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Determinants of Enrollment in Comprehensive Health Insurance Scheme and Implementation Challenges: A Study in Kerala, South India

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Abstract

Background: Diseases are creating sudden economic shock to households as well as it leads to out of pocket expenditures, undermines income generation and future economic welfare. When people are poor and out of pocket spending is high, it can lead to debt and forced to adopt copying mechanisms. Consequently many poor people do not have the access or go for substandard care. Low public health spending, high out of pocket payments, lack of comprehensive risk pooling mechanism, etc. affect the equity in health financing of India. So, the government, as response to these in efficiencies and a move towards universal health coverage, introduced a community based health insurance scheme in 2008. Introduction of this scheme is designed to improve health care utilization through balancing demand and supply effects of members, healthcare providers and insurance scheme.

Objectives: This study is trying to document 1. The demand side and supply side factors affecting the implementation of Comprehensive Health Insurance scheme (CHIS) in Kerala, 2. To explore the Impact of CHIS on equity concerns and moral hazard.

Methods: The study uses a qualitative case study design. A variety of stakeholders were interviewed using a combination of purposive and snowball sampling to trace out the supply side issues. In depth group interviews conducted to document the demand side factors.

Results: The major demand side factors traced out through in depth group interviews are (1) lack of awareness regarding the benefits of the scheme, (2) outpatient care is excluded, (3) coverage is not enough, (4) provider choice is limited, (5) not happy with the public health facilities etc. The supply side factors are (1) delay in getting funds from government, (2) less incentives, (3) over work load etc. Moral hazards were less compare to other insurance schemes.

Conclusion: Poor people were benefited through the scheme, but delay in settling finds. Gender equity is addressed. Real beneficiaries were not identified and included in the list. So income based equity is questionable.

Keywords: Community based health insurance; Enrollment; Moral hazard; Equity

Abbreviations: OOPs: Out of Pocket Payments; CHIS: Comprehensive Health Insurance Scheme; RSBY: Rashtriya Swasthya Bima Yogana; BPL: Below Poverty Line; APL: Above Poverty Linec

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Introduction

Background: Health systems in many low-and middle-income countries (LMICs) are funded primarily through out-of-pocket (OOP) payments [1-4]. OOP payments are one of the most inequitable forms of health financing [5]; they act as a barrier to access, contribute towards household poverty, generate little revenue (usually less than 5% of total health care budget), and promote perverse incentives, bureaucracy and corruption [6-8]. About 1.3 billion people worldwide do not have access to adequate health care or they are forced to depend on substandard care because of weak health care financing systems [2]. WHO done an analysis of 116 household expenditure surveys in 89 countries established that 13% (approximately 44 million) households faced financially catastrophic health care costs in any given year and 6% (approximately 25 million) are pushed below the poverty line only because of high health care spending [9,10]. NHA 2004 reported that public health spending in India has varied a small between 2000 and 2010, about 1% and out of pocket spending is about 70%, one of the highest in the world.

When people have to pay fee for health care, and the out of pocket payments are so high in relation to their income that it results in "financial catastrophe" for the individual or the household. Such high expenditure for health care can mean that people have to cut down on necessities such as food and clothing, or are unable to pay or withdraw their children from schools or putting them in to government schools etc. Moreover, the impact of these out-of-pocket payments for health care goes beyond catastrophic spending alone. Many people may decide not to use health services, because they cannot afford either the direct costs, such as for consultations, medicines and laboratory tests, or the indirect costs, such as for transport and special food. Studies have shown that Poor households are likely to affect with more diseases and sink even further into poverty because of the adverse effects of illness on their earnings and general welfare. Consequently, the poor either do not reach the health system or receive sub-standard care. Even small payments for health care can push poor in to debt or deepen their poverty [11,12].

WHO has proposed that health expenditure can be viewed as catastrophic whenever it is greater than or equal to 40% of a household's non-subsistence income, i.e. income available after basic needs have been met. However, countries may wish to use a different cut-off point in setting their national health policies. WHO also noted that there are three reasons have to be present for catastrophic payments to arise: (1) the access and availability of health services requires out-of-pocket payments; (2) low household capacity to pay; and (3) lack of prepayment mechanisms for risk pooling like health insurance coverage. Many low and middle income countries in Asia and Africa is facing the problems of high out of pocket payments for health followed by severe financial catastrophe especially the people who are affected with non-communicable diseases [13]. Increasing number of NCDs is a major public health challenge in developing countries and studies shown that a single episode can push a household below poverty line.

