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COMPREHENSIVE HEALTH INSURANCE SCHEME AND FACTORS ASSOCIATED WITH HEALTH CARE UTILIZATION: A CASE STUDY AMONG INSURED HOUSEHOLDS IN KERALA

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ABSTRACT

Background: to protect the people from high economic cost of illness and providing financial protection at the time of hospitalization, government of Kerala introduced a unique health insurance scheme in 2008. This study is trying to explore the utilization among insured people and the problems regarding the utilization.

Objectives; to assess the role of CHIS and health care utilization among insured households in Kerala

Methods: ***Explanatory -Case study method***. Both quantitative and qualitative methods used to track the objectives. A community based cross sectional survey conducted among 150 insured households supplemented with qualitative data obtained from in-depth interviews and key informants interviews.

Results: Majority of the respondents were females and 97.4% from BPL families. Main source of income of 40% households were from daily wages and don't have any other formal insurance coverage. About 30.4% people utilized the service. People have positive attitude towards the scheme and wants to expand the coverage to out- patient's care also. Many eligible members exempted because of coverage limit.

Conclusion: Poor people were benefited through the scheme but delay in settling of claims. Empanelled Government hospitals should expand the facilities and improve the quality to attract more people in to public health system.

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INTRODUCTION

Political promises have underlined the link between coverage with essential health services and financial risk protection, and translating these promises into a reality at country level is not a simple task. Although the right to health and social security is well established in the constitution, many times government of India failed to provide these rights to millions of citizens mainly because of insufficient public health funds (Steven, 2005; NCMH, 2007; WHO, 2010). Good health is essential to sustained economic and social development and poverty reduction. Access to needed health services is crucial for maintaining and improving health. At the same time, people need to be protected from being pushed into poverty because of the cost of health care (World Bank, 2013). Financing is the most critical of all determinants of a health system. There are many ways to promote and sustain health of the citizens. But timely access to health care is a critical issue in developing as well as developed countries (National Commission on Macroeconomics and Health, 2005; Planning Commission, 2005; Berman and Ahuja, 2008; Planning Commission report, 2008; MoHFW, 2009). The World Health Assembly resolution 2005 says "everyone should be able to access health services and not be subject to financial hardship in doing so". Recognizing this WHO committed to develop health financing systems to all member countries, so that all people have to access to services and do not suffer from financial hardships paying for them. This goal was defines as universal coverage or universal health coverage (WHO, 2005). Universal coverage incorporates two different dimensions: health care coverage (adequate health care) and population coverage (health care for all). The concept behind health financing policy is towards universal coverage is that of society risk pooling. Through this risk pooling each individual sharing the financial risk of total health care costs. So the larger the degree of risk pooling the less people will have to bear the financial consequences of their own health risks, and the more they are likely to have the access of health care they need (WHO, 2005; WHO, 2004; Aden Wagstaff, 2007; Carrin, 2002; Paul, 1998; Germen Health Insurance System, 2002). Equity has been considered as an important issue in health sector. Yet an

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inequality between the poor and the better off persists in almost all developing countries (WHO, 2005; The Hindu, 2010). Insufficient public health spending, high out of pocket payments and lack of comprehensive risk pooling mechanism etc raises health care costs and affecting the equity in health financing of India (The Hindu, 2010; Hsiao, 2008). NHA 2010 reported that the main financer of health services in India is the individual households and they meet about 70% of the total health care costs by out of pocket payments at the time of illness[19-20].Government sponsored Health insurance is a health care financing method expected to protect people from economic burden of diseases and attract more people to public health system.

MATERIALS AND METHODS

A case study conducted in one of the rural districts in Kerala has limited number of public and private facilities. Targeted families for CHIS coverage in the district are 118729 and enrollment status is 92936. One block panchayath and 1 Grama panchayath selected conveniently and 1ward randomly selected from the panchayth. Total insured household number was 156, and 2 households were excluded because of non availability of members for interview and 4 household data was not complete. Finally150 households (620 members) were participated in the survey. The result of the study follows:

