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EXTENDING HEALTH INSURANCE TO THE POOR: SOME EXPERIENCES FROM SEWA SCHEME

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ABSTRACT

This paper presents the health expenditure, morbidity pattern, demand for insurance and health seeking behaviour of low income households covered under ESIS, mediclaim and SEWA health insurance scheme. Survey reveals that share of direct medical costs was about two-thirds in the total costs in all groups and rural households invariably paid higher costs as compared to their urban counterparts. The per capita expenditure on treatment was much lower for ESIS households as compared to SEWA and non-insured households both in rural and urban areas. A majority of households indicated strong inclusions for any kind of health insurance scheme and demand for SEWA scheme was the highest among the non-insured. Both rural and urban households were willing to pay an annual per capita premium of Rs.80 and Rs.95 respectively for the coverage of services of hospitalisation, chronic ailment, specialist consultation and the like. The author strongly feels a need for health insurance among low-income households due to heavy burden of out-of-pocket expenses while seeking health care.

More than 90 per cent of Indian population and almost all the poor are not covered under any health insurance scheme. Their health care needs are primarily met through direct out-of-pocket expenditure on services provided by the public and private sectors. However, various studies on the use of health care services show that the poor and other disadvantaged sections as scheduled castes and tribes are forced to spend a higher proportion of their income on health care than the better off. The burden of treatment is particularly unduly large on them when seeking inpatient care.[1] The high incidence of morbidity cuts their household budget both ways, i.e. not only they have to spend a large amount of money and resources on medical care but are also unable to earn during the period of illness. Very often they have to borrow funds at very high interest rate to meet both medical expenditure and other household consumption needs. One possible consequence of this could be pushing these families into a zone of permanent poverty.

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There are also concerns about problems in accessibility and use of subsidised public health facilities. A majority of the poor households, especially rural, reside in backward, hilly and remote regions where neither government facilities nor private medical practitioners are available. They have to depend heavily on poor quality services provided by local, often unqualified practitioners and faith healers. Further, wherever accessibility is not a constraint, the primary health centres are generally either dysfunctional or providing low quality of services. The government's claim to provide free secondary and tertiary care does not stand; in reality they are charging for various services. [2]

Non-governmental Organizations (NGOs) and charitable institutions (not-for-profit) have played an important role in the delivery of affordable health services to the poor but their coverage has always remained small.[3] The issue, which continues to bother us, is how to reach the unreached and more recently, how to insure the uninsured to get quality services.

The public insurance companies so far have paid very little attention to voluntary medical insurance because of low profitability and high risk together with lack of demand. From the consumer point of view, the insurance coverage is low because of lack of information about the private health insurance plans as well as the mechanisms used by the health insurance providers are not suitable to consumers. Further, in comparison to the Employees' State Insurance Scheme (ESIS) and also the community-based schemes, the private plans cover a modicum of benefits (Table 1) i.e. only hospitalization and with a lot of exclusions.

TABLE 1
TYPE OF HEALTH CARE BURDEN ON HOUSEHOLDS COVERED UNDER HEALTH INSURANCE SCHEMES

	Type of Care/Cost	ESIS	SEWA	Mediclaim
Inpatient	Medical	✔	✔	✔
	Transport & other direct costs	X	X	X
	Loss of earnings	✔	X	X
Outpatient	Medical	✔	X	X
	Transport & other direct costs	X	X	X
	Loss of earnings	✔	X	X
Preventive & Promotive	Immunization	✔	X	X
	Ante-& Post-natal care	✔	X	X
	Maternity care	✔	✔	X
	Family planning	X	X	X

Note: SEWA and Mediclaim are reimbursement plans (subject to sum assured) whereas ESIS is a facility-based plan.

There is also a gender bias with men having better access to health care when compared to women due to various socio-economic and cultural reasons. More specifically, the poor women are most vulnerable to diseases and ill-health due to living in unhygienic conditions, heavy burden of bearing children, low emphasis on their own health care needs and severe constraints in seeking health care for themselves. Institutional arrangements have so far been lacking in correcting these gender differentials.

MATERIALS AND METHOD

Prior to assessing the need of health insurance as a social security measure for the poor section of the society, a review of existing health insurance schemes was undertaken and lessons were drawn to explore the possibility of extending coverage to workers engaged in the informal sector[4]. The study looked into issues in greater details regarding accessibility and use of health care services, the level and composition of out-of-pocket expenditure on health care and the need for health insurance for poor households pursuing varied occupations in both rural and urban areas. It has also examined the feasibility for health insurance to poor people in terms of both willingness and capacity to pay for the services including the mechanism for the delivery of such type of services.

In 1999, a primary household survey was undertaken in Ahmedabad district of Gujarat. The survey included about 1200 households in rural and urban areas classified into four categories according to their health insurance status. About 360 households belonged to contributory plan known as Employees State Insurance Scheme (ESIS) for industrial workers. Another 120 households subscribed to a voluntary plan (Mediclaim) and 360 households were members of the community-financing scheme, which was run by an NGO called SEWA. Since 1994, the SEWA has been extending a unique plan (covering health insurance, maternity benefits, life coverage and asset insurance) to poor women engaged in petty occupations. The remaining 360 households were non-insured and were purchasing health care services directly from the market. This last sub-sample was taken to serve as a control group. The idea of selecting such stratification was to understand the health care needs, use pattern and the types of benefits received by the sample households in different health insurance environment. Also, the survey was designed to estimate the demand for health insurance and the willingness and capacity to pay for services across socio-economic categories of the households.

SEWA Health Insurance Scheme

SEWA is a trade union of 2,15,000 women workers of the unorganised sector. It gives them full employment and self-reliance at the household level. Full employment includes social security, which in turn incorporates insurance. SEWA's experience repeatedly revealed that despite women's efforts to come out of poverty through enhanced employment opportunities and increased income, they were still vulnerable to various crises in their lives. These prevented them from leading a life free of poverty. The crises they continue to face are death of a breadwinner, accident damage to and destruction of their homes and work equipment, and sickness. Maternity too often becomes a crises for a woman, especially if she is poor, malnourished and lives in a remote area. One of the SEWA studies observed that women identified sickness of themselves or a family member as the major stress event in their lives. It was also a major cause of indebtedness among women.

The health insurance programme was, from the start, linked to SEWA's primary health care programme which includes occupational health services. Thus insured members also have access to preventive and curative health care with health education. Health insurance accounts for the majority of claims and for fifty per cent of the premium paid out to the insurance programme by SEWA members. The scheme was introduced by the SEWA Bank in March 1992 with initial enrolment of 7000 women from Ahmedabad city[5]. Later on it was extended to cover rural woman members from nine districts of Gujarat. Now its enrolment is 30,000 of which 50 per cent is from rural areas.

Health insurance is an integral part of the insurance programme of SEWA. The main motivation behind the initiation of a health insurance scheme for women is that maintenance of a active health seeking behaviour which is a vital component of ensuring a good quality life, The coverage of the SEWA health insurance programme includes maternity coverage, hospitalisation coverage for a wide range of diseases, and occupational health related illness and other diseases specific to women (Table 2).

SEWA health insurance scheme functions in co-ordination with Life Insurance Corporation of India (LIC) and New India Assurance Company (NIAC). SEWA has integrated the schemes of LIC and NIAC into a comprehensive health insurance package to address women's basic needs. The claimants are the needy health-benefits seekers and as the insurance is an additional benefit, the beneficiaries willingly pay the premium. Most of the insurers opt for fixed deposit of Rs.500 or Rs.700 (depending upon the type of coverage) with the SEWA Bank

TABLE 2

TYPE OF COVERAGE UNDER SEWA SCHEME

Provider	Description of coverage	Coverage Amount (Rs.)	Premium (Rs.)
New India Assurance Company (NIAC)	Accidental death of the woman member loss of assets	10,000	3.50
	Accidental death of a member's husband	10,000	3.50
SEWA	Loss during riots, fire, floods, theft, etc.: (a)of work equipment (b)of the housing unit	 2,000 3,000	8.0
	Health insurance (including coverage for: (a)gynaecological ailments (b)occupational health related diseases)	1,200	30.00 (10) (5)
	Maternity benefits	300	--
Life Insurance Corporation of India (LIC)	Natural death Accidental death	3,000 25,000	15.00

Note: Total premium for the entire package is Rs.60 plus Rs.5 as service charge.

and the interest accrual goes towards annual payment of premium. It is the large membership and assets of the SEWA Bank that has made possible the provision of the insurance coverage at low premiums.

FINDINGS

Morbidity Pattern

The annual incidence of morbidity is around two episodes per capita which does not vary substantially among the households having different health insurance status except those subscribing to Mediclaim. However, the female morbidity turns out to be higher than their male counterparts in all the seven population groups studied. As expected, both in rural and urban areas, the private sector has played a dominant role in providing services for ambulatory care (acute and chronic morbidity). Even among the ESIS households, particularly in rural areas, there is greater reliance on the private facility for the treatment of acute illnesses. The survey results clearly pinpoint the poor outreach of ESIS panel doctor, dispensary and hospital facilities for the rural insured households. In urban areas too, only 54 per cent of acute and chronic ailments of the insured population were treated at the ESIS facility. However, for inpatient care, there is some reliance on government hospitals by all categories of households, except Mediclaim beneficiaries.

Expenditure on Treatment

A special effort was made to collect information on three types of expenditures on treatment: (i) direct or medical costs (fee, medicines, diagnostic charges and hospital charges), (ii) other direct costs (transportation and special diet) and (iii) indirect costs that included loss of income of the ailing and caring person and interest payments on amount borrowed for treatment. The share of medical costs in the total costs is about two-thirds in most of the population groups. Even among urban ESIS households who have used ESIS facility to a greater extent, the share of medical costs in the total costs has remained around 50 per cent. The average total expenditure on treatment, irrespective of health insurance status, turns out to be higher for rural than urban households. Getting insured has helped in mitigating expenditure on treatment only for the urban ESIS households. Their out-of-pocket expenditure on treatment for acute and chronic ailments turns out to be about 30 per cent lower and for hospitalisation about 60 per cent lower, as compared to SEWA and other `non-insured' households, or compared to their rural counterparts. Mediclaim beneficiaries indicate high level of expenditures on all the three types of illnesses.

Burden of Health Care Expenditure

The burden of out-of-pocket expenditure on households is computed after estimating the annual per capita expenditure on treatment of illnesses, use of MCH services and health insurance premium. The per capita expenditure on

treatment turns out to be higher for the rural population. In urban areas the per capita out-of-pocket expenditure among both ESIS and Mediclaim is lower than in SEWA and `non-insured' households. The expenditure as proportion of income (burden of treatment) was the lowest for Mediclaim households and the highest for rural SEWA households. If one includes the expenditures by households on MCH and insurance premium then the burden increases further. The burden of total health care costs varies between 18 and 21 per cent in three categories of rural households, and the corresponding range for urban households is between 10 and 18 per cent.

Users' Perceptions on the Delivery of Health Insurance Services

In regard to satisfaction with the schemes, the subscribers of the three insurance schemes under study responded differently. SEWA beneficiaries are largely satisfied with the various aspects of the working of the scheme. SEWA beneficiaries feel that low premium and the maternity benefits are the most positive aspects of the SEWA scheme. The point of dissatisfaction worth mentioning is with the coverage of family members. In the same vein, the dissatisfaction expressed by the ESIS beneficiaries is the distance and inconvenient locations of dispensaries in the case of rural households, and the time taken to seek treatment in the case of urban households. Mediclaim beneficiaries (30 per cent) feel that the process of filing claim should be made simpler as well as quick settlement of claims. About 26 per cent of the respondents expect the coverage of OPD expenses/domicilary hospitalisation in the Mediclaim plan.

