HEALTH INSURANCE IN KERALA-AN ANALYSIS OF RSBY

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ABSTRACT

Provision of health care has a cost component. Financing of health care is concerned with the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively in the health system (WHO, 2000). This is met by several groups that include the central government, state government, local bodies, private or voluntary organizations, insurance companies and the affected individual himself. The delivery of health care is a major cost for all developed countries and total health care expenditure is continuing to grow rapidly in most countries, both in real terms and as a percentage of GDP. One of the universal and economic tools to meet up challenges emerging due to health issues is Health Insurance. Health insurance is an insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons. This study attempts to explore the RSBY insurance scheme which was implemented in Kerala as CHIS and its various dimensions from the experience of State of Kerala

KEYWORDS

CHIS, coverage, health Insurance, health utilization, out-of-pocket expenses, RSBY

INTRODUCTION

Around the world, a huge number of individuals are driven into neediness consistently because of medical services expenses. Improving wellbeing is essential to human government assistance and financial development. This was perceived by the Alma-Ata Declaration many years ago in 1978 and by the World Health Organisation (WHO) in 2005. WHO encouraged nations to build up their wellbeing financing frameworks to accomplish Universal Health Care.UHC has arisen as one of the significant wellbeing financing ideas in this decade, and the World Health Organization (WHO) asked nations to build up their heath care frameworks around UHC.WHO set forward social health insurance (SHI) as a methodology for accomplishing UHC in low-and middle income countries. In the previous 20 years, a considerable lot of these nations have picked SHI plans, and in India additionally, there was a push for health care coverage by National Health Policy 2002. The initial move toward SHI was started by the presentation of the Universal Health Insurance scheme in 2003. Subsequently, in 2008, the Ministry of Labour and Employment, Government of India (GOI), presented a health insurance scheme named Rashtriya Swasthya Bima Yojna (RSBY)

RASHTRIYA SWASTHYA BIMA YOJNA

RSBY is a plan for below poverty line (BPL) families as characterized by the Planning Commission, GOI. The primary target of the scheme is giving monetary security to hospitalization-related costs to BPL families. For a yearly enlistment charge of INR 30, a BPL family of up to 5 individuals gets a biometric-empowered smart card and a yearly inclusion of up to INR 30 000 for hospitalization-related costs across both private and public RSBY empanelled emergency hospitals. The government has fixed bundle rates for the hospitals for various intercessions. This cashless scheme covers only pre existing conditions, and there is no age limit.

The premium is set through a competitive bidding between public and private insurance companies. The scheme is implemented voluntarily by the state governments, and they contribute 25% of the premium; the remaining 75% is borne by the GOI. The Government of Kerala has extended the benefits of RSBY to above-poverty-line households and introduced the scheme as the Comprehensive Health Insurance Scheme (CHIS) on October 2, 2008, with a slight modification in premium.

With the current shift from public health care delivery system to insurance and the increased demand for health insurance as a health financing option, there is an emerging need for a comprehensive

exploration of the RSBY scheme. The draft National Health Policy 2015 by the GOI recommends transformation of the health sector based fully on insurance through the UHC program.

In this context, it is very important to look at the utilization of health care services and out-of-pocket (OOP) expenses incurred by the beneficiaries of the existing insurance schemes such as RSBY and CHIS. But there are no published studies assessing the impact of CHIS on the same.

Therefore, this study attempts to (a) compare the socio demographic and health utilization pattern (outpatient and inpatient services) of below-poverty-line (BPL) households insured under CHIS, (b) examine the OOP expenses for inpatient services).

METHODOLOGY

A comparative cross-sectional survey of 149 insured and 147 uninsured BPL households was conducted in Kozhikode district of Kerala. The Kozhikode district had 34 empanelled hospitals under RSBY in 2019

SAMPLE SIZE AND SAMPLE SELECTION

Taking the hospitalization rate among the uninsured BPL households as 7% and that among the insured as 19% (utilization rate of the insurance in the state of Kerala), the sample size arrived at was 276, with 95% confidence intervals (CIs) and 20% precision the final sample size was 300 BPL households—that is, 150 insured and 150 uninsured. A 3-stage random sampling technique was adopted to select the participants.

DATA COLLECTION

A 3-stage sampling technique was adopted to select the participants. The stages were selection of panchayats (local self-government at the village), selection of wards (subdivisions of panchayats), and selection of participants. From the list of panchayats, 2 were randomly selected. From each selected panchayat, 3 wards were randomly selected. House listing of the BPL households in these 6 wards was performed to create sampling frames separately for the insured and uninsured house- holds. A total of 25 insured and 25 uninsured households were randomly selected from the respective sampling frames. Every third household in the sampling frames was selected, and if the house was closed or the member was not available, then the household was visited one more time. If the attempt was unsuccessful, then the household was replaced with the next third household.

