly or through
insurance, the health care of their employees and target populations; (iii) households through out-of-pocket (OOP) expenditures, including user fees paid in public facilities; (iv) other insurance-social and community- based; and (v) external financing (through grants and loans). Amongst all these sources of financing, insurance and tax-based financing are considered the most equitable systems of financing and out-of-pocket expenditures as the most inequitable. In India, the financing of the health system is mainly dependent on government budgetary allocations and private financing, while, the private financing (most of it is OOP) dominates the share of total health expenditure. The trends indicate that the proportion of total health expenditures paid OOP has been significantly higher, while the share from government revenue sources has not been increasing significantly to reduce the increasing share of OOP.

The other important source of financing is the insurance system which is considered as being equitable and efficient as compared to OPP OOP system since it is based on the principle of cross subsidisation unlike the ability-to-pay under OOP system. Health insurance as a financing option has been gaining momentum since liberalisation in 1991 and with the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999. There are three broad health insurance systems available in India, namely; private, social and community based/ micro health insurance. Social health insurance (SHI) is regarded as one of the best systems of financing healthcare. However, India does not have the financial means and institutional capacity to offer state-based social health insurance to its entire population. Given the limitation of public healthcare systems, private and community-based health insurance offers a potential alternative to insure against the cost of illness. Government-sponsored voluntary health insurance would be the next best option to reach targeted sections of the population.

In India, voluntary private health insurance (PHI) schemes are offered by public and private sector insurance companies in the open market. Since the liberalization of the insurance industry in 2000, India has been supporting private players to enter the health insurance market. With the enactment of the IRDA, the industry now has a regulatory framework to protect the interests of policy holders. However, private health insurance has not achieved the desired goal of health
financing due to traditional insurance offerings, fee-for-service-based payment system, based on risk-rated premiums, and lack of viable risk pools.

 Nonetheless, while both private and social health insurance have failed to provide health insurance to the majority of the population staying outside the formal sector and and to those belonging to low income groups, community-based insurance and some government initiated health insurance schemes have stepped in to fill the gap to some extent. Such schemes have accommodated many low income and unorganised sector workers into the umbrella of healthcare cost protection.

 While looking through the lenses of health financing functions (revenue collection, pooling of funds and purchasing care) framework suggested by World Bank (2000) these schemes have got both positive and negative outcomes. In terms of revenue collection, general taxation is the main source of funds for government-run health insurance. Thereby, the schemes’ sustainability relies upon the fiscal health of the state and centre as well as the political willingness to continue the scheme. The risk pool for most schemes is comprised of the BPL population with least ability-to-pay leading to segmentation of the population. If the same schemes are extended to other populations of the society who are charged some amount as premium, the pools will become bigger and more financially sustainable as in the case of the rich subsidizing the poor in typical health insurance.

 In case of community-based schemes, although such schemes are self-sustaining, they also depend upon external funds and donation. Again, the pool is very small resulting in low revenue collection and higher loading cost, leading to suppressed demand. On the whole, both government and community based schemes have failed to provide comprehensive packages to the targeted sections due to the fear of moral hazard, adverse selection and cost containment. The benefit package and package rates are the tools of purchasing care that government-run schemes have used to control costs of treatment whereas they are lacking in community-based schemes as they only reimburse the predefined maximum amount which is defined under the scheme’s benefit package. The scheme administration doesn’t have any regulatory control over the cost of treatment incurred by clients while approaching health providers.
7.2.2 Healthcare utilisation behaviour: Examining the impact of health insurance

In chapter-4, the impact of health insurance, along with socio-economic and demographic factors, on healthcare utilisation has been studied. Tobit and Multinomial Logit models have been used to examine the impact of health insurance, in general, on healthcare utilisation behaviour of the individuals. For our analysis, healthcare utilisation has been defined as the number of days spent in hospital (as the dependent variable for Tobit model) and choice of healthcare providers (as the dependent variable for Multinomial Logit model). IHDS (2004-05) data has been extensively used for the analysis.

The results from Tobit Model show that health insurance has a statistically positive significant impact on utilisation behaviour, implying that it improves healthcare utilisation. The insured people utilise more inpatient services compared to the uninsured while controlling all other socio-economic factors.