Demand for Health Insurance

The responses indicate a strong inclination towards subscription to health insurance schemes by the households in general and by workers in the informal sector in particular. A majority of the low-income households wish to get enrolled to any health insurance scheme, despite the perception of the many, in both rural and urban areas, that their health status is 'good' or 'excellent'. The demand for SEWA health insurance scheme is the highest both among the SEWA members who are not enrolled as well as the 'non-insured'. About two-fourths of Mediclaim households have also expressed interest in joining the SEWA health insurance scheme. The next to follow in the preference order is the Jan Arogya. There is a substantial percentage of 'non-insured' and ESIS households in the urban areas, which are willing to enroll to the Jan Arogya Scheme. The main reason for preference towards both SEWA and Jan Arogya is its low premium. It may be worthwhile to point out that there is a substantial percentage of non-enrollment among the SEWA members (42 per cent). The reason put forward by majority of both SEWA members and those belonging to

the `non-insured' category is the 'no knowledge of insurance'. The knowledge of insurance is also very limited among those who have subscribed to one of the schemes. They have expressed very little knowledge about the alternative schemes. It is, therefore, not surprising that large sections of the sample whose income levels are not high are ignorant of the Jan Arogya Scheme. Jan Arogya has been basically designed for those who cannot afford high levels of premium. The respondents suggested that those managing the scheme(s) should adopt more rigorous methods of spreading knowledge and awareness of the different health insurance schemes.

Expectations from a New Health Insurance Scheme

As far as broad expectations from a new health insurance scheme are concerned, among rural households the coverage of all illnesses and timely attention seem to be paramount. Among the urban households, however, it is the price of insurance scheme that seems to be the most important factor considered for determining the enrollment. Among the specific medical care benefits, coverage of hospitalisation expenditure is desired by more than 90 per cent of the respondents in both rural and urban areas. Hospitalisation being expensive, there is strong demand for the coverage of the costs among the respondents. To quantify, coverage of hospitalisation expenditure is desired by more than 90 per cent of the respondents in both rural and urban areas. The coverage includes fee, medicines, diagnostic services and hospital charges in rural areas. The urban respondents expect specialist consultation, as part of the coverage of hospital expenses. Also about 50 per cent of households wanted the coverage of expenses on transport to be included in the plan. The expectation of coverage of OPD and MCH follows next to that. The availability of OPD facilities at government hospitals rather than at dispensaries and clinics is a better way of providing coverage towards expenses incurred for OPD health care. The room for improvement as suggested by the respondents lies in increasing the coverage of family members and coverage of services. The SEWA beneficiaries are, in particular, interested in coverage of additional household members.

Willingness-to-pay for the New Health Insurance Scheme

It is not that the respondents expect the above mentioned health insurance services free of charge. The rural respondents are willing to pay an annual per capita premium between Rs.80 and Rs.95 for the coverage of services of hospitalisation, chronic ailment, specialist consultation and the like. Further, with the coverage of the costs such as fee, medicines, diagnostic charges, transportation, etc., the respondents are willing-to-pay an amount that is higher by 16 per cent. For additional benefits, such as life coverage, personal

accident, etc., the respondents are willing-to-pay an additional amount that is higher by around 7 per cent when compared to the amount that they are willing to pay for coverage of costs. The urban respondents, barring Mediclaim beneficiaries, are willing to pay an amount ranging from Rs.82 to Rs. 84 by type of coverage of services. In addition to the above services, the respondents are willing to pay an amount extra by 13 to 25 per cent for the coverage of costs, and further 11 to 14 per cent more for the coverage of additional benefits. The corresponding percentages for the Mediclaim beneficiaries are 23.5 and 19.5.

The preference for the type of management for a new health insurance scheme varied by the place of residence. A substantial proportion of the rural respondents preferred management by non-governmental organizations (NGOs), followed by public hospital-based management. Also, a section of the rural respondents are of the opinion that village level institutions, such as panchayats, should be delegated the responsibility of running the new health insurance scheme. In the urban locations too, with the exception of Mediclaim beneficiaries, management by NGOs is most preferred public insurance company. Thus, it is quite indicative that most of the low-income households have faith in the public system for delivering the services.

Implications for Designing an Affordable Scheme for the Poor

The paper addresses some critical issues with regard to extending health insurance coverage to poor households in general and those working in the informal sector in particular. These issues have become extremely important in the current context of liberalisation of the insurance sector in India. There is no doubt that health insurance will be one of the high priority areas as far as consumers, providers and insurance companies are concerned. However, developing and marketing of unique and affordable health insurance package for low-income people would be of a great challenge.

First of all, there is strongly expressed need for health insurance among low-income households in both rural and urban areas. This need has arisen primarily because of heavy burden of out-of-pocket expenditure on them while seeking health care. Despite a significant reliance on public health facilities, the poor households tend to spend nearly one-fifth of their income on treatment. Even among the fully insured households under ESIS, the burden is unduly large particularly among rural ones. This clearly reflects upon a large scale inefficiency operating in the delivery of services by both government and ESIS sectors.

The existing private health insurance plans just cover hospitalisation expenses, which, our analysis shows, amounts to lonely between 10 and 20 per cent of the total cost of curative care. If one includes medical expenses towards

outpatient care then it forms 55 to 67 per cent of the total cost of curative care[6]. Therefore, the new health insurance plan should aim at covering two-thirds of the total health care burden on households.

While, innovative measures for improvement in ESIS and mediclaim programmes are a necessity, nevertheless these will continue to cover a small proportion of the population. There are hence many other emerging issues as far as future health insurance schemes are concerned. Expectations of low-income households from a new scheme indicate that coverage of illnesses, coverage of services, amount of the premium to be paid as well as the procedural aspects such as filing claims are critical in the decision to buy an insurance. A strong preference for SEWA type of health insurance scheme reinforces that the beneficiaries desire a system, which is not only affordable but also accessible in terms of easy settlement of claims and other related administrative procedures. The range of services expected to be covered include hospitalization, maternal and outpatient facilities.

There are several important issues regarding formulating, designing, operationalising and managing an affordable health insurance scheme for low-income households. Before launching a novel and unique plan, varied designs in different settings can be tried out on a pilot basis preferably at the district level because some of these would be having severe cost and management implications. The critical points and steps to be considered in this process are discussed below:

(i) Defining the Benefit Package

The type of benefits to be included are: (i**) Inpatient care: T**he event is unpredictable but rare and the cost of treatment is either unaffordable or payment pushes people, even the better-off, into indebtedness and poverty. (ii**) Outpatient care**: Insurance is generally not well suited to routine ambulatory care because its requirements tend to reasonably predictable and are of relatively low cost and people might be expected to meet these costs out of the pockets as they go along without too much hardship. Most people, however, do prefer it to be included at least those services (diagnostic and clinical) having bearing on their pockets. (iii) **Chronic care:** Insurance is also poorly placed to meet the needs of chronic care as such conditions although high cost, are not unpredictable. As long as members of a scheme may be willing to subsidize others in rare times of extreme; need, they may be unwilling to heavily subsidies them on a regular basis. This is not to say providing protection for those with chronic illness is not important just that insurance is not the best way of doing it. (iv) **Maternity care:** Another area that generates considerable discussion is that

of the possible inclusion of deliveries in the package. It is possible to argue that mothers have nine moths to plan to meet the financial costs of normal delivery and should be expected to do so themselves; but that a scheme might include emergency deliveries which are rarer but expensive.

If schemes do decide to include outpatient care and chronic care they must expect premiums to rise. Also, experience tends to suggest that women groups do want deliveries to be included. If so the costs of the scheme may rise and again a future requirement might be to include all antenatal care.

Individual schemes may wish to deviate from these broad principles. One option might be to offer greater protection to the poorest in the group by perhaps offering them greater benefits, i.e. to cover the cost of ambulatory care where this benefit is not enjoyed by better of member. Alternatively, schemes could decide to meet the non-medical costs of treatment (e.g. transport costs) or they may even wish to extend benefits beyond just health care to cover loss of income though this is unlikely and should only be considered when there is a demonstrated record of financial sustainability and ability to pay.

Another possible approach is whether referrals to the more specialised facilities are to be included. Should a scheme's benefits be restricted to secondary hospitals or should referral for say specialist cancer treatment or heart surgery be allowed. This could potentially be very high cost and could drain the scheme resources.

What is an appropriate role for the State? The Government would presumably wish to give some freedom to determine the benefit package but may wish to insist that certain elements be included e.g. inpatient and preventive care. Also a minimal benefit package should be defined so as to ensure delivery of only cost-effective services.

(ii) Deciding a Panel of Providers

If services are free there is little point in getting insurance. If most of the costs are in the form of unofficial fee again health insurance can do little to help. Health insurance only makes sense when fee is charged and this may rule out involvement in Government facilities. However, fee may differ significantly from government facilities where services may be free to NGO providers to expensive for profit providers. The question is whether the services should be restricted to just one provider or whether members should have choices. This depends largely on what members want and where they are currently getting their services but the decisions have some implications as set out below.

In some areas, especially rural and hilly areas, there may be little choice. Such an approach is perhaps easier to implement although lack of competition reduces any pressure on the provider to improve the services. In urban areas there may be a number of potential providers. Dealing with a number may be more difficult from a managerial point of view but does offer better potential for driving up quality. A scheme offering a choice of providers must include incentive for members to access the quality of care they need in the cheapest setting. One way to do this is to charge higher co-payments for higher cost providers.

(iii) Type of Membership and Population Coverage

Whether the scheme would cover just the villagers, slum dwellers, poor, occupation groups, thrift and credit groups (e.g. DWCRA), select geographic unit, workers, women or adult groups. Unit costs will differ if switching over from individual to household memberships because children and other dependents (elderly) have different health needs than working population. Clearly, on the one hand the more people covered the higher the premiums per household but on the other hand reduction in adverse selection.

(iv) Reducing Moral Hazard and Preventing Adverse Selection

If services are free to members once they have paid a premium they have a strong incentive to use services even if their need is not great. One way of preventing such overuse (also called moral hazard) is to charge co-payments – a small amount charged when services are used although far less than the user fee this would at least provide a deterrent to unnecessary use.

(v) Management Arrangements

Management will be important at all stages of preparation, design, implementation and evaluation. One approach might be to contact an NGO to take this role. They might carry out the initial groundwork and be responsible for monitoring schemes perhaps even negotiating special discounted rates with providers. If the groups are small the managing agency may wish to introduce an additional element of risk pooling by taxing schemes and redistributing these funds to schemes in need. The role of evaluation would, of course, be given to another institution.

(vi) Payment Mechanisms

There are a number of options here, in short, the approach should be as simple as possible and not open to fraud. Funds could be retained within the age

group or held at the facility (if they can be trusted). Members might be given a card with photographs on and be exempted at the facility with the scheme reimbursing the provider afterwards. Alternatively, the member might be expected to make payment up front and be reimbursed by the scheme later- though this may present a significant barrier to some.

(vii) The Role of Government

A number of important roles emerge for government in the development of health insurance scheme, which includes financing, management, training, monitoring and evaluation.

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HEALTH INSURANCE, SOCIAL CAPITAL AND ROLE OF PANCHAYATS

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ABSTRACT

This paper attempts to (i) Delineate the prospects and problems of health insurance in rural areas; (ii) Elaborate the role of social capital as an enabler of health insurance; and (iii) Discuss the significance of Panchayati Raj Institutions in the creation of social capital on sustainable basis. In addition, the paper deals with (i) What is the social capital and what are its constituent elements? (ii) How can social capital be developed? What are the common elements between social capital and health insurance? and How can Panchayati Raj Institutions either create social capital or channelize the existing social capital stock for removing the problems, which any health insurance programme has to account for as a first necessary pre-condition. Finally, the role of PRI in health insurance has been highlighted in this paper.

Debates and discussions on health insurance in the existing literature have been carried out from two perspectives: social security framework and trade theoretic framework. Both these perspectives are important and provide a rationale for health insurance. There is no trade-off between the two, the author feels. Enough empirical and theoretical evidences are available which suggest, unlike the conventional wisdom, there is a close link between saving, insurance, credit and economic development in the rural areas. They are closely related to issues of: poverty, ill health, hunger, famines, starvation and social security. [1, 2]

The case for social security rests on the provision of benefits to households and individuals through public or collective arrangements to protect these against low or declining standards arising from a number of basic risks and needs [3]. The case for expanded social arrangements arises partly from ethical considerations of basic equality, and partly from more direct contribution they can make to the well being of the persons who benefit from them. [2] Advocates of

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trade theoretic approach define health insurance as a trade across the states of nature and focus on the gains of this trade to the parties concerned and conditions necessary for maximizing the gains.