RESULTS

A total of 149 insured and 147 uninsured households, with 667 and 578 members, respectively, were included in the study. Table 1 shows the basic characteristics of the insured and uninsured households.

COVERAGE OF RSBY

The overall mean ± standard deviation (SD) age of the sample was 33.0 ± 18.2 years. There was no significant difference between the mean age of insured (33.5 years) and uninsured (32.4 years) participants; P = .267. The overall mean ± SD household size was 4.2 ± 1.8 members. There was a significant difference in the mean household size of insured (4.4) and uninsured (3.96) partici- pants; P = .027. Of the 667 individuals in the insured households, 513 (76.9%) were insured under CHIS. The uninsured families had very poor socioeconomic status as compared with the insured BPL families (odds ratio [OR] = 2.95; 95% CI = 1.74-5.03). The remaining 154 individuals who were not insured under CHIS did not directly benefit from the scheme, so they were not included in the comparative analysis (Table 1).

HEALTH CARE UTILIZATION

The overall utilization of outpatient and inpatient services was 29.1% and 38.5%, respectively. The utilization of outpatient services was not significantly different in the insured (31.5%) and uninsured (26.5%) households; P = .342. The inpatient service utilization was significantly different (insured, 44.3%; uninsured, 32.7%) with a P value of .04. Insured participants had higher inpatient service utilization (OR = 1.57; 95% CI = 1.05-2.34). Insurance status was found to be a significant correlate for inpatient service utilization after adjusting for age, sex, and chronic diseases

OOP EXPENSES ASSOCIATED WITH INPATIENT SERVICE

The mean OOP expenses for inpatient services among insured participants (INR 448.95) was significantly higher than that of the uninsured households (INR 159.93); P = .003. About 79% of the hospitalized households used one or more distress financing mechanisms such as unsecured loans, gold loans, sale of assets, assistance/gift, mortgage of assets, and mortgage of land to meet the expenses associated with hospitalization. It was found that 59.7% of the hospitalization was not covered by RSBY in the insured households.

Table 1. Sample Characteristics.

Variables	Insured, n (%)	Uninsured, n (%)	*P* Value
Household size (members)			
□2	16 (10.7)	25 (17)	.006
3-4	71 (47.7)	86 (58.5)	
>4	62 (41.6)	36 (25.5)	
Occupation of head of household			
Clerical/Self-employed	24 (16.1)	12 (8.2)	.002
Unskilled laborer	94 (63.1)	79 (53.7)	
Unemployed	31 (20.8)	86 (38.1)	
Household income (INR/per month)	48 (32.2)	82 (55.8)	<.001
□900			
901-1200	28 (18.8)	32 (21.8)	
1201-1900	21 (14.1)	9 (6.1)	
>1900	52 (34.9)	24 (16.3)	
Religion			
Hindu	72 (48.3)	73 (49.7)	.533
Muslim	15 (10.1)	20 (13.6)	
Christian	62 (41.6)	54 (36.7)	
Caste			
SC/ST	50 (33.6)	43 (29.3)	.353
OBC	90 (60.4)	99 (67.3)	
Others	9 (6)	5 (3.4)	
Type of house			
Pucca	38 (25.5)	19 (12.9)	.005
Semi-*pucca*	71 (47.7)	67 (45.6)	
Kutcha	40 (26.8)	61 (41.5)	
Age (years)			
0-5	6 (1.2)	30 (5.2)	<.001
6-15	66 (12.9)	90 (15.6)	
16-45	270 (52.6)	317 (54.8)	
>45	171 (33.3)	141 (24.4)	
Sex			
Male	246 (48)	270 (46.7)	.305
Female	267 (52)	308 (53.3)	
Years of schooling (excluding <7-year-old child)			
No formal schooling	102 (20.3)	94 (17.7)	.011
Up to 7	146 (29.1)	215 (40.4)	
7-10	174 (34.2)	156 (29.3)	
>10	80 (15.9)	67 (12.6)	
Marital status			
Single	178 (34.7)	211 (36.5)	.143
Married	302 (58.9)	316 (54.7)	
Widow/Separated	33 (6.4)	51 (8.8)	

Occupation			
Unskilled laborer	156 (30.4)	163 (28.2)	.323
Homemaker	102 (19.9)	120 (20.8)	
Clerical/Self-employed	31 (6)	22 (3.8)	
Unemployed	106 (20.7)	120 (20.8)	

