Keeping the ‘Health’ in Health Insurance

SAPNA DESAI

The Rashtriya Swasthya Bima Yojna and National Rural Health Mission have the potential to transform the health and financial security of poor households. The experience of VimoSEWA indicates that health insurance must be firmly linked to an effective public health system. A high percentage of claims for preventable illness, unnecessary expenditure on medicines, increasing hysterectomies and inequitable claims patterns are four trends that are likely to be seen in the implementation of RSBY. To ensure that health insurance plays its intended role, appropriate investment in prevention, particularly in water and sanitation, as also, community involvement and a strengthened public sector are essential.

Ilness is a leading cause of household financial crisis in India. Visit any slum or a village and a familiar story will emerge: a landless worker indebted for 10 years to pay for a child's kidney operation; a family that sold its land to obtain private treatment for tuberculosis; or a young girl withdrawn from school to help care for a parent with cancer. A range of more systematic assessments confirms this basic story.1

In principle, Indians can access subsidised health services provided by a public sector with extensive coverage. However, by almost any account, public sector health facilities offer care of poor quality, characterised by long waiting times, high rates of absenteeism among medical personnel, particularly in primary care facilities in rural areas, and unavailability of drugs (Garg and Karan 2009; Mahal 2002). This state of affairs has forced a large majority to depend on the private sector, mostly in the form of out of pocket spending that accounts for more than 70% of all health spending in India (National Commission on Macroeconomics and Health 2005).

Two recent government initiatives seek to shift this burden away from households. First, the National Rural Health Mission (NRHM) introduced in 2006, has sought to increase public health spending to improve the health infrastructure, strengthen human resources and decentralise the delivery of healthcare services, primarily in the public health sector in rural areas. Second, in 2008, the ministry of labour announced the Rashtriya Swasthya Bima Yojna (RSBY), a healthcare benefits package that covers up to Rs 30,000 for hospitalisation-related expenses for families that hold below poverty line (BPL) cards. The goal is to extend coverage under RSBY to all workers in the unorganised sector, under the Unorganised Workers Social Security Act.

These two programmes have the potential of transforming poor households' health and financial security. They (as also water and sanitation programmes) should also act in synergy: NRHM seeks to address common, primary illnesses, while RSBY covers expenditure associated with serious conditions that result in hospitalisation and that can destroy a family’s finances. It is too early to determine the impact of either programme, and while one expects that separate evaluations of both are to ensue in due course how the programmes interact with each other, however, may not be reviewed. This is a critical issue, and one that should be raised now.

The experiences of VimoSEWA, a micro-insurance programme implemented by the Self-Employed Women’s Association (SEWA), indicate that health insurance must be linked to health itself, if it is to be sustainable and effective. A review of Vimosewa’s hospitalisation claims data provides an indication of how RSBY is likely to develop, and raises issues that must be addressed early in its implementation.

SEWA Health Insurance

SEWA, a trade union of 1.1 million women workers in the informal economy across nine states, promotes an integrated life, hospitalisation, and asset insurance product. Hospitalisation claims require 24-hour admission and cover expenses up to Rs 2,000 annually for an individual, under the most popular scheme. VimoSEWA’s team of grassroots promoters and claim servicing agents are women drawn from the SEWA membership itself, and live in the communities they serve.

In a recent analysis of VimoSEWA’s claims from 2007 to 2009, four key issues with implications for India’s health system emerged:

1. Over 40% of claims are for readily preventable conditions or conditions that can be treated without hospitalisation.
2. Drug expenditures – even in public hospitals – comprise the bulk of expenditure.
3. Hysterectomy is amongst the top reasons for using insurance for women.
4. Claims patterns are inequitable.

Illness Claims

In 2007 and 2008, 12,027 hospitalisation claims were submitted to VimoSEWA, amounting to an overall claim rate for health insurance of 3.5%. About 90% of the claims were approved.

The author thanks Ajay Mahal for his insightful comments. Special appreciation is due to colleagues at VimoSEWA for review of these findings and assistance in data analysis. Sapna Desai (sapna.i.desai@gmail.com) is a public health specialist with the Self-Employed Women’s Association.
Figure 1: Illness Claim Pattern

<table>
<thead>
<tr>
<th>Illness</th>
<th>Claims per 1,000 Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterborne disease</td>
<td>4.9</td>
</tr>
<tr>
<td>Fracture/injury</td>
<td>4.1</td>
</tr>
<tr>
<td>Fever</td>
<td>3.1</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>2.3</td>
</tr>
<tr>
<td>Respiratory infection</td>
<td>2.4</td>
</tr>
<tr>
<td>Malaria</td>
<td>1.9</td>
</tr>
<tr>
<td>Eye-related</td>
<td>1.6</td>
</tr>
<tr>
<td>Urinary/bladder</td>
<td>1.1</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1.1</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Source: VimoSEWA claims data, 2007-09.