There is a general consensus among the leading advocates of both approaches that all gains from health insurance cannot be exploited due to lack of imperfect/missing: markets, institutions, social enforcements and state intervention particularly in the rural areas of the developing countries. Through effective state interventions and development of social capital many industrialized countries have been able to develop reliable social security systems. In the developing countries different programmes of social security like health insurance, both in content and coverage have been discouraging to say the least.

Health insurance across the developing countries has been a preserve of organized sections of the society. According to the ILO estimates more than 2 billion people in the world are not covered by any type of formal social security protection-contribution based social insurance scheme nor by tax financed social assistance. If one takes the number of covered persons as a percentage of the number of persons of working age, it is estimated that some 90 per cent of population in Africa is without any formal protection, whatsoever, while in the more developed parts of the world only 20 per cent remain outside the scope of social security. In India the situation is no less depressing particularly in the informal sector. According to the 1991 census about 91 per cent of the working population is in the unorganized sector. In absolute terms this would account for 286 million workers. These include marginal farmers, landless agricultural labourers, fishermen, building construction workers, leather workers, handloom workers, weavers, rural craftsmen, salt workers, workers in brick kilns and stone quarries, toddy tapers, head load carriers, loaders and unloaders, drivers of animal driven vehicles, midwives, domestic workers, barbers, vegetable and fruit vendors, newspaper vendors and bonded and migrant labourers. Most of these workers either live in rural areas or come from the rural areas. A profile of this workforce presents a disquieting situation[1]. Social security networks are either non-existent or ornamental. Distribution of basic educational infrastructure, basic health care services and provisions for basic needs are not only skewed across the space but also missing in most of the rural areas. Empirical studies have demonstrated that ill health and poverty are positively correlated[4]. Thus absence of basic health care services is bound to intensify poverty. Calamities, loss of earning power, lifecycle crisis and sudden large expenditure further deepen the intensity of poverty. Many studies on rural poverty/famines have

brought these points to the fore. Government's response to this challenge has been far from satisfactory. The main thrust of this response has been enactment of legislation (from Workers, Compensation Act of 1923 through Beedi and Cigar Works Act 1976), creation of welfare funds, spreading workers' education and encouragement to NGOs. A National Social Assistance Programme comprising three separate schemes was launched in August 15, 1995. The objectives of this programme are to extend financial assistance to: (i) old persons having little or no regular means of subsistence; (ii) households living below poverty line in case of death of the primary bread winner; and (iii) the pregnant women of the households below poverty line upto two live births.

Evaluation studies of these programmes are either not available or are suspect. The presence of formal/private health insurance intermediaries is also nominal. Informal institutions aimed at providing insurance are especially important in the light of the limitations of the formal insurance markets. These have existed historically in many countries.[1] Not much is known about the informal insurance markets in rural India though these do exist in varied form across the Indian villages.

Thus even for the sake of argument if we treat health insurance from contrasting perspectives the necessary conditions for its effectiveness and the end product (its contribution to human development both collectively and individually) remain the same. Insurance is sustained essentially by trust which is cemented by social capital. Institutions such as family, firms, markets, indigenous rural institutions, rules and regulations, social norms etc, play a crucial role in generating social capital. Role of institutions to human development has been widely demonstrated from Hume to modern Institutional Economists[5]. Against this backdrop the role of social capital as one of the effective enablers {we don't deny the primacy of other means but focus on this aspect only} of health insurance offers interesting prospects in the context of vast and colossal heterogeneous rural India. For the development of social capital rural institutions of self-governance like Panchayats are obviously the most suitable means to create the desired social capital. But this is easy said than done. Whatever the motivation of extending the health insurance to the rural areas it is indeed a challenging task. Besides the necessary conditions (mentioned below) its success depends on serious and sustained research in the areas of: social security, rural poverty/starvation/hunger/malnutrition, social capital, rural institutions and policy inputs in an integrated manner. This effort will obviously be constrained by the lack of resources {of all types}; the sheer magnitude of the problem and heterogeneous frame of reference.

In view of this scenario, extending health insurance to rural areas demands a dispassionate comprehension and understanding of all the critical

issues involved. It is against this backdrop that this paper attempts to: (Delineate the prospects and problems of health insurance in rural areas; (Elaborate the role of social capital as an enabler of health insurance; and Discuss the significance of Panchayati Raj Institutions in the creation of social capital on sustainable basis.

Health Insurance: Problems and Perspects

Health insurance, like any other form of insurance, basically entails risk pooling, vulnerability reduction and provision of complete compensation. All these are (together or separately) implementable through formal channels (private, public and corporate) or through informal channels (self-help groups, voluntary organizations, etc.). Exact nature of insurance mechanisms and their success will depend upon a host of factors such as socio-economic profile of the individuals to be covered, policy objectives, contract enforcing mechanisms, type of collateral and coverage and quality of available health services to the reference groups. As discussed earlier health insurance can be approached from two perspectives. Understandably these shall determine objectives, resources needed, implementation mechanisms and types of contracts/ collaterals/institutions. In India given the constitutional commitment to growth with social justice and socio-economic realities (particularly in the rural areas) health insurance cannot be exclusively based on trade theoretic perspective though the recent policy formulations purport this view obliquely. Naturally a viable alternative at this stage of development for covering large segments of rural population under any form of health insurance has to be based on social security perspective. This would also be in tune with the rural development and anti-poverty strategies in operation. This by no means implies that rural health insurance should be the monopoly of the state. Social security perspective of health insurance has to be based on the explicit consideration of equity. Poor, disadvantaged, destitutes, assetless, illiterate and unorganized cannot be brought under health insurance networks. The reasons are obvious; for example, lack of collaterals, higher transaction costs, unassured sources of income and missing markets. Extension of health insurance through state or collective interventions is the first best option to reduce the vulnerability of the said categories of the people. This will reduce the impact of household losses due to calamities (flood, drought, fire, civil unrest and famines), loss of earning power (disability, ill health, loss of assets), life cycle crisis (death and marital breakdown) and sudden and large expenditures (hospital and weddings). Absence of social security such as insurance exacerbate their poverty and ill health. [3, 6] This will also enhance their ability to take advantage of other available opportunities offered for their economic development. “One part of the task of reducing social and economic inequalities in India involves the expansion of social security provisions, broadly understood as social arrangements to protect

all members of the society from extreme deprivation and insecurity. The availability of independent means of subsistence based on social support makes it that much easier for agricultural labourers to resist exploitative employment relations, for oppressed castes to rise beyond humiliating occupations, for women to challenge the patriarchal institutions. It is difficult to claim that all human beings have equal rights in a substantial sense while the streets are full of unemployed labourers, hungry children, destitute beggars, abandoned widows and forsaken victims of dreadful diseases. Social security is an essential requirement of social justice." [2]

Be that as it may. The prospects of extending the health insurance on trade theoretic perspective should not be sidetracked. The prosperous segments of rural society provide a rich potential for commerce-oriented insurance schemes. From trade theoretic perspective health insurance is trade across state/circumstances/situations having an inter-temporal dimension. It also fits into risk management as it reduces the impact of risks on loan and saving portfolios and generates additional revenues. The central problem of this framework is how to sustain trade and maximize gains from trade? It would need special types of mechanisms and interventions. "Thinking the impediments to trade may be helpful in understanding the institutional framework and defining the functions of government" .[1]

Thus irrespective of the perspective adopted the problems at various levels have to be identified, assessed and accounted properly. Some problems will be of general in nature which need universal solutions. Context-specific problems could be resolved once basic formulations are in order.

In the literature on rural health insurance markets two types of problems have been identified. These are problems arising out of: information asymmetries and enforcement of contracts. First category is further bifurcated into "Moral Hazard" and "Adverse Selection". Insurers may fail to discern/discover the actions that their insured person takes. Its converse is also possible. Trust (which is the basis of contracts in the first instance) provides the basis for both default as well as observance of the contract. There has to be some institutional mechanism, which will take care of the problem of moral hazard (i.e. anti-trust law, community-based arrangements for social exclusion, etc.)

Adverse selection would imply that parties to the insurance contract are unable to observe the characteristics of each other. This can happen willfully. For instance the selection procedures in state-sponsored insurance programmes may be distorted to help the vested groups at the exclusion of the targeted groups. It can in turn affect the profitability of the contract. This demands removal

of information asymmetries, collection of relevant data on sustained basis and provision for termination of contracts.

An insurance contract is a promise by one party (the insurer) to another party (insured) to pay a certain amount if an iffy future outcome occurs. Such contract also presumes an institutional/legal framework or societal arrangements of enforcement, adjudication and penalties for the breach of contract. Absence of any of these or imperfections can defeat the very purpose of insurance or render it inefficient. Examples are abounding to show how insurance schemes have failed because of the absence of enforcement arrangements. A problem peculiar to informal sector is lack of desired collaterals. These are considered by some as important means of mitigating default and enforcing a screening mechanism to avoid adverse selection[7]. Some propose using peer pressure for fostering repayments. This is also called social collateral[8]. Collaterals are missing in rural areas for a large proportion of population (agricultural labourers, rural women enjoying no property rights, sharecroppers, etc.). Absence of institutional framework, in which collaterals are used, aggravates the problem further. Land or tenancy rights are not well formed so that individuals could use them as collaterals. Even if these are well defined the fear of loosing the collateral permanently inhibits poor people to enter the insurance markets with them. Under these circumstances the idea of social collaterals can fill the vacuum. However, these come under the purview of social enforcement, which have their roots in the social codes, conventions and norms that affect individual behaviour in a group setting. Norms of honesty, trust, reciprocity, reputation and the like color: human experience, interaction and social behaviour. These are basic facets of social life and provide basis for enforcing contracts.[9, 10, 11] Health insurance can also be endured under imperfect markets or missing markets by creating institutions on a decentralized basis {such as Panchayati Raj Institutions in India} that can directly circumvent problems arising out of enforcement, default or lack of collaterals. Credit evaluation institutions in the West provide examples of such arrangements, which were originally designed to assess the credit history of the concerned parties.

In view of the nature of health insurance and problems associated with it, State intervention has to be supplemented, but not supplanted, by social intervention. This boils down to creation of social capital.

Social Capital: Concept and Significance

To discuss the importance of social capital for the development of health insurance network in the rural areas, questions which need to be addressed are: (i) What is the social capital and what are its constituent elements? (ii) How can social capital be developed?; (iii) What are the common elements between social

capital and health insurance? and (iv) How can Panchayati Raj Institutions either create social capital or channelize the existing social capital stock for removing the problems, which any health insurance programme has to account for as a first necessary pre-condition.

The origin of the term 'social capital' can be traced back to the nineteenth century classics of sociology. However in its present form and usage social capital owes its currency to sociologists, Pierre Bourdieu and late James Coleman. In 1970s Pierre Bourdieu initiated the concept for the first time and defined it as "advantages and opportunities occurring to people through membership in certain communities". For Coleman social capital meant "a resource of individuals that emerges from social ties…it differs from the financial capital found in bank accounts and human capital inside people's heads; instead social capital inheres in interpersonal relations". Social capital describes the durable networks that form social resources through which individuals and groups strive for mutual recognition. As such social capital is the necessary infrastructure of civic and community life that generates norms of reciprocity and civic engagement social capital by analogy with the notions of physical capital and human capital (tools and training that enhance individual productivity) refers to features of social organization such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit. [12, 13] Both Putnam and Fountain argue that the networks and bonds of trust have been found to increase society's productive potential. The idea of esprit de corps or team spirit for work in two distinct ways. First, corroborating cooperation with the economic meaning of capital thereby indicating growth potentialities from a group's capacity to work jointly. Second: configuration created from the collaborative endeavours is treated as capital. Fountain (1998) [13] observes that "well-functioning partnerships, consortia and networks are themselves a 'form of social capital'. Capital is located both in sharable resources held by individual institution in a network and in the overall structure---the relationship among the institutions in a network."

Social capital, like human/physical capital, cumulates when used efficiently. Traditional growth theories gloss over the accretion or growth possibilities of cooperation. Closely correlated to accretion is the self-reinforcing nature of social relations. Based on trust these tend to augment in the positive direction.