RESULTS

Table 1. Socio demographic characteristics of the Household Survey

No	Socio-demographic Variables	Frequency	Percentage
1	Sex		
	Male	46	30.7%
	Female	104	69.3%
2	Residence		
	Urban	13	8.7%
	Rural	137	91.3%
3	Age		
	<18	0	0%
	19-25	1	.7%
	26-45	24	16.0%
	46-55	57	38.0%
	56-65	40	26.7%
	>66	28	18.7%
4	Income status		
	APL family	4	2.6%
	BPL Family	146	97.4%
5	Main source of income		
	Government Employment	5	3.3%
	Private Employment	16	10.7%
	Self Employment	11	7.3%
	Farming	45	30.0%
	Business	7	4.7%
	Pension	3	2.0%
	Bank investment	2	1.3%
	Other works(daily wages)	61	40.7%
6	Economic Dependence		
	Fully Independent	89	59.3
	Partially dependent	52	34.7
	Fully dependent	9	6.0
7	House ownership		
	Own	142	94.7
	Rented	8	5.3
8	Living arrangement		
	Alone	4	2.7%
	With spouse	10	6.7%
	With spouse and children	123	82.0%
	With children	12	8.0%
	With grand children	1	.7%
9	Persons supporting		
	Spouse	80	53.3%
	Children	61	40.7%
	Parents	6	4.0%
	Grandchildren	3	2.0%
10	Educational status		
	<1	3	2.0%
	1-5	34	22.7%
	6-10	84	57.3%
	11-12	25	16.7%
	>12	2	1.3%

The CHIS utilization, Awareness about the services under the scheme and reasons for enrollment in the scheme etc was the main objectives of the household survey and the result are given in Table 2 and table 3.

Table 2. Reasons for Enrolling in Comprehensive Health Insurance Scheme

Reasons	Frequency (n=150 households)	Percentage
We are poor so we can't afford hospital expenses when we are sick	20	13.3%
Family members had chronic diseases so we need financial assistance	43	28.3%
No other form of insurance to give protection from hospital expenses	12	8.0%
Compulsion from Kudumbasree members	7	5.1%
In the future my family may need money for treatment	68	45.3%

Table 3. CHIS utilization among insured households- results of household survey

Variables	Frequency (N=150 households)	Percentage
At least one person in the house have chronic illness	51	34.0
Had History of cardiac problems	20	13.3%
Had History of diabetes	19	12.7%
Utilized smart card for hospitalization (at least once) since last one year	63	42.0%
No other forms of health insurance coverage	137	91.3%
Cost of health care is high so some financing mechanism is needed	77	51.3%
The CHIS coverage is not enough	86	57.3%
Information on CHIS through Kudumbasree	146	97.3%
Awareness about the services available under CHIS	47	31.3%
Outpatient coverage also must be included in the scheme	132	88%
Awareness about CHIS Plus scheme	12	8%

The concept behind the scheme is financial protection and rational choice. Many respondents complained about the delay in settling claims and quality of health care received and provider choice.

Results of in- depth interviews

Seven in-depth interviews done on randomly selected kudumbasree members and their families. The results of interviews are giving below. Majority about 97% of the families were enrolled through kudumbasree and the information regarding the CHIS was explained in the regular meetings. But members faced problems of getting cards.

Delay in enrollment and getting card

"*I went several times to take the photo with my family members, sometimes the photographer was not there. Sometimes overcrowded and asked us to come on another day. After few days our photos taken and finally got the smart card" (Female, housewife, 62yrs)".*

Eligible members were exempted

"*I went with my family, husband and two sons. But many times photo was not taken and finally two children were excluded from the list because they were in the school and photos were not taken" (Female, self employed, 45yrs).*

"We are six members in the family, but only five people were permitted to enroll .so my elder son is not insured. Government should expand the coverage to all people in the family" (Female, housewife, 46yrs)".

Reasons for enrolling

"My wife is in kudumasree group. We got the information from the secretary of the group and she asked us to enroll in the scheme. We only two people in the family and both are suffering with hypertension and diabetes and we need medicines daily. My pension is not enough to cover household expenses and medicine charges. If some serious problems coming we don't have money to go to hospital. So we took this insurance scheme (Male, pensioner 68 years)"

Majority of the respondents who utilized the scheme were complained about the delay in settling claims and transportation charges and quality of services availed. Respondents reported that there is no other choice of hospitals so they used public facility.

Provider choice is limited

"My husband had chest pain and his BP was very high and admitted in the hospital, we used the smart card. We purchased many medicines from outside pharmacy and bill given to CHIS room. It takes more than 6 months to get back the money. It was not possible to use the card in the nearby private hospitals so we adjusted in the government hospital general ward. It was overcrowded and dirty (Female, housewife, 55 yrs").

