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Market for Health Insurance in Rural India

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Abstract: *In the midst of high cost of health care both at the macro and micro levels, health insurance becomes a viable alternative for financing health care in India. The first real attempt at insurance was carried out well before Independence, with the passing of the Insurance Act in 1912, which set down rules and regulations specific to the insurance industry. Then there was a more fundamental shake up in 1938 with the Insurance Act, 1938 and this led to an insurance wing being set up, attached to the Ministry of Finance. The main objectives of this paper are to examine the sources of finance for healthcare expenditure and willingness to pay for health insurance scheme in Rural India. The study used the UGC major research project data on healthcare consumption of 600 rural households in Tamil Nadu. Most of the people stated they are willing to join and pay for the health insurance scheme. However, the probability of willingness to join was found to be greater than the probability of willingness to pay. Indeed, socio-economic factors and physical accessibility to quality health services appeared to be significant determinants of willingness to join and pay for such a scheme. The discussion suggests that insurance companies in India should take serious note about the people's willingness to pay for health insurance scheme.*

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I. Introduction

In the midst of high cost of health care both at the macro and micro levels, health insurance becomes a viable alternative for financing health care in India. There is growing evidence that the level of health care spending in India – currently at over 6 per cent of its total GDP – is considerably higher than that in many other developing countries. This evidence also suggests that more than three-quarters of this spending includes private 'out-of-pocket expenses' (World Development Report 1993, EPW, 2000). It is also a way of mobilising private funds for improving health care delivery at the macro level.

The first real attempt at insurance was carried out well before Independence, with the passing of the Insurance Act in 1912, which set down rules and regulations specific to the insurance industry. Then there was a more fundamental shake up in 1938 with the Insurance Act, 1938 and this led to an insurance wing being set up, attached to the Ministry of Finance.

Objective

The main objectives of this paper are to examine the sources of finance for healthcare expenditure and willingness to pay for health insurance scheme in Rural India.

Methodology

To achieve the objective, the study used the data collected for UGC Major Research Project on healthcare consumption in 600 rural households in Coimbatore, Erode and Thanjavur districts of Tamil Nadu. A set of probing questions were put to individual members of the selected households to ascertain various information related to financing of healthcare services, knowledge about insurance and whether they willing to pay for health insurance scheme. In analysing the data the study used a contingent valuation method to assess the willingness of households to join and pay premiums for a Health Insurance scheme. The willingness to pay deal with the amounts that the respondents willing prepay to be beneficiary members of health services.

Review of Literature

The last decade there has been a growing interest in the introduction or expansion of solidarity based health care financing schemes in developing (Abel-Smith, 1986; World Bank, 1987, 1993; Vogel, 1990a, b; Shepard et al, 1992; WHO, 1993; Ahrin, 1995 and Schneider et al, 2000).

The households contribution for financing the health care brings up the problem of furniture and ratification of public goods as discussed by Whittington et al. (1990); Kristöm (1993); Diamond (1994); Li and Fredman (1994); Frykblom (1997) and Whittington (1998).In the literature, this technique of assessment of the willingness to pay is based on the contingent Valuation Method (CVM). The basic principle of this method is that the preferences of the individuals must be used as a basis for the assessment of the profits and losses of non-market goods and services. It is then allocated to the individuals to express their preferences through the concept of willingness to pay. Owing to the fact that it is based on the self-report, economists in particular remain sceptical with regard to the value of this method, insofar as the stated intentions often do not correspond to the behavior of the individuals. Moreover, because of its hypothetical nature, several biases can occur during the survey (Mitchell and Carson, 1989; Neill et al., 1994; Whittington, 1998; Frykblom, 1998; Bateman and Willis, 1999; Smith, 2001). Munasinghe (1996), Smith (2001) provide several examples on the contingent evaluation method to assess the quality of environmental resources in developing countries. Whittington et al. (1990) used this method to assess the financial contribution of the rural population to pay for water services in developing countries.

In literature, some authors concluded that the willingness to pay was influenced by economic characteristics, socio-demographic characteristics and the characteristics of the good in question (Whittigton et al.,1990; Coffie,1997; Flores and Richard, 1997; Pokou,1998; Houdegbe, 1998; Bloom and Shenglan,1999; Atim,1999; Criel et al., 1999). Tshinko et al. (1995) in the ex-post evaluation, grouped these factors in three different categories namely predisposition factors, facilitating factors and reinforcement factors. In addition to socio-demographic characteristics such as age, the level of education , gender, religion, the family size, the predisposition factors generally arise from the socio-cultural environmental of the respondent.