The above overview of the concept 'social' clearly shows that Trust, Norms and Networks are its principal components. For the efficient functioning of financial intermediation (e.g. health insurance) these components are the necessary and critical inputs. This is where the twin meets. Trust grows overtime as individuals acquire faith in the genuineness of others in a sequence of

interactions. Transitivity of trust is critical to the expansion of social capital. Close personal contacts are not necessarily required under all circumstances. "Relatively large networks may exhibit generalized trust without close personal contacts among all the members. Experts have noted that norms of reciprocity are fundamental to production relationships…closely linked to reciprocity is a norm that actors will forge their immediate self-interest to act not only in the interest of the group but in their own long-term interest." [13]

Reputation and trustworthiness are crucial both to the working of insurance markets and collaborative networks. It is a double-edged weapon - a tool that may be employed for good or ill. Trust enables the parties concerned to engage in productive collaborations. It also serves a necessary condition for default, fraud and adverse selection. Similarly norms decrease transaction costs and regulate behaviours. But when misused these may stifle creativity and difference of opinion, which are necessary for resolving new and complex problems. Be that as it may, social capital is 'powerful resource' that emanates from productive social relations. Its use is functionally associated with values and objectives of the concerned parties/players. The benefits flowing from it far outweigh the dangers provided public security of the collusive activities is robust and fair. Compared to the economic perspective {which surmises individualism-particularly its neo-classical brand--adore closely held information and autonomy} social capital paradigm suggests, rather paradoxically for some, that cooperation increases competitiveness, information sharing leads to joint gains, and importance of reputations and trust ensure reciprocity within the given framework. "Although in most situations all the parties would be better off were they to cooperate, collective action theory agrees that in the absence of overacting authority to enforce appropriate behaviour or clear mechanism to commitment individuals will tend not to take the risk of cooperation…but during the past decade or so, social scientists from a variety of disciplines, as well as an increasing number of policy experts, have noted and have sought to explain the proliferation and success of collaborative arrangements in the variety of policy settings. The broad term 'social capital captures' many of the salient properties that allow these arrangements to prosper."[13]

Given the above conceptual framework and significance of social capital one may surmise that the most of its core features are ethereal like sentiments of trust expectations and mutual obligations. Intangibility does pose some problems but these are not insurmountable. The significance of social capital for health insurance need not be undermined by these considerations.

How can Panchayati Raj Institutions as a form of democratic governance or a form of community organization (whose functions and administrative frameworks are constitutionally defined) serve as the bedrock for building the

social capital? Keeping in mind the problems of insurance markets {both formal and informal} or the essential requirements under which these could be established and sustained {either on commercial/social security consideration or both} the present paper has argued that social capital is as important as physical or human capital. We believe that there is lot of social capital, which has remained, unexplored in the rural areas. There is also vast scope for generating the required social capital. Unfortunately in the models of rural development this variable has never accounted for—even for the sake of academic curiosity. This in turn has become Achilles' heel of our rural development programmes. People who want to insure the health of rural India should first ensure that they get first insured against the old grooves and ruts of rural development. Next section explores role of Panchayati Raj Institutions in generation or sustaining the existing stock of social capital.

Role of Panchayati Raj Institutions in Health Insurance

Panchayati Raj is a process of governance - a system organically linking people from Gram Sabha[b] to Lok Sabha.[c] It is different from the word 'Panchayat', which connotes a local body, limited to a geographical area [14]. India's experience with this form of governance, which dates back to 1200 BC, has been mixed. There have been periods when Panchayati Raj Institutions served as: 'Pivot of administration, centre of social life, and focus of social solidarity'. But these have also been used as instruments oppression, social segregation and centralization. Charmed by the functioning of village communities in India, Sir Charles Metcalfe {provincial governor between 1935-36} called these 'the little republics'. But for Dr. Ambedkar these republics have been the ruination of India…sink of localism, a den of ignorance, narrow-mindedness and communalism[15]. Gandhiji [16] on the other hand viewed them both as a means and also as an end. For him village panchayats were complete republics based on perfect democracy and individual freedom. Gandhians believed in their immense potential for democratic decentralization and for devolving power to the people. Inaugurating Independent India's first Panchayati Raj institution on 2 October, 1959, at Nagaur (Rajasthan), Nehru described the system as "the most revolutionary and the historical step in the context of New India". His flamboyant Community Development Minister S.K. Dey while romanticizing the Panchayati Raj, visualized an organic and intimate relationship between the 'Gram Sabha' and 'Lok Sabha'. The government resolution of 18 May, 1882, during Lord Ripon's Viceroyalty, has been eulogized as the Magna Carta of local democracy in India. National Movement's commitment to democratic decentralization and Gandhi's abiding faith in its relevance and viability, the first draft of Free India's constitution did not even append a footnote on it. After Gandhiji's intervention and Madhav Rau's (A member of constituent assembly) defense of the system organization of Panchayats was included in the

directive principles of the state policy (which however are mandatory). Despite the initial hiccups 'Balwantray Mehta Committee' proposed a seminal developmental role for Panchayati Raj Institution in rural development and termed these as necessary adjuncts for the success of community development and national extension programmes. Against the backdrop of these recommendations Nehru and S.K.Dey were instrumental in motivating the 'National Development Council' and the state governments to affirm the basic principles of democratic decentralization. This argued well for Panchayats. By 1959 all states had passed Panchayat Acts. By mid 1960s more than 217300 Panchayats (covering 96 per cent of 579600 inhibited villages), and 92 per cent of the rural population were established. This phase has been described by some as 'first generation' Panchayati Raj of Independent India.[14] With the death of Nehru in 1964 the process of democratic decentralization passed into oblivion and a state of prolonged suspended animation. Even the nodal ministers both at centre and states were first sidelined then downgraded and finally closed. We ended up in creating an impregnable alliance of urban officialdom, political elite, and rural rich, which abhorred the very idea of 'little republics'. Decentralization was projected inimical to both national integration and economic transformation of rural India. Unfortunate consequences of this HARA KARI were not far to seek. By early seventies the god of Growth First Model of rural development had failed its masters. Surplus foodgrain stocks were accompanied by poverty, unemployment, hunger and even starvation in Sir Charles Metcalfe's 'the little republics'. Appointment of 'Ashok Mehta Committee' heralded into the reincarnation of democratic decentralization in 1977. While Balwantray Mehta study team had put development central to Panchayati Raj 'Ashok Mehta Committee' proposed 'Panchayats' as 'genuine' political institutions of local self-governance necessary for the health of our federal polity. It took our lawmakers another 16 years to incorporate the spirit of 'Ashok Mehta Committee' report in the constitution's (seventy-third amendment) Act 1992 and constitution's (seventy-fourth amendment) Act 1992. What a great consolation to Lord Ripon departed soul! Even after a lapse of 100 years when he had first time outlined the idea of self-government concept. These constitutional developments have ushered into two changes of far reaching consequences: (i) The democratic base of Indian polity has expanded, and (ii) India is on the move to become multi-level federation with the elected local bodies at the district level and below.

Before the amendments our democratic structure was restricted to two houses of Parliament, 25 state assemblies and assemblies of the two union territories with just 4963 elected representatives. Now there are more than 500 district Panchayats, about 6000 Block/Mandal/Tehsil Panchayat at the intermediate level and 250000 Gram panchayats in rural India where about 73 per cent of India's population lives. Urban India with about 27 per cent population has 96 city corporations, 1700 town municipalities and 1900 Nagar Panchayats.

Today after every five years about 30 lakh representatives are elected by the people through the democratic process, out of which 10 lakh are women. Women head 175 district panchayats, more than 200 Block/Mandal/Thesil Panchayats and about 85000 Gram Panchayats. Likewise more than 30 city corporations and about 600 town municipalities have women chairpersons. A large number of excluded groups and communities are now included in the decision-making bodies. About 66,000 elected members in the rural and urban local bodies belong to the scheduled castes and tribes.[14]

At present union and states de jure constitute the federal India. When subjects mentioned in the 11th Schedule and 12th Schedule are brought under the VII Schedule these will assume the status equal to that of union and state lists. These changes in the Indian federal structure offer tremendous opportunities for channeling the potentialities of men and material which have remained untapped for too long. These can go a long way in improving the quality of life and broaden the choices of freedom for the hitherto excluded and exploited people of our 'little republics'. As per the 11th Schedule (Article 243G) 29 areas of socio-economic development come under the jurisdiction of Panchayats which among other things include: education, family welfare, poverty alleviation, sanitation, maintenance of community assets, cultural activities, markets and fairs, women/child development, public distribution system and welfare of the weaker sections. Any agenda for health insurance to rural India cannot gloss over these developments. The reasons are obvious.

First: The space in which health insurance has to operate in future is being governed by this new polity. Irrespective of the quality of governance this new polity is bound to affect rural social structures, institutions, networks and norms of collective action. This in turn is expected to increase awareness about health insurance. Conventional schemes may not necessarily be relevant in this new space.

Second: It will be easy for the parties to the insurance contracts to avoid moral hazards, adverse selection, defaults, problems associated with collaterals/screening, etc.

Third: This extended base of polity can be used as a laboratory for generating social capital which in turn can be used to overcome the impediments coming in the way of insurance markets or remove their imperfections. For example Panchayats at the grassroot level (compared to any higher form of governance is in an advantageous position to collect and collateral up-to-date reliable information about the people to be insured, their credit history, sources of income, nature of collaterals, etc. This information is crucial for health insurance (either based on commercial consideration or social security perspective) for

avoiding adverse selection or wrong identification. Panchayats, due to their central place in the village polities and administration, can perpetuate the trust between the insurer and insured which a fundamental requirement for the stability of insurance market.

Fourth: Panchayats can be the most effective instruments of motivating the illiterate and poor people to: take advantage of health insurance schemes: enforce contracts; abide by the norms and pool risks due to their close proximity to the people at the grassroot level. Since the performance and actions of Panchayat executives are subject to social audit by the 'Gram Sabhas' it is bound to develop trust and transparency which are crucial for the viability of health insurance.

Fifth: Panchayats have to perform as many as 29 functions under the 11th Schedule. They include: both vertical and horizontal networking with the sister/higher levels of governance, availability of human and financial resources, development of information/data collection mechanism, updating of asset records (particularly land, water land-use pattern, cropping pattern); development of rural markets and social and physical infrastructure. Some of the networks are already in place and new are bound to come. These networks can be used to remove information asymmetries. Thus, the interface among health insurance, social capital and Panchayati Raj reminds me of Jane Mansbridge who said, "Participation does make better citizens. I believe it. But I can't prove it. Nor can any one else".

CONCLUSION

Health insurance can be approached from two perspectives: trade theoretic and social security. Both are important. Problems emanating from information asymmetries and enforcement of contracts are recurring and should be properly appreciated in any health insurance programme.

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VOLUNTARY HEALTH INSURANCE IN VIETNAM: AN EVALUATION

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ABSTRACT

This paper summarises the findings of a series of articles which evaluate the impact of State-implemented voluntary health insurance (VHI) on the Vietnamese health system. The results are generally positive with clear equity gains in terms of utilisation and expenditures, and no evidence of consumer moral hazard. However VHI appears to negatively affect the quality of care, which patients trade off with expected financial gain. Whilst VHI suffers from adverse selection, rather than limiting access to high-risk individuals, more concerted and marketing strategies are required, in particular those targeting the low-educated and remote communities. There is clear evidence that members of voluntary organisations are significantly more likely to purchase a VHI policy. Whilst targeting such groups would promote risk-sharing and limit adverse selection, it is likely that government subsidies will be required for the foreseeable future.

Many governments in low and middle-income countries are introducing health insurance schemes, on the basis that they will increase the private financing of health care services, in turn reducing the burden on the public sector, whilst protecting individual welfare through maintaining or improving access to health care services .[1] In 1986 the Vietnamese Government introduced market economic reforms, known as *doi moi* (renovation). For government health services this meant the introduction of user charges in 1989, followed by the government implemented not-for-profit health insurance in 1992. The system comprises two schemes: compulsory insurance and voluntary insurance.