Socio-economic inequality in utilisation has also been found from the result. The income variable has a positive and statistically significant impact on utilisation implying that the rich have better utilisation behaviour compared to the poor. We also find gender inequality with females spending lesser number of days in hospitals than males. Similarly, individuals from urban areas spend, on an average, more number of days in hospitals as compared to those from rural areas. Patients suffering from long-term morbidity which are chronic in nature and entail higher healthcare costs, on an average, spend more number of days in hospital than others. This suggests that there is a need for a health financing policy that focuses on chronic diseases which account for more than fifty percentages of total deaths in India. Hence, governments have to take necessary steps to prevent the incidence of long-term diseases, mainly of lifestyle, through awareness, financial assistance and insurance provision. Similarly, since the elderly spend more days in hospital, old-age health policies or programmes should be formulated and implemented. The government should ensure that all old age persons are covered under suitable health insurance programmes. We also find regional disparity in utilisation of hospitalisation. The number of days spent in hospital is higher among the individuals from central, west, east and south Indian states than the north Indian states. This is because, the availability of health facilities in central, west, east and south Indians states is better than that in the north Indian states. However, this result
needs further investigation since availability, in isolation, always cannot enhance utilisation as accessibility and affordability are also major factors that affect utilisation behaviour.

Multinomial Logit regression results show that insurance increases the probability of availing healthcare both in the private and public sectors. The insured tend to use the private sector to a greater extent than the public sector. However, in India, the private health sector is largely unregulated and they often prescribe unnecessary care and which inflates the cost of healthcare. Therefore, on the policy perspective, it will be prudent on the part of governments to bring in a sound regulatory system for the private sector to ensure the efficient functioning of the health insurance sector for the benefit of the insured. The government should also implement educational programmes regarding the benefits of health insurance and persuade the private sector to educate their insured members holistically about their insurance products.

As far as other socio-economic and demographic variables are concerned, income is one of the important factors that significantly affect the healthcare utilisation behaviour. It has a positive sign in all the models. This implies that with the increase in income, an individual’s healthcare utilisation improves (probability of treatment seeking, hospital days spent and choice for private provider increases). These results have important equity implications as it reveals that the rich have better healthcare utilisation levels as compared to the poor. The rich can afford better quality of services in the private sector while the poor have to either compromise with low quality services in the public sector or impoverish themselves after receiving treatment in the private sector. Therefore, the government should improve the quality of service in public sector health facilities and initiate various poverty alleviation programmes.

The other significant variable that has policy implication is place of residence. It is found from the results that urbanites have better utilisation as compared to those in rural areas although both rural and urban people prefer private to public providers. However, the probability of people from urban areas using both public and private facilities is higher as compared to those from rural areas. The reason behind this disparity in utilisation can be traced to the existence of inequality in both
income and access to healthcare facilities. Most of the rural healthcare facilities are dysfunctional or ill equipped and people have to travel to the urban areas for better services. Hence, government should upgrade the healthcare facilities in rural areas by increasing health workforce and provisioning of essential drugs and equipments.

Moreover, since health insurance status leads to increase in utilisation of healthcare in private facilities over public, there is a higher possibility of incurring higher medical costs as we have discussed and face inevitable impoverishment. Hence, government should upgrade the existing public health facilities to create a competitive environment and regulates the private sector with an effective regulatory mechanism to curb induced expenditure.

7.2.3 Healthcare Financial Risk Protection: The Role Of Health Insurance

In chapter-5, we investigated the impact of health insurance on out-of-pocket payments and financial risk protection for healthcare services. Both bi-variate and econometric analyses have been used to study the impact of health insurance, along with various socio-economic variables, on the extent of OOP expenditure and probability of catastrophic expenditure and impoverishment. Econometric models such as two-part model (TPM) have been used to study the impact of health insurance on OOP expenditure while logit model has been used for probability of facing catastrophic expenditure and impoverishment.

In TPM, regression is exercised in two parts. In part-I, the probability of incurring positive OOP expenditure is calculated and, in part-II, the extent of OOP is calculated. Both part-I and part-II of TPM results show that other things remaining constant, health insurance has a statistically significant and negative impact on OOP expenditure, which implies that the likelihood of incurring positive OOP expenditure is higher among uninsured than the insured. HHs with insurance incur lower average OOP expenditure than those without insurance. Socio-economic, demographic and environmental factors such as; income, caste, religion, place of residence, educational level of the HH members, HH size, number of old persons and children, availability of toilet and separate kitchen in the HH have statistically significant impact on the OOP expenditure. With increase in HHs’ income, the expenditure on health increases since the capacity-to-pay increases with increase in income. Socially backward HH namely, SC, OBC and ST, rural HHs, and HHs with
higher number of children and old persons have higher probability of positive OOP expenditure. HH Environment plays a major role in health condition of the members and hence the probability of positive OOP expenditure. HHs with separate kitchen and toilet facility (in-house) spend less on OOP expenditure than HHs without such facilities.