Table 2: VimoSEWA Claims for Medicines, 2007-08

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Public</th>
<th>Private</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount claimed for medicines (Rs)</td>
<td>845</td>
<td>847</td>
<td>414</td>
</tr>
<tr>
<td>Share of total claim amount disbursed (%)</td>
<td>65</td>
<td>34</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: VimoSEWA claims data, 2007-08.

Over 40% of hospitalisation claims were for primary, preventable illness (Figure 1). Secondary or tertiary illness, that which ordinarily requires care available in a hospital, such as a hysterectomy or cataract surgery, comprises 45% of all claims. Notably, non-communicable disease such as cardiovascular disease accounts for 9% of all claims (categorised as falling under tertiary care). The growing burden of chronic disease in India is indeed affecting the poor, albeit at much lower levels than primary illness.

Table 1: Claim Rates for Common Illnesses

The first two reasons squarely point to the performance of the public health system. Without affordable and dependable options for outpatient care of basic illness, the poor often turn to hospital-based treatment. When costs of outpatient care and medicines that must be borne out of pocket are high, given that patients often have to visit private sector providers, hospitalisation for diarrhoea may seem more convenient and economical, especially if covered by insurance, than costly outpatient care.

Delay in seeking healthcare is fairly common amongst poor workers in the informal economy. We have observed that rather than spend time and money in treating the early onset of illness, SEWA members often wait to address an illness until they are absolutely unable to work. When treatment is eventually sought, it is more expensive and may require hospitalisation even for primary illnesses. Another reason is a lack of access to affordable care in the neighbourhood and inadequate awareness of one’s health, both of which point to a gap in health services.

Then there is the role of health insurance coverage in influencing health seeking and treatment behaviours. The product design – a limit of Rs 2,000 coverage – may promote hospitalisation for basic illnesses by the insured, while the non-insured may seek outpatient care. These behaviours may be strengthened by incentives to promote hospitalisation that health insurance coverage creates among healthcare providers. VimoSEWA has initiated longitudinal research to investigate these issues and to test interventions to stem primary illnesses. The aim is to prevent unnecessary hospitalisation, which results in loss of wages for workers in the informal economy, as well as ultimately increases the cost of providing health insurance.

Claims for Drug Expenditures

VimoSEWA has found that expenditure on medicines is the primary cost component of hospitalisation claims.

Table 2 shows that costs of drugs is similar whether treatment is obtained in the public or the private sector, and confirm the findings of a recent evaluation undertaken of the NRHM: drugs are largely not available within the public system, forcing patients to buy medicines from private chemists (Gill 2009). Nearly two-thirds of the VimoSEWA claim amounts related to public sector treatment end up paying for “missing” medicines, rather than allowing the poor to benefit from coverage towards procedures or other treatment. Furthermore, the significant difference between drug costs in trust and other hospitals raises questions of regulation of treatment protocols, in both the public and the private (for profit) sector.

Hysterectomy: At first glance, a high claim rate for women for reproductive health-related issues indicates that VimoSEWA is achieving one of its key goals – to improve women’s access to healthcare. However, 43% of the gynaecological claims are for hysterectomies. The average age of hysterectomy claimants is 37 years, and as low as 22 years. It is difficult to ascertain if these hysterectomies are indeed required. Qualitative investigation and initial interviews with SEWA members indicated that, if a provider prescribes hysterectomy, the patient is very likely to undergo the procedure, without a second opinion. With insurance, she will feel financially secure about her decision.

Access to gynaecologists in the public system is severely limited, leaving most poor women to seek care only in emergencies, and without second opinions. Further research is required to understand if high hysterectomy rates indicate that insurance
coverage enhances incentives for hysterectomy, potentially induced by providers, and whether it is necessary. Equally important, these rates reflect the lack of gynaecological care and options throughout a woman’s lifetime. With widespread health insurance and in the absence of safeguards, there is strong likelihood of a rise in unnecessary hysterectomies that – not unlike trends in the west – must be monitored and addressed to preserve women’s basic health security.

**Equity:** Despite a membership that is almost evenly spread across urban and rural Gujarat, VimoSEWA claim rates are much higher in Ahmedabad city. In fact, the health claim rate in Ahmedabad city was 75.8 per 1,000 insured in 2008, more than double that in rural Gujarat (35 per 1,000 insured). Insured persons in urban areas have greater access to healthcare facilities, and in SEWA’s experience, tend to be savvier, and hence more confident than their rural sisters in negotiating healthcare institutions and schemes. VimoSEWA has found that consistent communication and education are critical to ensuring that insured persons actually utilise their coverage when necessary. Rural members often require hands-on support in identifying and accessing healthcare facilities. This is a key lesson for any national scheme. Without education and community-level, claim rates will be low, and benefits will not reach the poorest.