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Despite adopting health insurance few countries have systematically evaluated its effect on their health system, in relation to stated health policy goals.[2] This paper summarises the findings of a two-year research project, which examined voluntary health insurance (VHI) in Vietnam[1]. The motivation for focussing on the VHI rather than the compulsory scheme was that it presents both the greatest challenges and potential benefits for the Government of Vietnam. The project focussed on two broad areas of investigation. First, it evaluated the effect of VHI on the utilisation of health care services, from both efficiency and equity perspectives, together with an evaluation of its effect on the quality of care. Second, the study was concerned with the future development of VHI with a focus on why some individuals purchase a policy whilst others don't, and an assessment of the scheme's financial sustainability.

Both econometric and qualitative methods are used to analyse the data collected as part of the research. Detailed analysis of each question is presented in a series of separate papers[3,4] amongst its members, and hence greater inefficiency in the system? Moral hazard, the term commonly used to describe such over-consumption, is expected to occur as a result of the reduction in price to the consumer at the point of service.[5, 6] The results of empirical tests of each question are summarised in this paper.

Together with a range of explanatory factors, two key concepts are used to analyse why certain individuals purchase VHI whilst others don't. Risk aversion, which draws on the theory of marginal utility of income, is used in economics to predict which individuals will purchase an insurance product. The second concept, adverse selection, describes the situation whereby higher risk individuals are more likely to purchase insurance, in larger quantities than healthy individuals, due to actions resulting from information asymmetry. Under adverse selection the average probability of illness in the risk-pool, and hence insurance claims, tends towards one, leading ultimately to financial instability if not addressed.[7, 8] The study examined two further issues: does VHI actually lead to reduced health expenditures and if so who benefits, and what is the effect of VHI on quality of care?

Overview of State Health Insurance

Both compulsory (CHI) and voluntary health insurance (VHI) schemes are not-for-profit and implemented by the Government of Vietnam at the province level. CHI targets State employees and employees of large firms, who contribute one per cent of their income into the scheme, with employers contributing a

further two per cent. Approximately seven million people out of a total population of 76 million are eligible for CHI of which around 85 per cent are currently enrolled.[9,10] VHI targets the remainder of the Vietnamese population. The development of a separate voluntary scheme for the bulk of the population is principally motivated by administrative constraints i.e., in assessing income levels and collecting premia from a largely self-employed population. The presence of such constraints in Vietnam is confirmed in a study that predicts the feasibility of compulsory insurance in a range of countries[11].

VHI targets three population sub-groups: (i) schoolchildren, (ii) individuals in households eligible for humanitarian assistance to whom VHI should be provided free-of-charge, and (iii) other adults, including the self-employed (e.g. farmers and service workers), employees of small enterprises, and government employees in certain provinces at the district level and below. Apart from relatively high coverage amongst schoolchildren, the uptake of VHI amongst paying adults has been minimal to date, standing at around 0.6 per cent of eligible adults. The analysis presented in this paper focuses on sub-group third above i.e., self-employed adults including rural farmers, who are further separated into members and non-members. VHI is implemented and administered by Provincial Health Insurance offices, which have autonomy over premium levels and benefits within a range specified by central government. As such the scheme is essentially organised in a top-down fashion. An annual policy costs on an average between 60,000 and 120,000 Vietnamese Dong (US$ 4-9). As a not-for-profit scheme, premia are not risk-rated, with all individuals facing the same premium level within any one province.

Two types of insurance policy are typically offered under VHI; the one covering only inpatient services, and the other covering both inpatient and outpatient services. The benefits of VHI are purely financial with members receiving 80 per cent reduction in any applicable user charges with a ceiling on annual health expenditures set at six months of the minimum basic salary.[12] No further benefits are offered e.g. treatment in a separate facility, or by different medical professionals. At the time of purchase the insured person must designate a public health facility at which all benefits can be obtained. Members cannot, for example, use the insurance policy to reduce charges at private or non-designated public facilities.

Sampling and Data Collection

Data were collected through a tailor-made household survey conducted in three provinces in Vietnam: Hai Phong, Ninh Binh and Dong Thap. Hai Phong Province is located in the north-east of Vietnam, with a population of 1.7 million, and with one-third of the population classified as urban. It was selected given its

uniqueness as the first province where health insurance was introduced in 1989[13], allowing a comparison between a more advanced and less advanced scheme. Two additional provinces were selected, one in the north of Vietnam and one in the south. All provinces with a functioning VHI scheme were considered[(a)]. Ninh Binh in north-eastern Vietnam and Dong Thap in the Mekong Delta region in the south-west were selected. Both Ninh Binh, with population of 1 million, and Dong Thap, with around 1.5 million, are predominantly agricultural provinces, with over 80 per cent of the population defined as rural.

Within each province, one urban and two rural districts were randomly selected, reflecting the predominantly rural population structure of Vietnam. In each district three communes, referred to as wards in urban areas, were randomly selected giving a total of twenty-seven communes included in the sample. VHI members were randomly drawn from lists supplied by the respective Provincial Health Insurance offices. Non-members were selected from lists of residents in each selected commune, provided by the local Commune People's Committee. The number of individuals who had purchased VHI was extremely low in most communes according to the lists provided, and hence this group was over-sampled in order to constitute approximately 50 per cent of the total sample. Weighting was applied in the statistical analysis to correct for this.

Fieldwork was conducted during the period April to June 1999. The survey included questions on household socio-economic characteristics, utilisation of health services, health expenditures, health insurance and patient satisfaction. Interviews were conducted in the respondents' household by trained interviewers. A total of 1,649 adults were interviewed, of which 19 per cent were conducted in Ninh Binh, 40 per cent in Hai Phong and 41 per cent in Dong Thap. A response rate of 90 per cent was achieved, a figure not uncommon amongst rural communities in Vietnam. In addition to the household survey, in-depth interviews were conducted with fifty-four respondents, selected through stratified random sampling in order to ensure a mixture of VHI members and non-members, age, gender and income levels. Attitudinal issues such as satisfaction with VHI and health services, and sensitive issues such as unofficial payments for health services were investigated using this method.

Explanatory Variables for Econometric Analysis

Similar explanatory variables are used to address the research questions and were divided into three categories: health status, socio-economic variables and VHI membership status. Health status is used as a proxy for need and

(a) All provinces had a VHI scheme at the time of the survey, but only fifty five out of sixty-one provinces had an operating VHI scheme.

measured using two variables, the first based on self-assessed health status for the 12 months preceding the survey. Two dummy variables are created to represent good and fair health status. Individuals with poor health status thus form the reference category. The second variable assesses whether or not the respondent has a long-standing limiting illness and is entered as a dummy variable.

Respondents are grouped into four age categories, three of which are entered into the model as dummy variables. Individuals aged over 65 years form the reference group. Income, religion, marital status and province of residence are included in the model as socio-economic characteristics. Per capita annual consumption expenditure in the respondent's household is used as a proxy for income for two reasons. Firstly, survey responses regarding household expenditures are considered more reliable than those regarding income, given the sensitivity of the latter issue. Secondly,income tends to vary considerably by season, particularly amongst farmers who form almost 40 per cent of the sample, leading to potential problems of bias in cross-sectional data. Consumption expenditures on the other hand tend to vary less across seasons and are hence preferable as a measure of economic status.[14] A range of other variables are used to represent social status, including age, sex, years of schooling, religion, and whether an urban or rural resident. Distance to health facilities was also collected. Finally in order to compare VHI members with non-members, and hence the independent effect of VHI, a dummy variable representing purchase of a VHI policy since January 1997 was created. This cut-off point in time was necessary to capture sufficient numbers of members for the survey, whilst limiting problems of recall[(b)].

RESULTS

The Effect of VHI on Utilisation Levels (An Empirical Test of Moral Hazard)

We first analyse whether or not an individual has been ill during the three months prior to the survey, and if so, their subsequent utilisation behaviour. Information was collected retrospectively at the time of the interview. Utilisation is defined either as a visit to a health facility, which includes any government or

(b) As a result of the need to include individuals, who had purchased a VHI policy since January 1997, VHI membership is defined differently according to the research question. For example when analysing the impact of VHI on utilisation only members at the time of survey were included. For the general analysis of demand for VHI however, those were not current members, but had bought a VHI policy previously were included in the definition.

private health facility and private pharmacies, or a visit by a health worker to the respondent's home. Contacts with service providers relating to preventive care, which are not covered under VHI, were discounted from the analysis. Amongst ill individuals, a Poisson or a negative binomial model is used to estimate the effect of a variety of factors on the frequency of service utilisation amongst the ill[©]. In the sample, a large proportion of those respondents who did not utilise health services during the three months preceding the survey had not been ill. The distribution of health service utilisation amongst ill individuals is presented in Table 1.

TABLE 1
UTILISATION OF HEALTH SERVICE AMONG ILL INDIVIDUALS

Number of contacts with health services	Percentage of individuals
0	10 per cent
1	33 per cent
2	26 per cent
3	14 per cent
4	4 per cent
5 or more	13 per cent

The results of the two models (illness, and utilisation conditional on illness) are presented in Table 2. The non-significance of the 'VHI' dummy variable in the utilisation model suggests that there is no significant difference in utilisation levels between members and non-members, controlling for health status and various other factors. This implies that moral hazard is not present in the scheme. Individuals with higher levels of education, are significantly less likely to have been ill during the period in question. Individuals living in Hai Phong province have a significantly lower probability of being ill than residents of Dong Thap Province, a finding that merits further investigation. One possible explanation might be the differing environmental and climatic situation between Dong Thap province in the Mekong River Delta of southern Vietnam, and Hai Phong province in the north-east of Vietnam.

(c) A full justification and description of the regression model used can be found in Jowett and Martinsson, 2000b, available from the author.

TABLE 2

ESTIMATION RESULTS FOR ILLNESS AND UTILISATION MODELS

	Illness model		Utilisation model	
	Coefficient	**Standard error**	**Coefficient**	**Standard error**
Constant	1.207***	0.263	0.711***	0.176
Good health status in last 12 months	-1.416***	0.192	-0.580***	0.136
Fair health status in last 12 months	-0.884***	0.174	-0.413***	0.098
Long standing limited illness	-0.095	0.253	0.220*	0.133
Hai Phong	-0.913***	0.128	-0.749***	0.123
Farmer	0.071	0.152	0.184*	0.105
Government employee	0.119	0.361	0.579**	0.279
Service worker	0.114	0.186	-0.017	0.143
Hired worker	-0.081	0.215	0.097	0.149
Ancestor worshipper	0.088	0.130	0.163	0.117
Buddhist	0.236	0.157	0.161	0.125
Catholic	0.055	0.328	-0.388	0.236
Female	-0.139	0.103	-0.049	0.077
Married	-0.069	0.126	0.075	0.093
5-9 years education	-0.224*	0.130	-0.232**	0.092
10-15 years education	-0.411**	0.179	-0.120	0.140
>15 years education	-1.489	1.015	-0.303	1.191
18-35 years old	-0.198	0.206	0.157	0.132
35-50 years old	0.039	0.202	0.305**	0.131
51-65 years old	0.148	0.216	-0.111	0.141
VHI	-0.372	0.847	0.005	0.594
VHI in Hai Phong	0.551	0.757	0.241	0.586
Consumption expenditure per capita (VDN '000s) and a VHI member	0.076	0.117	-0.018	0.072
Consumption expenditure per capita (VDN '000s) and not a VHI member	0.026	0.028	0.040***	0.014
Number of adults		**862**		**397**

* Significant at 10 per cent level ** Significant at 5 per cent level *** Significant at 1per cent level

The Effect of VHI on Income-related Inequality in Service Utilisation

As part of the regression analysis highlighted in earlier section, two interaction terms were included combining consumption expenditures and VHI membership/non-membership. These two interaction terms allow an analysis of differences in utilisation levels amongst individuals of different income levels, firstly amongst all VHI members, and secondly amongst all non-members. The key finding, as presented in Table 2, is that amongst VHI members, income has no significant effect on an individual's level of service utilisation. Amongst non-members, however, the estimation shows a positive and signficant relationship between income and utilisation. These results indicate that membership of VHI removes income-related inequality in the utilisation of health services.