We also observe a regional disparity in OOP expenditure in India. HHs from rest of India has a higher probability of incurring positive OOP expenditure than northern states. The magnitude of expenditure is higher among eastern and southern states as compared to northern states. This is because of the issue of availability, accessibility and affordability. The probability of incurring positive health expenditure is higher because of frequent occurrence of ill health due to unhealthy environment and poverty but degree of amount spent on health is less since their capacity to pay and awareness is very low.

From both the Logit models of probability of catastrophic expenditure and probability of impoverishment, we found that other things remaining constant, insurance has statistically significant negative impact on likelihood of catastrophic expenditure and impoverishment. This implies that health insurance reduces the likelihood of facing catastrophic expenditure. Some of the other independent variables that affect negatively are socio-economically better-off HHs, availability of toilet and separate kitchen in the HH, HHs from urban area, educational level of the HH members and HHs from other religion (Sikh, Christian, Jain and Buddha). The presence of higher number of children and old persons in the HH positively affects the catastrophic expenditure. Similarly, HHs belonging to socio-economically advanced HHs, from urban area, with better HH environment and with highly educated members has lower probability of experiencing impoverishment due to illness than their counterparts.

7.2.4 Healthcare Financial Risk Protection to the Poor and The Role of Rashtriya Swasthya Bima Yojana (RSBY): Evidence From Cuttack District of Odisha

The objective of any health insurance scheme/programme is to reduce healthcare cost and increase healthcare utilisation so that equity is achieved in the healthcare system. In the same way, the objective of the RSBY scheme is to provide financial protection against catastrophic inpatient expenditure and improve
utilisation of inpatient services through cashless facility at the time of use. Hence, in chapter-6, we have empirically investigated if RSBY has been able to provide enough financial security to the targeted group and made them less dependent on inefficient mechanisms like borrowings, selling of assets and other household valuable belongings to finance their health expenditure.

To investigate the above assertion, a primary survey has been conducted in two blocks of Cuttack district in Orissa. Among the 17 districts wherein RSBY is implemented, Cuttack district has been selected for three reasons. Firstly, the hospitalisation rate is around 4 percent which represents the state average of 3.9 percent. Secondly, it has an equal or nearly similar number of empanelled private and public hospitals that could be selected by beneficiaries for their hospitalisation requirements. Lastly, it ranks higher in HDI amongst all the RSBY implemented districts except behind Khurda and Jharsuguda. However, the district lags behind on many health and social indicators as compared to the national situation. Since it is positioned higher on HDI, it is expected that utilization and effectiveness of RSBY should be better. Upon selecting Cuttack district as the sampling district, a three stage sampling technique was employed to get the sample households for interview purpose. In the first stage we purposively selected two blocks. One is urban block (UB) and another as rural block (RB), where RSBY has been implemented and the coverage is the highest. In the second stage, under each block two villages has been purposively selected where coverage of RSBY is also the highest. In the last stage of sampling, we randomly selected RSBY holders from RSBY list and non-RSBY holder from BPL list.

Both quantitative as well as qualitative research techniques have been used for data collection and analysis. Information on Socio-economic and demographic characteristics of the household has been collected by using a structured questionnaire. Also, information on health status, healthcare expenditure on inpatient and outpatient care, choice of healthcare providers and its reasons, knowledge and perception about RSBY, utilisation of RSBY etc. has been probed. A case-control method of study has been undertaken to obtain information and evaluate healthcare utilisation and sources of healthcare financing, where, households with RSBY card constitute the treatment group and non-RSBY households constitute the control group. In-depth interviews were conducted with a
few inpatient cases of RSBY beneficiaries and their experiences in availing inpatient services under the RSBY scheme were noted.

The average OOP expenditure (both inpatient and outpatient) and its catastrophic impact on RSBY beneficiaries vis-a-vis non-RSBY beneficiaries has been compared. It is hypothesised that, on an average, RSBY beneficiaries will experience less catastrophic expenditure than the non-beneficiaries since RSBY provides a cashless financial benefit to its beneficiaries and hence, reduces dependence on inefficient sources of financing mechanisms such as borrowing, dis-saving, contribution from relatives, sale of assets and livestock etc.