Delay of getting funds

"Hospital people were supporting When I was admitted in the hospital with asthma insurance counter people told me that I will get 100 Rs for transportation .I spend more than 200/ Rs to get that 100/ Rs- going many times to counter to check the amount reached or not". Finally one day they called me by phone and asked to come and collect the cheque" (Male, Coolly, 60yrs).

CHIS Reduces financial burden

"My wife had a history of fall and fracture of thigh bone. Surgery done and we spend more than 50,000/Rs, including borrowing from private chits person and a gold loan. I got the insurance amount. Even if it is not enough to cover the full expenses it was a relief at that time (Male, private employee, 48yrs)".

Key informants were selected from the empanelled hospitals and officials of nodal agency and insurance scheme.

Results of Key informant's interview

"Policy of the government is good. But we don't know how to manage without money. A huge amount of claim is pending, and we are struggling to pay the money to purchasers. Incentives to staffs etc. Many challenges related to issue of smart card also. (Administrative officer, nodal agency)".

"When I am hearing the name of CHIS I am in tension. There should be enough money for day to day activities. Large amount of claims are not settled and patients always complain about the delay. If a small amount is released from government we have to settle the bills of pharmacies, laboratories etc (Medical superintend hospital2)."

"Everyday people are coming and asking for money. Sometimes I am feeling very sorry for the delay of giving money for poor people. At least their transportation cost (100/Rs) is possible to give on time I am happy. But it is not happening because of delay in releasing money from government (PRO, Hospital 3").

DISCUSSION

According to economic analysis report 2013, Indian economy is showing positive trends but the gap between affluent and non affluent is widening within the country. The problem of high out of pocket payment will not reduce with rising income, rather an effective pooling and financial risk protection is needed. Health policy makers in developing countries are always looking for and how to develop a mechanism to protect poor from high economic cost of illness. Government of India tried various demand side mechanisms to protect poor and vulnerable people since 1945. But only few percentage of the population were benefited through government schemes and there was huge inequality in health exists between states. Demand side financing focus on financing function either from government or contribution from employees and mediated by an insurer. Health care can be from either government or private providers. It creates the freedom for consumers to make a rational choice between providers[22-23].But this study results showed that the number of empanelled hospitals are limited and respondents preferred government facilities so the concept of rational choice and quality health care is questionable.

Even if the education status and health awareness is high in Kerala, the attitude of APL (above poverty line) families towards the scheme is not encouraging. A similar study conducted in Thiruvanathapuaram district among insured and uninsured households of BPL families reported that health service utilization is increasing but the out of pocket spending is not reducing through the scheme[24]. One of the main issue raised through group discussion was many households have had the history of at least one chronic patient in the family who needs continuous medication and frequent follow up. But

the expenses of Outpatient care were not included in the insurance scheme, and creating financial barrier to seek heath care when they are in need. Previous Studies reported that households per capita out of pocket expenditure increased significantly during last five years and it is mainly due to hospitalization expenses. So rising precipitate health spending associated with increase in catastrophic payments reported by many studies. This clearly indicates the need for a sustainable financing mechanism to protect poor people especially those who are suffering from chronic diseases for their outpatient coverage also. The adherent problems of health insurance are adverse selection and moral hazards are noticed in this scheme also. But previous studies showed that the average hospital utilization days and hospital expenses are less compared to other health insurance schemes.

Target oriented approaches (BPL Population) become a failure in many states. The major reason is identification of real beneficiaries is a difficult task. This study also noticed the same issue. It is encouraging to see the active role of kudumbasree and ASHA workers for the successful implementation of the scheme. The involvement of female is more mainly because of kudumbasree units and their contribution is appreciable in rural villages of Kerala. The government can expand many micro financing schemes through kudumbasree units. The in-depth interviews and key informants interviews revealed the fact that there is delay in settling claims and hospital authorities are complaining that they are facing problems to settle the due amount of pharmacies and labs outside the system. Because of large amount of claim is pending from the government side and many private providers are withdrawing the services. The study revealed the fact that the scheme is facing some implementation challenges and needs more attention. Majority of the respondents are optimistic and have positive attitude towards the scheme. Government and policy makers have to take necessary steps and concerted effort is needed for the successful implementation of the scheme and sustainability should be maintained.

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