VHI also has several other effects on utilisation behaviour. First, it appears to encourage persons with illnesses to use government health services rather than self-treat. Assuming that the quality of care is superior in government health facilities, this is one way in which VHI is probably having a positive health effect for its members. By reducing self-treatment with medicines bought privately, it is possible that indirectly VHI assists in reducing the growing resistance of patients to antibiotics and other medicines such as anti-malarials.

The Effect of VHI on Health Expenditures

A range of questions were asked concerning the total cost of the respondent's last contact with health services, including travel costs, official payments for consultations, other tests (e.g. X-ray), medicines, and any extra or unofficial payments. Table 3 presents total out-of-pocket payments cross-tabulated by insurance status and consumption expenditure quartile.

The findings presented in of Table 3 reveal that average payment in the highest income quartile is VND 420,000, 150 per cent greater than individuals in the lowest income quartile. Substantial difference in out-of-pocket expenditures between VHI members and non-members has also been observed. In each consumption quartile except the highest, VHI members consistently paid less than non-members. In the lowest consumption quartile non-members paid on an average 50 per cent more than members. In most cases the difference in average payments between the two groups far outweighs the cost of purchasing a VHI card, implying that, on an average, the card paid for itself after only one visit.

TABLE 3

HEALTH EXPENDITURES AT LAST VISIT BY CONSUMPTION QUARTILE
(VIETNAMESE DONG)

Consumption quartile (annual per capita expenditure in respondent's household)	**Members**	**Non-members**	**All respondents**
1 <= 1,912,000 VND	153,000 (8.9)	183,000 (17.1)	171,000 (13.1)
2 1,912,000 to 2,703,000 VND	158,000 (4.4)	224,000 (12.8)	188,000 (7.8)
3 2,703,001 to 3,816,000 VND	174,000 (3.6)	319,000 (9.1)	236,000 (5.8)
4 > 3,816,000 VND	477,000 (6.7)	346,000 (6.7)	420,000 (6.7)
Average =	245,000 (5.8)	260,000 (11.9)	252,000 (8.4)

(Figures in parentheses indicate percentages.)

Further it can also be understood from data presented in Table 3 that an individual living in a low-consumption household, health expenditures during the last visit were on an average 13.1 per cent of annual income, compared with 6.7 per cent in high-income households. This finding confirms the pattern found in several studies in low-income countries[15,16] that richer households sacrifice substantially less in financial terms in order to access health services. When VHI members and non-members are compared within income quartiles, the impact of VHI membership becomes more evident. For example, in the lowest consumption quartile, non-members paid on an average 17.1 per cent of their annual income during their most recent contact with health services, compared with 8.9 per cent for VHI members.

The Effect of VHI on the Quality of Health Care Services

The household survey included a series of questions regarding patient satisfaction with the quality of service received during their most recent contact

with health services. Table 4 presents the correlation coefficients between several aspects of patient satisfaction collected as part of the survey and VHI membership.

TABLE 4

CORRELATION COEFFICIENTS OF VHI MEMBERSHIP AND PATIENT SATISFACTION

	VHI member
Satisfaction with district hospital	-0.2146***
Satisfaction with provincial hospital	0.1479***
Satisfied with waiting time	-0.2015***
Satisfied with attitude of health worker	-0.2044***
Satisfied with advice of health worker	-0.1283***
Satisfied with skill of health worker	-0.0706**

** Significant at 5 per cent level *** Significant at 1 per cent level.

The correlation results show a strong, negative correlation between VHI membership and almost all aspects of patient satisfaction. Only general satisfaction with provincial hospitals shows a positive correlation. Several further questions were also asked specifically of VHI members regarding satisfaction with the insurance scheme. The findings reveal that there is some dissatisfaction amongst VHI members over the length of time they had to wait to receive health care (e.g. administrative procedures). Dissatisfaction is also stronger amongst VHI members regarding the attitude of health staff during consultations. The dissatisfaction amongst VHI members is in part due to the impression that patients making direct payments to service providers receive a substantially better service. In general VHI members are satisfied with the insurance scheme, in particular when financial benefits, for example at provincial hospitals, are substantial.

Demand For Voluntary Health Insurance

Those individuals not eligible for either compulsory insurance or subsidised voluntary health insurance are confronted with the choice whether or not to purchase VHI. A random utility framework is applied to analyse this choice.[17] In practice VHI is sold through promotion activities organised by Provincial Health Insurance offices, which target a limited number of communes at any one time. These campaigns are sporadic, and no detailed information on such activities is available. Their effectiveness will vary across provinces in part as a result of the competence of each insurance office. Intuitively, individuals only face the decision whether or not to buy VHI if they are aware that the product exists, an

issue similar to that of constrained choice sets outlined in the UK.[18] Thus we first examine those factors influencing whether or not a respondent has heard of VHI, which might be considered a proxy for the effectiveness of marketing strategies, followed by an analysis of demand only amongst those individuals aware of VHI.

A two-part model is used to estimate the two models using the maximum likelihood technique. This model allows for the possibility of non-random sample selection given that the approach uses choice-based sampling[d] (i.e. the second model is based on a positive response in the first model, and hence only a sub-sample is used to estimate the second model). The results of the estimations are presented in Table 5.

Although health status has no significant effect on awareness of VHI, those individuals reporting good health are, ceteris paribus, significantly more likely not to have purchased VHI. This finding indicates that adverse selection is present in the scheme. Per capita consumption expenditures, which are used as a proxy for income, have neither a significant effect on the probability of an individual being aware of VHI, nor on the likelihood that they have purchased a VHI policy. This suggests income does not influence the purchase decision and contradicts the findings of studies in other countries.[19, 20]

Individuals who say they worry less about future health, used as a proxy for risk-aversion, are significantly less likely both to be aware of VHI and to have purchased it. This finding is in line with economic theory i.e. that risk-averse individuals are less likely to purchase insurance[(e)]. There is a positive schooling effect with better-educated individuals more likely both to have heard of and to have purchased VHI. Distance from an individual's household to the nearest district hospital has a significant and negative effect on awareness of VHI, suggesting that current marketing activities are ineffective at promoting the scheme in remote communities. Distance also has a negative effect on the likelihood of VHI purchase. Given that individual demand for health care is inextricably linked with demand for health insurance [21] and that there is evidence that distance has a rationing effect on demand for health care.[22]

(d) The full model is outlined in Jowett and Martnson, 2000

(e) An exploration of the theory of insurance in terms of risk aversion can be found in most economics textbooks.

TABLE 5

MODELS OF AWARENESS AND DEMAND FOR VHI

	Heard of VHI		Purchased VHI	
	Coefficient	**Standard error**	**Coefficient**	**Standard error**
Constant	2.055***	0.290	3.921***	0.285
Good health status in last 12 months	-0.209	0.178	-0.322**	0.148
Fair health status in last 12 months	-0.083	0.156	-0.041	0.129
Long standing limited illness	-0.037	0.193	-0.129	0.148
Consumption expenditure per capita (in VDN 1000)	0.049	0.031	-0.018	0.021
Low level of worry about future health	-0.228*	0.130	-0.304**	0.122
Intermediate level of worry about future health	-0.254**	0.126	-0.256**	0.108
Distance to district hospital	-0.021**	0.010	-0.041***	0.009
Hai Phong	1.092***	0.206	-0.405***	0.145
Ninh Binh	0.968***	0.158	-1.261***	0.141
Farmer	0.262*	0.150	-0.234*	0.136
Government employee	1.935***	0.260	0.620***	0.187
Service worker	-0.114	0.180	-0.276	0.174
Hired worker	0.595**	0.235	-0.332	0.232
Ancestor worshipper	0.016	0.157	-0.131	0.112
Buddhist	-0.080	0.181	-0.185	0.156
Catholic	-0.015	0.203	0.117	0.168
5-9 years education	0.374***	0.122	0.179	0.139
10-15 years education	0.806***	0.169	0.341**	0.165
>15 years education	0.991**	0.386	0.399	0.263
18-35 years old	-0.331*	0.188	-0.264	0.172
35-50 years old	-0.278	0.180	-0.401**	0.160
51-65 years old	-0.024	0.195	0.051	0.160
Female	-0.522***	0.119	-0.068	0.087
Married	0.227**	0.100	0.051	0.112
Rural	-0.593***	0.144	-0.596***	0.132
Number of adults		**1319**		**1013**

* Significant at 10 per cent level ** Significant at 5 per cent level *** Significant at 1 per cent level.

DISCUSSION AND CONCLUSION

The results are generally positive, with VHI having several positive equity effects in the system as a whole and no negative effect in terms of greater inefficiency. However VHI does appear to have a negative effect on the quality of care received by patients, something they trade-off with the financial gains to be made. An analysis of moral hazard, which implies unnecessary over-consumption of health services as a result of being covered by insurance, shows no significant difference between members and non-members. The problem of moral hazard appears to have been countered through the introduction of a 20 per cent co-payment. Regular monitoring is however required as the data presented here refer only to one point in time.

The equity effect of VHI is evident in terms of the significantly lower expenditures made by VHI members, when compared to members, particularly amongst the poor. Similarly an analysis of income-related inequality in utilisation, shows that whilst such inequality is present amongst non-members, this disappears when the utilisation behaviour of VHI members is analysed. This finding is positive and suggests that the government's policy objective related to protecting access amongst the poor have been met. However, the financial implications of the scheme i.e. the extent to which there is a net increase in funding to the health sector, and whether or not the scheme is sustainable requires further analysis. Preliminary calculations suggest that government subsidy is likely to be required for some years.

The main negative effect of VHI appears to be the perceived quality of care received by members. In addition to restrictions on the facility at which the financial benefits can be obtained, members report longer waiting times and worse attitudes of the staff compared to when user charges are paid. Patients thus appear to trade-off the financial benefits of an individual consultation and related interventions, and the time and other costs of lower quality. The result is that for minor health problems, members frequently do not use their policy, preferring to pay full user charges. However when user charges are substantial, patients are more likely to accept lower quality. Another issue, which may complicate this picture, is the unofficial rent-seeking behaviour of health staff. It is possible that health staff believe the private financial gains to themselves are greater when treating non-members. The payment of unofficial charges is widely reported in Vietnam.

Finally the issue of adverse selection requires greater clarity of thought on the part of the Vietnamese Government. Whilst this creates greater financial pressure on the scheme, by reducing the efficiency of risk-sharing in the scheme, it is the case that for many individuals health needs are now being met as a

result of VHI membership, whereas, possibly they were not when full user charges were faced. Whilst some measures can be taken to limit the pool of high-risks, and might be considered unethical in a non-profit insurance scheme. The primary focus for the government should thus be to promote membership amongst relatively healthy individuals to improve the efficiency of risk sharing.

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HEALTH INSURANCE: WHAT CAN WE LEARN FROM OTHER NATIONS' EXPERIENCE?

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ABSTRACT

Health insurance is one of the financing options available to India to mobilize the resources. It gained importance especially after the enactment of the Insurance Development and Regulatory Authority Act, 1999. Since the coverage of health insurance in India so far is limited to the extent of only 4 per cent of the population, the whole concept of health insurance is relatively new to the Indian public. Low coverage also gives us an opportunity and scope to correct the ills of the existing mechanism. Since the Indian experience in health insurance is limited, the experience of the other nations, where insurance exists as an option, could offer us valuable lessons regarding the viability of the proposal and its impact on access to health care. It is in this context, this paper reviews the experience of few countries that have implemented this option of financing on earlier occasions.

Health system in India appears to be in transition. Several changes are occurring with respect to each of the control knobs concerning the system, viz., financing, organization and regulation and rationing. Blood bank regulation, decentralization, hospital autonomy, insurance, integration of vertical services into the mainstream services and public-private partnership can be cited as the recent attempts to transform the present system into an efficient one.

The term 'external force' here indicates other sectors of the economy. At least two of the measures such as, decentralization and insurance, are basically the products of other sectors. They are brought into the health care system as mere extensions. Interest in decentralization and health insurance is growing in India particularly after the 73rd Constitutional Amendment Act, 1992 empowering

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the local bodies and Insurance Regulatory and Development Authority Act, 1999 came into existence. This is, however, not to say that decentralization and insurance are irrelevant to the health sector.