The results from the analysis show that, on an average, an ill person with RSBY spends a lower amount on healthcare as compared to the non-beneficiaries. On the other hand, when we compare in terms of relative burden of healthcare, there is little difference between the beneficiaries and non-beneficiaries. The share of OOP expenditure to total consumption expenditure is almost equal for both beneficiaries and non-beneficiaries. Similarly, the share of OOP expenditure to non-food expenditure is almost equal for both beneficiaries and non-beneficiaries. The percentage of households facing catastrophic expenditure is higher among beneficiaries of RSBY than the non-beneficiaries irrespective of status of place of residence. In a nutshell, the effectiveness of RSBY in achieving the goal of reducing OOP expenditure and occurrence of catastrophic expenditure is questionable.

7.3 Policy Implications:

Analysis of secondary data indicates that health insurance, in general, decreases the degree of OOP spending, the probability of facing catastrophic spending and impoverishment. Hence, the recent introduction of health insurance programme by various states and central government is a welcome move. However, when we specifically examined the impact of RSBY on utilisation and financial risk protection, we found that the program has been largely ineffective. The main reason for the ineffectiveness is the lack of awareness among the insured about the usability of the scheme in terms of when, where and how to use the smart card provided under the scheme. Additionally, although the scheme is highly relevant, the scheme’s effectiveness has been constrained by its ineffective implementation at various levels. For example, the issuance of the RSBY smart card to the insured was
delayed. In addition, some of the insured were found to be provided smart card with inaccurate names, photographs and gender specification. It is observed that this could be a deliberate act to avoid higher rate of hospitalisation claims so that they can get super normal profit. From group discussions with the insured, it was found that some of the beneficiaries had to avail their card by paying fees ranging from Rs. 50 to 150 to the ASHA/Anganawadi workers. During sample household selection, some of the households we came across did not have the card even though they were listed. Many cases are found with inaccurate names, age, gender and photograph on their smart card. Hence, government should be proactive and vigilant during implementation. An independent Government-appointed nodal agency or an independent agency outside government should supervise and regulate the scheme during implementation. An interim quarterly performance audit of the insurance companies and the empanelled hospital should be done by the nodal agency or an independent agency.

On the other hand, from the beneficiaries’ point of view, the sense of ownership and receptivity is missing since the beneficiaries are not paying any premium unlike the premium that would have to be paid when purchasing health insurance products marketed by the private players. When asked about their willingness to pay for a need-based scheme (most of them prefer some form of outpatient care to be included in the scheme), a significant proportion of them replied positively. Their willingness to pay varies from Rs. 10-150 per month. Since the scheme is for the BPL families only, many people who genuinely need the scheme but do not belong to the BPL category are deprived from the benefit of the scheme. Hence, it should be universalised than targeted and should be charged some amount of premium for a comprehensive health insurance package that caters to the needs of the people. In addition, it is also well-known that the selection of BPL families is flawed with a large proportion of the needy being left out of the schemes. Our result also supports the fact that along with the poor HHs, higher income groups also face the problem of higher healthcare burden but. Hence, universalization of health insurance is essential. Moreover, under this scheme, the risk pool is comprised of the BPL population with least ability to pay. If the same scheme is extended to other populations of the society and a premium is charged, the pools will become bigger and more financially sustainable as in the case of rich
subsidizing the poor in typical health insurance. The present government willingness to roll out National Health Assurance Mission (NHAM) is a welcome move. Under this mission existing RSBY will be revamped to expand its span to make it more universal in nature. All citizens will be able to avail the benefits unlike RSBY which is mostly limited to below-poverty-line families.

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, leaving a large part of OOP expenditure not covered under the scheme. For example, in case of RSBY, we found that since the scheme does not provide the requisite benefit, beneficiaries are unwilling to use the benefit. During the in-depth interviews among the inpatient experienced households, it was found that the perception towards the scheme was overtly negative. They treat the RSBY scheme just like any other government scheme. According to them it also is a political gimmick. Some of the beneficiaries treat this scheme as a tool of vote bank politics. Some respondents also stated voice that these kinds of schemes were a government move/ploy through which it tried to bind the voters, but not to improve the quality of life through sincere effort. Some of them also termed the scheme as another government scheme which did not have any value. Hence, there is a need for rethinking on the designing and effective implementation of the scheme if the government-sponsored insurance scheme has to emerge as attractive and effective.