Table 1. (continued)

Variables	Insured, n (%)	Uninsured, n (%)	*P* Value
Inpatient service utilization			
No	42 (28.2)	61 (41.5)	.016
Yes	107 (71.8)	86 (58.5)	
Chronic diseases			
No	53 (35.6)	64 (43.5)	.191
Yes	96 (64.4)	83 (56.5)	
Understanding regarding insurance			
Unaware	29 (19.5)	45 (30.6)	.038
Slightly aware	65 (43.6)	64 (43.5)	
Fully aware	55 (36.9)	38 (25.9)	
Types of insurance aware of			
Only health insurance	80 (53.7)	79 (53.7)	.190
LIC, vehicle insurance	69 (46.3)	68 (46.3)	

DISCUSSION

This is one of the initial studies from Kerala looking at the utilization and OOP expenses of CHIS. It was an attempt to determine whether the whole BPL population in Kerala was covered under the health risk protection umbrella of CHIS and its impact on the health service utilization and reduction in OOP expenses for the poor.

COVERAGE OF CHIS

The population coverage of CHIS or RSBY is not 100% among the BPL even in the state of Kerala, which has the highest literacy rate and health indicators. The present study found that CHIS failed to insure poorer BPL families. The existing literature on government-sponsored health insurance schemes (GSHIS) for the poor also states that the neediest in the target population are excluded in most of the cases. The major factors associated with poor coverage of the insurance scheme were lack of awareness among the members of the community about the scheme/benefits and political will. In this study also, uninsured participants reported that the major reason for not being insured was unawareness about the scheme and enrolment dates. It was also seen that the insured households had more number of people with chronic diseases, suggesting adverse selection from the point of view of an insurer, an expected phenomenon in a voluntary health insurance scheme.

HEALTH CARE UTILIZATION

The insured and uninsured had similar outpatient care utilization because CHIS only covered inpatient care. It has increased inpatient utilization in the insured, which is consistent with the results of studies on GSHISs in Vietnam, Mexico, Colombia, and India. In this study, the uninsured were much poorer compared with the insured households. This could be the reason why there were not many hospitalizations among the uninsured households because they were unable to seek care because of financial barriers. Even though CHIS increased hospitalization in the insured, only 40% of the hospitalization was covered by insurance during the study period.

OOP EXPENSES ASSOCIATED WITH INPATIENT SERVICE

CHIS or RSBY did not reduce OOP spending during hospitalization among the insured, in contrast to the findings of many other studies—for example, from Vietnam and also a systematic review by Spaan

et al from Asia and Africa. These studies found that insurance reduced OOP expenses.18-23 Our finding might be a result of the limited service coverage, high prevalence of chronic diseases in Kerala, lack of drug coverage by insurance, and the belief that insurance will cover the other expenses. The other reason for this is the fact that 60% of the hospitalizations among the insured households were not covered by CHIS. They were either uninsured from the insured households or they could not use the card. The main reasons for not making use of the card were lack of knowledge regarding the list of empanelled hospitals/benefit package, referral from an empanelled hospital to an non empanelled hospital, refusal from the empanelled hospital to accept the card, smart card reading machine not working in the hospital, and diagnosed case not covered under CHIS if costs were more than INR 30 000.

The study has all the limitations of a cross-sectional survey. Also, this study measured self- reported expenses, which can lead to over- or underestimation because of recall bias.

CONCLUSIONS

With the increased focus on achieving UHC through improved population coverage and financial risk protection, this study provides an insight into the extent to which these 2 dimensions of UHC are achieved through CHIS in Kerala. The major objective of CHIS/RSBY—protecting poor people from financial catastrophe—was not achieved by the scheme. Even though CHIS has increased the utilization of health care services, it did not enrol the poorest households among BPL. Both these findings have huge policy implications. The study findings suggest the urgent need for rigorous measures to increase awareness about insurance among the beneficiary population and pro- vide complete information regarding various benefits under the scheme and how to use the scheme to enrol more needy and poor families for whom the scheme is intended. It also suggests the need to provide a list of empanelled hospitals and services provided under CHIS along with the smart card to reduce faulty rejections and, thus, unnecessary expenses of insured households. The findings also suggest the need for implementation of a feedback mechanism from the smart card users to ensure that they receive complete and quality care and to confirm that the money deducted is in accordance with the treatment given.

In conclusion, the findings of this study call for urgent attention by the government to redesign and closely monitor the scheme. More comprehensive studies on the impact of the insurance schemes on risk protection are needed.

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