Health insurance in the Indian context is justified because of the unregulated nature of the private health care expenditure. Private out-of-pocket expense is the single dominant source of financing for health care in the country accounting for 75 per cent of total health care expenditure. It is important for the system to streamline the private resources for the overall benefit of the patient-consumers. In this context, insurance can be seen as the latest avatar. The size and distribution of the economy also suggest a large potential demand for health insurance and only lesser than one-tenth of it has been tapped so far.

While the need for insurance in the health sector is well understood, how should it look like and what will be its impact on the access to health care are not clear at the moment. The countries that have already experienced the influence of insurance in some form could offer us valuable lessons in this regard. With this purpose in mind, this paper briefly analyses the experiences of those countries that have already utilized this option of financing health care.

Value of Insurance

Insurance is a voluntary arrangement whereby individuals can make a prepayment in order to avoid possibly catastrophic out-of-pocket expenses in case of major illnesses. That is- it provides the means by which risks or uncertain events are shared among many people. Insurance relies on the fact that what is unpredictable for an individual is highly predictable for a large number of individuals. The important phenomenon here is that enough individuals must be insured in order to spread the risk widely. Apart from the desire to share risk, many people seem to prefer the convenience of having medical care payments periodically deducted from their wages in the form of insurance premiums[1].

The advantage of insurance includes protection against the cost of illness, mobilization of funds for health services, freedom of choice, redistribution effect, efficiency, sustainability and achievement of purchaser-provider split. People fall ill quite randomly and in most cases the probability of falling ill is quite low. Treatment of illness is costly and either the patients or providers of health care have to bear this high cost. Increasing complexity of medical technology further shoots up the level of expense far beyond the means of the average family. Insurance mechanism provides the family an opportunity to overcome such scenario. By making small but regular contributions, one can insure high expenses, especially when illness might make it even more difficult to raise the required funds.

Insurance has a great potential to contribute to revenue collection. Since insurance contributions are an earmarked contribution and kept separate for specific benefits. Compliance is generally higher even where general tax compliance is not very good. Moreover, most people find it easier to make small contributions at periodic intervals rather than large contributions at the time of illness. Further, members of an insurance pool may be able to choose to pay when they are more able, like harvest time, than when they are less able, like illness time.

The voluntary nature of the insurance enhances the health care seeking behaviour of the population and offers freedom of choice to its consumers. The redistribution of income from the healthy to the sick occurs because some participants draw out more than they pay in, as the occurrence of the event being insured against in uncertain. However, the nature and magnitude of the redistribution effect depend on the financing of the schemes and the way in which premiums are fixed. Improvements in economic and social efficiencies are achieved through risk coverage because risk coverage is seen as an efficient way to use scarce resources. Moreover, the insurance system has the potential to encourage providers to contain costs and the consumers to make least cost choices of type and sources of health care. One of the potential benefits of health insurance in the Indian context could be that it would bring the private sector, hitherto unregulated to a great extent, under some form of regulation.

Forms of Insurance

Insurance may be organized on a public or private basis and can be categorized as 'government' or 'private' depending upon who holds the common pool of funds. Private insurance, it is argued, will be necessarily linked to profit maximizing objectives, while public ownership will seek welfare maximizing as the desirable objective. An individual's demand for private health insurance will be determined by the price of insurance (i.e. the premium to be paid), the individual's assessment of the probability of loss (especially financial) resulting from illness, the likely magnitude of that loss, his/her income and attitude towards risk.[2]

Health insurance organized by the government or a public body is usually termed as social insurance, social security or sometimes, compulsory health insurance. Social insurance is compulsory for all individuals falling within the scheme and is seen as a source of community welfare. The conventional funding source for social insurance consists of payroll taxes levied on workers and employers, often supplemented by user fee and tax revenues. The contributions by employees and employers are considered not as insurance premiums but as

an earmarked tax. Since welfare maximizing would require that the insured contribute in accordance to their ability to pay, it is possible that total contributions, not individual payments, can be determined actuarially in the case of social insurance. This leads to cross-subsidization between haves and have-nots and healthy and sick. Social insurance also has no eligibility rules and there is often no ceiling on actual benefits either.[3]

International Experience

Social insurance exists in countries such as Germany, Japan, Latin America, Singapore, South Korea and some of the sub-Saharan African countries.[4-7] It serves varied objectives from self-reliance in Latin America and Singapore to equitable access in Japan, Germany and South Korea. In Latin American countries, it is typically self-financing and is funded primarily by payroll taxes. It does not include government subsidy to any considerable extent and government subsidy for social insurance falls in the range of 0-26 per cent.

In comparison, Singapore emphasizes accountability by requiring patients to pay when they demand health services. The country has Medisave plan to cover hospitalization and expensive outpatient costs and Medishield to treat catastrophic illnesses. Workers pay 3-4 per cent of their income to the Medisave account according to their age and in addition, employers match their employee contributions. The contributions (premiums) for the Medishield account are made from the Medisave account. The government also uses its tax revenue to subsidize the cost of public polyclinics and lower class wards in public hospitals. Patients can choose any class of service and pay accordingly. While the patients using the lowest class of service are required to pay 20 per cent of the cost, those using the highest class have to bear 80 per cent of it.

Japan has a well-knit comprehensive social insurance system to cover the entire Japanese population. There are three broad categories namely; employee insurance, insurance for self-employed and pensioners, and old age insurance. Each one of them branches out further to include specific subs-groups of the population. Employee insurance, for instance, has four types within itself government-managed insurance for those who are employed in small companies; society-managed insurance for those employed in large companies; seamen's insurance; and mutual aid associations for national and local government employees and private school employees.

Insurance benefits in Japan vary across various types of insurance and between the payers and their dependents. Employee insurance pays 90 per cent of the fee to the employees and 70 (outpatient) to 80 (inpatient) per cent to their dependents. Another scheme pays 70 per cent to both payers and their

dependents. In case of those who are 70 or older, the entire health care expenditure is paid. In such case, some co-payments are to be paid by the insurers directly to the provider. Overall 50 per cent of total health expenditure in Japan is funded by insurance contributions, one-third by the government and the rest by patient charges.

German social insurance system is relatively simple. Under this system health insurance is compulsory for 90 per cent of the population and the remaining 10 per cent (wealthy) may opt out. Employers and employees jointly pay the premium and the insurance is administered through non-profit insurance plans called sickness funds. In Korea, government has mandated that all citizens must be insured for health services. Insurance schemes cover 90 per cent of the population while the government initiated public assistance programmes serve the remaining 10 per cent (below poverty line). Like Japan, Korea also has different plans for different groups of people. Employees of corporate sector contribute 3.4 per cent of their income where as civil servants pay 4.6 per cent. For others, contributions are determined by the value of family assets and wage earnings. Financing responsibility of meeting the recurrent expense of their members rests with 313 independent non-profit corporate and regional insurance societies known as sickness funds. The government determines the extent and the level of benefits. Essentially, most outpatient and inpatient services are covered with the exception of some less common and high cost services. However, patients are expected to make a co-payment and the rate varies between a flat rate and 55 per cent of the cost.

While the term ‘social insurance’ carries varied connotations across the countries, the concept of private insurance is more or less uniform. Those countries giving much greater priority to individual freedom and choice than to equality in health care choose private insurance as their financing mechanism. Those nations refrain from imposing any compulsory measure on its citizens and so, rely on the free market to offer voluntary private insurance. Private insurance is an important source of finance in developed countries like the USA and, to a lesser extent, Australia. It also exists in developing countries such as Ethopia, India, Kenya, Namibia, Nigeria, Tanzania and Zimbabwe.[7-9] However, private insurance is not a major source of finance for developing countries and the proportion of population covered is less than 5 per cent. Its share in total insurance too is poor in those countries; it ranges between less than one per cent in most African countries and 16.5 per cent in Zimbabwe; it is 4 per cent in India.

What Do We Learn?

Of the two forms of health insurance, social insurance appears to be the most favoured choice of the nations. Unlike private insurance, social insurance finds its place in both developed and developing countries. It combines all the good characteristics of community financing and private insurance eliminating their shortcomings. The risk base of the social insurance is found to be broader than that of community financing. A well-structured social insurance does not exclude any specific sub-group of population, as is the case with private insurance. In this sense, the Japanese system easily qualifies as an ideal one as it covers the entire population. Yet,, the Singapore system is relatively more efficient as it has introduced private elements, making the system more accountable.

Looking at the concept of social insurance, it is not the same for all the countries that implemented it. This gives adequate flexibility to the health care system to choose its best possible course. World offers a range of choices within the social insurance framework from the simplest German model to the most comprehensive Japanese model. One common element, however, is that the resource mobilization objective is adequately fulfilled in almost all the countries where social insurance finds a place. This holds good for the developing nations such as the Latin American countries. In order to be successful in social insurance, it is important to ensure that the health infrastructure exists to provide required services and that there is some incentive to comply with the social insurance. At the same time, there will be considerable disquiet when people in serious medical need are refused treatment because of their inability to pay or lack of insurance. Often, the most vulnerable groups of the population are agricultural workers and those engaged in the informal sector.

Private insurance, on the other hand, has not found many takers in the past. It appears to promote inequality as it is directly linked to the purchasing power of the population. In the United States, for instance, private insurance left the elderly and the disabled uncovered because they are the high financial risks. The poor, unemployed and other low-income population are left out since they cannot afford the insurance premium. Despite the existence of Medicare and Medicaid programmes to cover the 'left-out' groups of population, 14 per cent of Americans still remain uninsured.[4] The least cost argument in favour of private insurance also does not seem to be working. Even a partial coverage of private insurance has led the nation to significant health care expenditure inflation in Australia. In the US too, insurance companies try hard to control costs through managed care and there is no mechanism to control the costs incurred by the patients on drugs and co-payments. The cost inflation is ascribed more to price than quantity changes.

Indian Context

From an egalitarian mindset in the European countries to the individual freedom of choice in the USA, countries differ a lot in terms of their overall approach to health care. Hence, the choice of the insurance option depends on the cultural, economic and political contexts of the concerned society. The performance of the insurance mechanism too depends on these factors. No option can work if it is simply replicated just because it is found successful elsewhere. The reason is that there does not exist a single blueprint for replication by other countries. Decentralization in Columbia failed to work because the country's cultural and political contexts were not taken into account while designing the policy. Similarly, Chinese Cooperative Medical System (CMS) cannot be replicated elsewhere because it existed in a special context. Even China failed to sustain it when the political and economic contexts changed during the nineties.

Nevertheless, past experiences do provide some dos and don'ts. One problem most insurance systems face is that of overuse, and to some extent, over-supply of insured services. With respect to the private insurance, its scope and functioning are too complex for the common man in a developing world, such as India, to understand even if he/she has the ability to pay the premium. Therefore, private insurance can find a place only in the literate society among the rich. It also opens up inequality. Nonetheless, it has the potential to generate adequate resource for health care. Apart from these specific comments, the success of any type of insurance, either public or private, depends on:

- The distribution of burden and benefits
- Quantity and quality of services financed
- Feasibility of existing coverage in the future
- Efficiency of insurance administration
- Efficiency of service provision
- Extent to which health insurance assists achievement of national health objectives.

In India, urban rich constitutes roughly one-third of the population and rural poor represents the remaining two-third. The present thinking in India appears to be in favour of tapping the resources of the former in order to fulfil the twin objectives of resource mobilization and cross-subsidization. At the outset, one cannot find fault with this thinking per se. However, the approach of using private insurance as tool to achieve this twin objective is questionable. Therefore, the flaw lies in the process, not the targeted outcome. The choice of the mechanism to accomplish the target itself leaves enough doubt about the success of the approach. The basic premise behind the approach seems to be

that the private sector would have enough resources generated through insurance premiums and it would be in a position to employ a portion of the resources thus generated to cross-subsidize the poor. The proposed control knob here to correct any deviation of the private sector is the government regulation. How far this control would be effective can be judged from its past history. In the past, government could not succeed in regulating the private heath care sector. In fact, the regulation of the private sector can be identified as the weakest link in the Indian health care system. Therefore, there is every reason to believe that this strategy might fail to deliver desirable results and the system might end up achieving only the first part of the twin objective (i.e., resource mobilization).