In general, health systems that requires lower out-of-pocket payments for health care offer better protection to the poor against high out of pocket spending. Where out-of-pocket spending is less than 15% of total health spending, very few households tend to be affected by catastrophic payments [13-15]. Countries can reduce the economic burden of out of pocket payments by relying more on prepayment and risk pooling mechanisms. In that way, people contribute to funding health services in a predictable way, and they are protected from unpredictable cost of illness. Prepayment mechanisms can reduce the chances of catastrophic spending, but they do not eliminate the burden of it. This is true when households must meet some of the costs of care for medication or investigations themselves through formal or informal payments. Now almost all LMIC are moving towards the concept of universal coverage and different approaches should be considered, which will depend on the stage of economic development of the country, the social and Political context, size of informal sector, extend of formal insurance coverage, household capacity to spend for health care etc. Policy-makers needs to consider how to:

- Extend comprehensive coverage through risk pooling & prepayment mechanisms;
- Protect the poor, disadvantaged and people working in informal sectors;
- Design a benefits package; and coverage limits
- Decide the level of cost sharing or co- payments by the households.

Many times Programs that specifically focus on the poor may not achieve the desired results in many countries and facing the problems of sustainability issues [15-17]. The most common shortcomings are that the benefits package includes only limited services and many times out patient coverage is not included which may be high in case of non-communicable diseases, and co-payments are also high. In addition, in practice it has been found that the beneficiaries of such programs are often not actually poor. Moreover, there are other disadvantaged groups such as the elderly, the handicapped, mentally retarded and those with chronic health conditions and special diseases; are often excluded [18-20]. There are many demand side and supply side factors are affecting the enrollment in health insurance schemes. A recent study conducted in Kerala pointed out that the major demand side factors are socioeconomic status, cultural practices, access to health facilities and lack of awareness about health insurance schemes affecting the enrollment in HI schemes. The supply side factors are availability of attractive HI products, ease of reimbursement policies and sustainability of the available schemes. Another important factor is moral hazard i.e. unhealthy people want to enroll and ready to buy more HI products than healthy people [21-25].

In this context this study is trying to explore both demand and supply side factors affecting the enrollment in comprehensive health insurance scheme and the impact of CHIS on equity concerns, both income based health inequality and gender based inequality will be addressed.

Methods

Data collection and settings: Exploratory qualitative case study method. A rural district of Kerala was selected for the study, then one Taluk selected conveniently and three Panchayths and three wards selected randomly. Six focus group discussions were conducted by the fist author on kudumbasree (women support groups) and each group consists of 10-15 members (Total 82). A qualitative semi structured interview design used to explore the demand side and supply side factors and problems related to enrollment in the scheme.

Research protocol submitted to ASECEND research network, Monash University, Australia and ethical clearance obtained. For In -depth interviews purpose of the research was submitted and permission took form the local administration office (Panchayth) and informed consent obtained from participants of kudumbasree groups before all interviews. Key informants informed consent obtained before interviews. Semi structured interview schedule was used. Confidentiality of all information kept. This paper is based on the qualitative part of the research done under ASCEND research program and the author is ASCEND research fellow from India.

Sample and recruitment: focus group discussions with kudumbasree members were arranged by the author on Sunday afternoons as usual their meeting day. All members attended the meetings were included for discussions. Key informants' interviews were arranged according to convenient time and place. Government Officials of nodal agency, insurance company and hospital authorities were selected using a combination of purposive and snowball sampling and interviews were conducted using semi-structured questionnaires. The purpose of the interview was explained consent obtained before interviews. Key informants' Interviews were recorded and field notes were taken by the interviewer.

Data analysis: all interviews and focus group discussions were recorded. Field notes were taken. Interview findings were coded and analyzed using a thematic frame work analysis model.

Results: eighty two members were participated in focus group interviews. All participants were the members of the kudumbasree group. The discussions were initiated by the secretary of the group and average length of time taken 1.30hrs for each group. Study identified many critical policy issues and challenges which is adversely affecting the utilization of the scheme. Results of the focus group interviews are following:

Delay in enrollment and getting CHIS 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 many days our photos taken and finally got the smart card. " (Female, Daily laborer, 62 yrs)".

Eligible members were exempted

"I went with my family, husband and two sons. But many times photo was not taken and postponed. Finally both sons were excluded from the list because they were in the school and photos were not taken" (Female, tailoring, 45 yrs).

"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, private employee, 46 yrs)".

Reasons for enrolling

"I am the member of kudumasree group. We got the information from the secretary of the group and she asked all members to enroll in the scheme. We only two people in the family and both are suffering with hypertension and diabetes and every day we need medicines. If some serious problems coming we don't have money to go to hospital. So we took this insurance scheme (housewife, 65 years)".

Outpatient coverage is essential

"Me and my husband are suffering with diabetes and need medication every day. But we are not getting the financial support through CHIS card because outpatient care is not included in the scheme. Every month we need a good amount of money for medicines and lab check. CHIS card should include outpatient coverage and lab investigations, otherwise it is useless for us (Female, house wife)".

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 rational choice so they used public facility.

Choice of health facility 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 in getting the transportation charges

""Hospital people were supporting when I was admitted in the Taluk 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" (female, coolly, 60 yrs).

CHIS reduces financial burden

"I 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 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 (female, housewife, 48 yrs)".

Six Key informant's interviews done and the response of participants are given below;

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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. There are many challenges related to issue of smart card also. (Official, nodal agency)".