Women are the primary holders of VimoSEWA insurance. Yet as Table 3 shows, claim rates for men are slightly higher than that of women, followed by children and lastly, women. Although further research to explore this finding is obviously necessary, lower claim rates amongst women may well be the result of the well-known male-biased allocation of household resources in India, or the inability to forgo work and household responsibilities for a 24-hour (or longer) hospitalisation period. Since the RSBY only allows for five family members to be covered, these data also portend the possibility that men and boys will be insured in preference to female household members when family sizes exceed that threshold.

<table>
<thead>
<tr>
<th>Table 3: Break-up of Claims Rates, 2007-08</th>
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<tbody>
<tr>
<td>Claims (thousands)</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Child</td>
</tr>
</tbody>
</table>

Source: VimoSEWA claims data, 2007-08.

Finally, previous research on the VimoSEWA scheme indicates that poorer members among the insured are less likely to submit claims both because of lower access to healthcare facilities at which they can obtain treatment and because of difficult claim procedures (Sinha et al 2006). RSBY provides for cashless insurance coverage, a feature that should address the latter, but not the former.

**Implications for RSBY and NRHM**

The VimoSEWA experience has obvious implications for RSBY and the public health system, indicating three corrective steps that can be implemented for more effective national programmes.
Primary Healthcare and Public Health:
Lack of clean water and sanitation is a key public health issue and interestingly, emerges as a central issue for the viability of health insurance – indeed, water-borne diseases constitute a major portion of claims in the VimoSEWA programme. The continuing high prevalence of malaria and diarrhoea reflects a lack of attention to, or the low efficacy of, public health interventions focusing on prevention, including clean water and sanitation. Until a strengthened public health system prevents these illnesses, or at least ensures that cheap outpatient treatment is readily available, health insurance will continue to finance preventable, primary illness. In other words, the health cost of substandard health insurance will continue to finance its gaps instead of addressing primary objectives. As VimoSEWA’s experience in Ahmedabad city suggests that, when given the choice, the poor will choose good quality care in the public sector over more expensive private hospitals. Without a public option, RSBY will further cement the privatisation of healthcare. Empanelling both public and private facilities should engender healthy competition. Yet as it currently stands, RSBY may forever alter the playing field for public providers.

Affordable access to drugs in the public system is a long-standing challenge, as indicated by the percentage of claims costs for drugs in VimoSEWA’s programme. Without improved access to drugs, out of pocket expenditure on illness in the public sector will not significantly decrease, even with increased utilisation of public services. As a result, health insurance will “pay” for leakages vis-à-vis drugs in the public system.

Community Involvement: The success of a health insurance programme depends on how effectively the benefits reach the poor. As VimoSEWA has learned over 18 years, constant education and community involvement – in both implementation and monitoring – are key to ensuring that benefits actually reach the poor. Households require support in identifying appropriate sources of care and negotiating the complexities of the healthcare system. Indeed, the success of RSBY will depend on the extent to which people’s organisations that facilitate the identification of beneficiaries and help them navigate the health system are involved in its implementation. Public monitoring and the involvement of community-based organisations could also help identify early warning signs such as a rise in unnecessary hysterectomies or lower claim rates amongst women. This calls for evidence-based learning, preferably early in the process via pilot programmes, rather than later.

Conclusion
A national health insurance programme such as the RSBY has the potential to reduce household indebtedness by addressing catastrophic health conditions, thereby providing a critical social safety net. Yet it may also promote unnecessary hospitalisation, at the expense of the public sector’s efforts to prevent and treat primary illnesses like malaria and diarrhoea. To be effective, RSBY and NRHM, as indeed water and sanitation interventions, must be viewed in tandem. In the absence of a strong public health system – one that integrates water and sanitation interventions, ensures quality and free care, and provides affordable access to gynaecologists, as one key instance – health insurance under RSBY may simply end up financing its gaps instead of addressing catastrophic conditions that are its primary objective.

NOTES
1 In a study of 5,500 households in 36 villages in three different districts of Andhra Pradesh, Krishna (2006) found that nearly 12% fell into poverty over a 25-year period. Poor health and high levels of health care expenditures were at the top of the list of factors driving rural Andhra Pradesh household into poverty; and using NSS consumer expenditure survey data for 1999-2000 Doorislaer et al (2006) found that head count poverty in India rose by 3.7 percentage points once health expenditures were netted out of consumer spending.
2 Primary care refers to illnesses that could be treated at a primary health centre, or through outpatient care, particularly if identified early.
3 Fracture-related claims, which account for approximately 12% of all claims, do not require 24-hour hospitalisation for coverage under VimoSEWA.
4 The web site of the RSBY (www.rsby.in) lists both private and public facilities that have been empanelled. As of September 2009, significantly more private facilities have been empanelled than public, though with interstate variation. Some states, such as Delhi, Jharkhand and Uttar Pradesh have no public facilities at all, while others, such as Gujarart and Bihar do include government hospitals.

REFERENCES

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