At the same time, one cannot do away with the private insurance for the simple reason that health care resources to the extent of 75 per cent are found in the hands of, say, top 30-40 per cent of the population. Only private insurance has the means and ability to tap those resources. Therefore, the first of the twin objectives (resource mobilization) can be best accomplished by the private insurance. Doubts arise only with respect to the second part (i.e. cross-subsidization). Evidence shows that the private insurance cannot accomplish this task because the private sector, by nature, seeks profit in whatever it does.

Hence, instead of asking the private sector to perform the role of a welfare maximiser, government itself must step in to channel the 'spare' resource from the private insurance sector to the needy 60-70 per cent of population. A common pool of resources can be formed with the help of resources thus generated along the lines of sickness funds in Germany and South Korea. Government can contribute to this pool. Even while the government manages this pool, the services can be provided to the poor by the existing providers of the public, private and the NGOs sectors. In this sense, the financing mechanism can alone be altered without disturbing the present health care infrastructure. The system can also be efficient because the purchaser-provider split is achieved. Thus, both equity and efficiency can be accomplished if the health sector chooses to mix both the forms of health insurance.

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INSURING TO ENSURE BETTER HEALTH CARE: HOW PROMISING IS THE NEW PARADIGM?

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ABSTRACT

This paper analyses some of the major issues related to health insurance schemes in India. Health insurance could provide better and timely health care with some sense of equity and efficiency. However, exclusion of certain diseases from the benefit package needs to be carefully designed with attempts to see if they are revocable with time. When insurance driven demand is more for medicare, the existing services may fall short and as a result bigger and metro-based hospitals might enjoy scarcity pricing. The paper advocates a social insurance mechanism with an attempt to finance the premia through a mix of sources including some of tax/cess on polluting and health hazardous manufacturing units, public transfers, user charges, etc.

Some of the serious paradoxes suffered by the health system in India emanate from the size of expenditure on health care in the country. Corroborating evidence in regard to aggregate health financing by the overall public and private sources equate this expenditure close to 6 per cent of the total GDP[1]; which is considerably higher than many other Asian economies. These estimates also reveal that over three-quarters of this expenditure comprise private out-of-pocket expenses. What makes the system to look so paradoxical may be judged from the non-conformity between the quality of health services and the size of health care expenditure. This is besides the low health status of a sizeable population in all ages due to high incidence of several conventional and newly emerging diseases in the country.[2]

Much of the worsening in the quality of public health care provisions is believed to be the outcome of inadequate financing and inefficient resource management by the government.[(a)] In this perspective, health sector reform is now considered essential without any more delay - with major emphasis on finding alternative sources to generate additional finances. Despite the problems

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(a) We refrain to go into the question of poor management vs. poor financing of the Government run health care institutions.

of adverse selection and moral hazard or both, expansion of medical insurance and its coverage fitted well in the emerging situation.

Existing Forms of Health Insurance

Going by the notion that protection against certain unforeseen financial risks can be treated as insurance. India has evolved many contributory or non-contributory plans to protect organised industrial and few other categories of workers against the risks of ailments, disabilities, maternity and other providential losses. Benefits under the Employees State Insurance Scheme (ESIS), Central Government Health Services (CGHS) and reimbursement plans by the large public and private establishments are just a few such examples. Often, none of these plans could stand the test of quality or timely assistance. At its worst, perhaps, is the ESIS, which is responsible for social security provisioning of over 7.5 million workers from across the States.

Since mid eighties, the General Insurance Corporation (GIC) has also been providing a Mediclaim cover to groups and individuals against the age-adjusted premia (i.e., premium charged by the GIC increases for successive age groups.[3] Now with increasing liberalisation and reformist policies of the government, many new institutions will soon be joining the insurance business, with a focus on health coverage as well. However, there are host of issues that need to be examined to ensure these entrants may really be able to help the insured. This note is prepared with a very limited objective and confines merely to identification of some of these issues, without going into their empirics or theory.

Limitations of Existing Health Care Benefits

Major quality issues have mired the otherwise well designed social and health security mechanism in the country. The inadequacies of the ESIS or the CGHS linked benefits may serve as example. As a result, more and more people are now awaiting for better options to ensure timely and quality medical care. The GIC Mediclaim policies have in recent years gained considerably because of these general perceptions.

Unfortunately, however, there are a few serious limitations that plagued the existing GIC medical plans. One is indeed the non-competitive environment in which the GIC and its subsidiaries used to work. But more than that is the exclusion rules allowing insurers to exclude the pre-existing conditions – that too almost forever.[4] Similarly, several important conditions are declared non-insurable including problems due to childbirth and pregnancies, AIDS, STD,

diseases caused by the use of drugs, etc. A disease prone country like India where even serious ailments are not very uncommon, exclusions are bound to discourage people to buy insurance plans. In addition, it leaves only a very limited number of risks to be covered under insurance policies. Not only that, such exclusions may as well compound issues grounded into the adverse selection criterion and its attendant technicalities.

Further, insurer agencies often encourage group-insurance plans and provide them major concessions. Individual policies thus suffer. This was especially the case with the GIC.

Issues for Proposed Reforms in Health Insurance

For some times now, several modifications are in offing to reform the insurance sector. A great deal of expectations is round the corner, especially among the buyers of health insurance services. Much of these expectations rest on the premise that the expansion of insurance activities and private participation may bring efficiency along with several new plans at a more competitive premium structure. Underlying these anticipations are also an efficient regulatory system with good understanding about the ground realities. The latter is however somewhat suspecting.

In our view, these expectations may come true provided two or three major caveats are looked into. One is obviously linked with the country's epidemiological profile and disease prevalence. Given that the morbidity level in India is very high – and also varies across different socio-ethnic groups - a well conceived exclusion mechanism need to be designed to ensure maximum benefit to the insured; though within the limit of the adverse selection criterion.[b] It ought not to be overlooked that many health conditions in India are caused by external (non-individualistic) factors including poor public health services, inadequate civic infrastructure, water and atmospheric pollutions, uncontrolled adulteration, lack of waste disposal facilities, growing migrations and slums, perpetual poverty, malnutrition, etc. Given these, a question may be: should or shouldn't the persons suffering from diseases caused by one or more of these external (non-individualistic) factors be excluded? Furthermore, if excluded, for how long? The externalities linked with these factors might as well be considered along with the arguments that favour role of market in medical care.

Another, and perhaps a far more serious issue, arises for the lack of a fully developed hospital chain and diagnostic centres in most part of the country

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(b) Adverse selection problems would arise if the average risk - associated with certain specific group of insured persons - exceeds the anticipated risk.

except in metros and certain major cities. With the possibility of insurance driven growth in demand for medical care, the corporate hospitals may not only gain through scarcity pricing (caused by demand-supply imbalances), but would also have a growing queue of wait listed patients. This may eventually help insurer agencies to raise the premia. It, therefore, seems critical to examine how government subsidies can be directed to promote investment in rural and lower income areas to offset the likely increase in resources that will occur in high-end urban hospitals. It may also require drawing lessons from other developed countries to regulate the practices of commercial health plans.

The third issue is embedded into the claim payment system. So far, the health insurance in India is basically a reimbursement mechanism and, in most cases, claims are subject to the satisfaction of the insurer agency. This does not only require the claimants to meet the full cost of treatment initially, but also to convince the insurer agency about the genuineness of the claim and all supporting documents. With the growing medical charges, and the delays (or several other risks such as exclusions and so on) involved in claim payments, treatment of even an insured person is becoming a major problem. These hassles remain even in presence of a Consumer Protection Act.

Yet another problem is to evolve a mechanism of social insurance for the low-income people and it's financing.

Despite certain complexities, none of these problems is new. Many countries have, for instance, evolved two (or even more) types of health insurance system. One is for the low income/low premium population - with health care organised by the government. And the second, private and more costly - mainly for higher income people willing to avail of facilities not provided by the official system. The former with certain modifications may be used to serve as a social insurance system in the country; through finances from a mix of cess on industries causing sickness (to illustrate, tobacco, paan masala, alcoholic beverages, whole range of polluting and other health hazardous industrial units, etc.), public transfers, subsidies, pay roll tax, user charges, etc. Hospitals run by State and local bodies may help to provide the necessary health care. Small private hospitals may also chip in.

The problem of adverse selection may be a major risk for any health insurance mechanism in high sickness societies like India. As the level of sickness in a society is the result of many complex socio-environmental factors, any attempt to cut down the level of sickness may not be an easy task. A solution with immediate application may therefore be to multiply the number of insured - with a maximum share of youngsters enjoying minimum health risk[c]. In certain

(c) Given the high level of malnutrition and sickness among the children, this may not prove an ideal solution in the Indian situation.

European countries, privately insured people pay a premium that reflects the average health risk of the age group when they were insured first. This could be a very big incentive for people to buy insurance cover at an early age when the premium is low. It would also help them to avail of premium benefit at the higher end of their life cycle (i.e., premium is not age adjusted). Attempts must be made to look into these possibilities, particularly keeping in mind the age structure changes in the country that will raise the share of younger population (along with older ones as well) to a very large extent. Insurance agencies may also consider insuring people with certain pre-existing conditions: (i) at a higher premium, and (ii) after a few years of recovery, provided the person(s) considered medically safe or insurable.

Perhaps not well within the purview of this discussion, however, changes in age composition and societal ageing are another emerging issue in the country. Unfortunately, our response to this issue remains completely tentative. Some freak old age pension programmes for the destitute elderly[d] or the half-baked National Policy on Older Persons (awaiting parliamentary ratification for about two years now) are among the two major responses we could have thought of so far. Perhaps this is an over simplification of the entire issue [5,6,7] - especially in view of the health-related needs of the elderly persons. Corroborating evidence also suggests that the share of "*old old*" in the country will increase rapidly. All that may exert pressure on available health and medical services. Existing health insurance system does not cover persons beyond 75. Where will the *'old old'* in age groups exceeding 75 go? This question ought to be linked with: (i) the declining health care services by the government, (ii) growing pressure to privatise health care on grounds of externalities and merit/non-merit goods argument, (iii) low health status of persons in general, and the elderly in particular, and (iv) perpetual poverty with growing burden of old age dependency on labour force facing large scale informalisation and job insecurities.

CONCLUSION

In India, expenditure on health care services is significantly larger than many other developing economies without matching results. Particularly the quality of public health care services is worrisome. Insufficient finances are believed to be among the reasons for this. Health sector reforms – particularly by enlarging the scope of health insurance in the country - are in the offing. While this note fully agrees with the positive effects of insurance to provide better and timely health care with some sense of equity and efficiency, there is whole range of caveats. A few mentioned in the note includes the exclusions – often permanent exclusion of certain conditions. In a country like India where most

(d) A recent addition is the 'Annapurna' scheme for those aged 65 and over, and faced with acute poverty. The scheme is yet to take a shape even after a year of its announcement.

people suffer from one or the other ailments, exclusions need to be carefully designed with attempts to see if they are revocable with time.

The other significant issue in the underlying context relates to the lack of medical services and infrastructure except in certain big cities and metros. With insurance driven demand for more and more medical care, the existing services may fall short. Bigger and metro based hospitals may enjoy scarcity pricing. They may also form some kind of cartel.

This note also advocates evolving a social insurance mechanism with an attempt to finance the premia through a mix of sources including some form of tax/cess on polluting and health hazardous manufacturing units, public transfers, user charges, etc. Initially, limited coverage may be offered to more vulnerable population groups with medical care provided by the public hospitals. Small private hospitals may also chip in.

A somewhat unrelated, but significant emerging issue may be found in the fast societal ageing with growing demand for medical care. Some of the more recent studies on ageing and its implications suggest acceleration in the growth of *'old old'*. These studies further reveal that the aged would outpace labour force in terms of its annual growth over the coming decades. These issues perhaps warrant serious attention without any more delay. Studies involving epidemiological issues and need for area specific development of medical infrastructure may therefore be undertaken keeping health insurance and its demand side implications in mind.

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