In this respect, provision of a universal coverage will be more effective. The present NDA government’s eagerness to revamp the present RSBY scheme under NHAM to expand its span to include universal coverage is appreciable. There is a plan by the government to offer a complete basket of services under mission. Around 50 essential medicines, a package of diagnostic services as well as around 30 alternative medicines such as ayurveda, homeopathy etc. will be included under the scheme. All citizens will be able to avail the benefits unlike RSBY which is mostly limited to below-poverty-line families.

Similarly, the private sector has increase its portfolio of health insurance schemes that targeting only middle and richer sections of the population with limited
insurance packages. They need to be innovative in designing and provisioning attractive and effective packages which cater to the needs and demands of the lower income groups. Hence, various players like government, private and non-government organisation has to play a vital role with respect to designing health insurance programmes that could cater to the needs and expectations of the large section of the population that is excluded from the traditional health insurance system.

However, most importantly, since insurance leads to moral hazard problem from both the healthcare provider and consumer side, with the former being more prominent and dangerous than the latter case, the consumer may end up with a higher OOP expenditure which is undesirable. Therefore, government must pay attention to this issue through a better regulatory framework in place to curb unnecessary healthcare consumption driven by providers.

Apart from the health insurance variable, various socio-economic variables such as income, place of residence, caste, gender, household environment and types of diseases are found to be statistically significant in utilization of healthcare and health expenditure. So, government should bridge the gap in the social and economic spheres by the provisioning of effective employment and income transfers to needy sections. Also, the government should increase awareness about the benefits of better household environment and also encourage and facilitate better water and sanitation facilities to curtail ill-health and its associated cost. There is also a need for gender equality in access to healthcare through gender sensitive health policies.

In conclusion, health insurance should be promoted by both the government and private sectors through innovative packages that cater to the needs of the masses. Most importantly, private players and government should educate the people about the benefits of health insurance. Government health insurance programmes will succeed if the government upgrades the existing health facilities and regulates the private sector with an effective regulatory mechanism failing which, people will choose private over public sector healthcare providers, bear higher medical costs and face inevitable impoverishment.


7.4 Limitations of the Study and Scope for Further Research:

The main limitation of the study is the use of secondary data (IHDS, 2004-05) which is quite dated. During that period the penetration of health insurance was very low accounting for only around 3 percent of the total population, whereas it is around 25 percent in 2011 due to huge government intervention and activities of the private sector. However, IHDS is the only nationally representative available data source which provides information on health insurance and other required information that the study could utilize. The data only provides information of persons/households that are covered under any health insurance scheme. It doesn’t provide any information on what type of health insurance (voluntary/compulsory) is availed. Therefore, this study assumed the possession of health insurance as exogenous, which is a very strong assumption though. Moreover, most of the health insurance holders are formal sector employees. Irrespective of their occupation in formal government and private jobs, the possession of health insurance was generally mandatory in nature. Other type of health insurance such as community-based schemes also provided health insurance on a mandatory basis to the customers who were affiliated to them. As far as private voluntary health is concerned, its penetration was very limited.

Also, the data also doesn’t provide information if the insurance scheme is a government or private provided scheme. Hence, we couldn’t bring any empirical evidence or support regarding the kind of health insurance which was better placed to cater to the problem of catastrophic expenditure and under-utilisation of healthcare services. Therefore, in the near future, if government data collection agencies such as NSSO could collect information on these aspects it will be useful for researchers to undertake better analysis and offer well-tested policy suggestions.

Nonetheless, we have conducted a primary survey taking a large scale government health insurance scheme (RSBY) that has been implemented recently in most parts of India as a case study. We conducted the survey only in two blocks of Cuttack district of Odisha. We employed a case-control method for the study with limited sample size of about 200 households (100 HHs each for treatment and controlled groups) to examine the differences in health seeking behaviour and financial risk protection. A similar study can be replicated for a large sample covering all the RSBY implemented districts for state analysis and all the RSBY
implemented states for analysis of the country as a whole. The most effective way of evaluating any scheme is through difference in difference method using longitudinal data which is lacking in India. Future studies can take care of the above limitations and make use of better data (if available) to replicate the study for better policy implications.