Health and Health Care Utilization in India: Role of Health Insurance

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Extended Abstract

1. Background

In India, the patterns of disease are shifting predominantly form disease of poverty like communicable, neonatal and maternal illness to the disease related to affluence, aging, cardiovascular, cancers, HIV, injuries etc (Crook 1996, Murray 1996). In response to these changes, health care is in transition and private health care sector is growing rapidly. With the technological development and modernization in the medical sector, new technologies evolve to combat various illnesses or accidents, and treatments associated with these new technologies typically involve a prolonged hospital stay, expensive procedures and drugs and a long period of recuperation.

In recent times, there has been a growing concern with the increasing cost of health services and the existing mechanisms for financing health care costs. Like other developing countries, in India, the Ministry of Finance seems to undervalue health development particularly for the rural and tribal population because all modern health facilities are getting concentrated in the urban areas. As a result, for health service development, tax collection increasing beyond the limits seems to be critical option for the government (Green 1992). In such a situation, a significant viewpoint has emerged to manage the problem. Taxing the poor most heavily to pay for the health for all may be better than making the sick for the sick, but it is hardly in the line with health for all policies, which identify poverty as major cause of ill health. It would be shocking to advocate making the poor still poorer by taxation (Abel-Smith 1986). The triumph over such complexity of taxation in relation to improve health status and quality of life of the people, health insurance emerges as a potentially better option. For the

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reason that health insurance offers a means of obtaining a substantial part of the funds for urban health services from employers and employees, so that the government can release tax based revenue for preventive and promotive actions for primary health care where coverage is very inadequate and totally absent especially in remote rural and tribal areas.

The present paper tries to address the importance of health insurance for equitable health care utilization, and whether health insurance can be a healthy option for health care financing. Before entering into analytical part of the study, scenario of existing health insurance schemes as a risk-pooling mechanism has been portrayed. With the help of secondary dataset of National Sample Survey (NSS 2004, 60th round) and World Health Survey (WHS 2003), morbidity pattern, extent of health care service utilization and associated health care cost have been analyzed for India as a whole and for selected states. It is further investigated whether health insurance status makes any difference in healthcare utilization.

2. Health and health care utilization

It is very difficult to provide a single parameter that completely defines or describes the human health. Health, which is a combination of physical, mental as well as social health, is measured in various ways depending upon the nature and requirement of the study. For the present study, estimates on prevalence of morbidity are used and obtained from the National Sample Survey data. The survey termed it Proportion of Ailing Persons (PAP), measured as the number of persons reporting ailment during a 15-day period per 1000 persons for some broad age-groups. The PAPs are found to be higher for children and much higher for the higher age groups – the lowest being the PAPs for the youth (age 15-29 years). At the national level, 12 to 15 percent of persons in the age group 45-59 reported ailments, the proportion was as high as 28 and 37 percent for the persons aged 60 years and above in rural and urban areas, respectively (NSSO 2004). Similar picture is depicted at the state level also.

There exist wide inter-state variations in PAP in both rural and urban areas. The states with relatively high morbidity reporting in the rural areas also reported high morbidity in the urban areas. In fact, in both rural and urban areas, the states of Kerala, Punjab, West Bengal and Andhra Pradesh were at one extreme reporting high levels of morbidity, while at the other extreme were Jharkhand, Uttaranchal, Bihar and Rajasthan with low levels of morbidity reporting.

It is seen that the percentage of ailments treated by government sources was reported to be nearly 20 percent in both rural as well as urban areas of the states of Madhya Pradesh, West Bengal and also at the national level. On the other hand, despite high treatment cost people in these two states and also at the aggregate level, more than three-fourth of the ailments was treated by private sources.

Persons who are ailing do not always get their ailments medically treated and sometimes resort to self-medication, home remedies or no medical care. Regarding the untreated spells of ailments, it is seen that, in the current round of survey as well as in the previous survey, the reason most often cited for no treatment was that the ailment was 'not serious'. This reason as reported by 32 percent and 50 percent of the cases of untreated ailments in the rural and urban areas, respectively. In the 52nd round, this reason accounted for about 50 to 60 percent of the cases of untreated ailment. The proportion is found to have come down considerably in the rural areas since 1995-96, pointing to an increase in health consciousness among rural households. The 'financial problem' was next in importance as a reason for no treatment, accounting for 28 percent and 20 percent of the untreated ailments in the rural and urban areas, respectively.

3. Health expenditure, health insurance and health care utilization

Health subsidies are not particularly well targeted to the poor in India, especially those living in rural areas. The household expenditure on health accounts for a major share of about 70-80 percent of the total health expenditure in India. Rural households in India bear the maximum burden as they account for about 85 percent of the total household expenditure on health (Sanyal 1996). The lack of appropriate and consistent information on out-of-pocket expenditure is found to be the prime reason for the exclusion of this important category from the health policy planning in India (Selvaraju 2000). The World Health Survey collected data on household expenditure on various services of health during the last one month. According to the WHS, household spending on health increased at higher income quintiles. In West Bengal, the highest income group spends over two times more on health than the lowest income quintiles.

The scarcity of relevant data in India restricts us to understand the relationship between the two fact- having any health insurance and utilization of health care services. Despite that, an attempt has been made to visualize the issue with the help of available data of

WHS. The survey asked questions to women in the ages 18-49 about maternal and child health care services availed for births during the five years prior to the survey. In the state of West Bengal, while all insured women[3] received antenatal care[4] and delivery care[5], only about 60 percent of uninsured women received antenatal care and 40 percent of uninsured women received delivery care. At all India level, while 65 percent of insured women received antenatal care, and 61 percent of insured women received delivery care, the percentages reduces to only about 48 and 34 in case of uninsured women. Discrepancy in utilization of child health care is also visible from the fact that, while 46 percent and 37 percent of children from insured household received DPT 3 immunization and measles immunization respectively, the percentages are much lower (22 percent and 15 percent) among children of uninsured household. In aggregate level, such discrepancy in child immunization among the insured and uninsured children is less pronounced.

4. Summary and Conclusion

Out-of-pocket-expenditure accounts for the largest component of total household health expenditure in the country, indicating the inadequacy of public spending and financing health care. The growing reliance on private curative health care even by the poorer people indicates the inability of the state system to cope with the requirements and points to the disturbing possibility that in future even more people will be denied health care because of their inability to pay. There is a need to enhance the effective utilization of existing resources and simultaneously to think of various ways of augmenting such resources. The findings indicate that a majority of households with catastrophic health spending are concentrated in low income deciles and that clearly point towards a higher burden of health spending for the poor households. More than three-fourth of the ailments in these two states and also at the national level are treated by private sources despite higher treatment cost compared to government sources. Findings reveal that in India and all the selected States, insurance coverage is very low and restricted to people of higher income quintiles. Although, regression analysis indicates households having any health insurance scheme tend to utilize health care services more compared to those without any health insurance, the paper recommends few

[3] Women belonging to household having any sort of health insurance scheme (mandatory or voluntary)
[4] Three times pregnancy check up and blood pressure measurement or testing of blood sample or complications in pregnancy.
[5] Care for delivery received at the hospital or maternity house and other type of health facility (attended by specialist such as gynaecologist, obstetrician, surgeon etc).

mechanisms how best the health care services can be offered to the poorer section of the society.