Real beneficiaries of the scheme should be identified

"Finding real beneficiaries is a real task. Many times a person belongs to APL category are included in the BPL list. So the concept of financial protection to the poor becomes meaningless. At the same time many families were excluded from the list. We have to identify the reasons also (official1, insurance company)".

APL families should attract to the scheme

"Currently the scheme is for BPL and APL families. But the numbers of enrolled APL families are less. More APL families should encourage participating in the scheme, so the pooling will be sufficient. (Official2, insurance agency)".

Financial constraints are affecting the program

"We don't have enough money to settle the bills. A huge amount is pending to settle the claim of patients, incentives for staff etc. Without enough funds it is difficult to run the program. People are less motivated because of these issues. Regarding sustainability, I don't know how long…….. (Administrative officer, hospital1)".

"When I am hearing the name of CHIS I am in tension. There is no money for day to day activities. Large amount of claims are not settled and patients are always complaining 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, Hospital3").

Patient friendly environment

"Our office is always creating a friendly atmosphere; four ASHA workers are working only for this scheme and trying to solve the problems of CHIS card holders. We are keeping proper records, preparing cheques on time, informing card holders etc. I think most of the CHIS Card beneficiaries are happy with our office" (ASHA woker, Hospital2).

Less incentive to staffs

"Many patients are utilizing the facility of Smart card in our hospital. Staff work load is high, but we are getting very less incentives from government side. More over the funds are not releasing on time" (Nursing superintend Hospital2).

Results and Discussion

Last few years India has achieved significant economic growth but still below its global comparators in terms of public health spending. Huge disparities seen among states and improvements in health system have not been shared equitably [26]. Several policies and strategies implemented in the last decade to improve the health system performance. National rural health mission (NRHM) is a health care reform program started in 2005, aims to improve health care utilization and reduce health inequalities between states. As a part of this program government introduced a demand side health insurance scheme known as Rashtriya Swasthya Bima Yogana (RSBY) for the people below poverty line [27,28]. The scheme stared in 2008 and almost all states implemented and practicing successfully. Kerala government modified the scheme in to comprehensive health insurance scheme and implemented in 2008 itself. Kerala the south Indian state well knew its achievements in health and women literacy level that may be the reason that the enrollment in comprehensive health insurance scheme is higher than other states [29,30]. Health insurance schemes are expected to reduce unexpected and unaffordable health care costs through resource pooling and risk sharing mechanisms. Many developing countries the social health insurance schemes are giving financial protection to formal workers, and private health insurance schemes coverage is limited to people have the capacity to pay for the premium and poor people were excluded. Recently there is a trend of emerging many community based health insurance schemes in India. They have been either intuited by local community, cooperative organizations, NGOs or even supported and introduced by government itself. But many times these schemes are facing implementation challenges and sustainability issues [30,31]. There are many positive and negative factors affecting the enrollment are pointed out through this study **(Table 1).**

Conclusion

Despite the rapid economic growth, out of pocket spending for health care is high in India and pushing many people in to poverty [31]. There should be appropriate balance between demand and supply side initiatives to improve the health system performance of the country. 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 [32,33]. 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.

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

Table 1 Factors related to Enrollment in Comprehensive Health Insurance Scheme, Kerala.

	Negative factors	Positive factors
Demand Side Factors	1. Provider choice is limited 2. Not happy with the facilities of public health institutions. 3. Outpatient care is not included 4. Coverage is not enough 5. Coverage is limited to five members in a household 6. Delay in settling claims	1. Awareness regarding the benefits of the scheme 2. Women enrollment is high. 3. Empowerment of women through kudumbasree. 4. Financial protection to poor 5. More people are attracted to public health facilities 6. Solidarity and risk pooling
Supply Side Factors	1. Less incentives for health workforce 2. Delay in getting funds 3. Over Work load 4. Sustainability of the scheme. 5. Low motivation	1. More competitive health care market 2. Public health faculties become more attractive 3. user friendly environment

Source In-depth interviews and key informants interviews

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 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.

RSBY have made a promising start, even though small in terms of public finance this scheme showing significant changes in the traditional health financing system of India [34]. But it needs to strengthen their managerial and technical capacity and should focus on better monitoring at district levels. As it is a demand side financing program CHIS need to revise their benefit packages and ceiling for claim. 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.

Ethical clearance

Research protocol submitted to ASECEND research network, Monash University, Australia and approved by the research coordinating team under the guidance of NIH. For In -depth interviews purpose of the research was explained and permission took form the local administration office (Panchayath) and informed consent obtained from participants of kudumbasree groups before the interviews.

Author's contribution

DN is the author of this publication and ASCEND research trainee from India. This paper is the qualitative part of her study conducted in Kerala in 2013. DN developed the research proposal under the supervision of Professor Brian Oldenburg, conducted the interviews and prepared the manuscript. Focus group discussions were conducted with the help of three ASHA workers from Kerala.

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Competing interests

I declare that I have no competing interest.

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