From this literature review, it appears that very little investigations on the analysis of the willingness to pay have been carried out in health sector in general and in Cameroon in particular. This study will contribute to the understanding of strategies used by rural household in order to improve their access to health care.

Financing of Curative Health Care in India

Recently, there have been many good reviews of India's health care financing [Berman and Khan 1993; Reddy and Selvaraju 1994; Upleker and George 1994; World Bank 1995; Alam 1998; Tulasidhar 1996; Mathiyazhagan, 1998. The various studies consistently show that a majority of people seek care during illness from private rather than public providers for out-patient care(Bhat (1993), Berman and Khan (1993) and Kumar, Krishna and Kanbargi (1994). Numerous studies have shown that even consumers from the lowest income quintile often pay considerable amounts out of pocket for curative treatment by public providers [Upleker and George 1994; Sundar 1995; Planning Commission 1996]. The financial burdens of health care in India are enormous and growing. Given the constraints and difficulties in raising additional public resources and the rapid growth in spending on health care, if will be very difficult for the public health system to keep pace (EPW, 2000). The lack of a governmental focus on curative care has led to almost unregulated growth in the private medical system.

II Analysis

Health care has always been a problem area for India, a nation with a large population and a larger percentage of this population living below the poverty line. In such a situation insurance becomes an important issue in the country. But surprisingly, for a country with the 5th largest economy, insurance in India has not been a sector that has taken off, considering its immense potential.

Source of Financing for Healthcare Treatments

Unlike other areas of spending, health treatment is neither regular nor predictable. Moreover, in the Indian context with poor environmental and general standards of living, all household members are likely to require health treatment, although women, children and the elderly are likely to suffer more from poor health. Unlike other categories of expenditure, spending on health treatment is often unavoidable, since illness may lead to lack of active life and long work. However, the amount spent may widely vary and may be determined by the nature of the illness, the type of treatment provided, system of healthcare from which treatment is sought and the healthcare service provider. Often people report sickness suddenly and there are incidences like accidents, which warrant emergency treatment. It is necessary to consider the sources through which the households obtained money for treatment.

Source of Finance by Individual Characteristics

There is the possibility for variation in the level of expenses incurred by households and sources through which such expenditure was met depending upon the individual characteristics of the patient and also upon the individual characteristics of member of household such as gender, age group, occupation, income earned etc.,. In the midst of lack of gender equality, difference in allotting household resources is bound to prevail and this may reflect in providing medical treatment. However with the growth of literacy and participation of more women in labour force, there has been growing awareness about reducing the size of family and the need for giving equal treatment.

The information we collected indicates that percentage expenditure for household healthcare treatment of females was slightly higher (85.5 per cent) than for male patients (82.1 per cent) considering the out of pocket source. Expenditure by sale of asset and borrowings from relatives is slightly higher for male than for female patients. So there was no discrimination against women in our sample households in financing healthcare treatment through different sources.

Table 1: Source of Finance by Individual Characteristics

Classification		Out of pocket/ savings	Sale of asset	Barrowing from relative/friends	Assistance from NGOs/Pvt/ Govt	Total
Sex	Male	256 (82.1)	6 (1.9)	45 (14.4)	5 (1.6)	312 (100)
	Female	332 (84.5)	4 (1.0)	48 (12.2)	9 (2.3)	393 (100)
Age Group	0 - 5 years	94 (88.7)	0 (0)	11 (10.4)	1 (0.9)	106 (100)
	6 – 14 years	60 (82.2)	0 (0)	11 (15.1)	2 (2.7)	73 (100)
	15 – 30 years	147 (84.5)	2 (1.1)	20 (11.5)	5 (2.9)	174 (100)
	31 – 60 years	244 (84.4)	7 (2.4)	33 (11.4)	5 (1.7)	289 (100)
	Above 60 years	43 (68.3)	1 (1.6)	18 (28.6)	1 (1.6)	63 (100)
Total		588 (83.4)	10 (1.4)	93 (13.2)	14 (2.0)	705 (100)

* Figures in parentheses indicate percentages

One could understand that willingness of households to spent on healthcare may differ depending upon the patients. For a member advanced in age beyond 70 years or so, apart from spending, source of financing will differ. In the absence of social security system, families bear the burden of taking care of the aged. However, in the case of low and middle income groups both the aged and others prefer to meet expenditure out of pocket and also resort to sale of asset. This view is supported by our data in that for 1.6 per cent of the people in the age group of above 60 years, their health expenditure is met through disposing of assets.

Among the various social groups which still have primitive culture, children carry less weightage than other family members. So correspondingly the expenditure incurred by the family and sources of financing will vary.

Source of Finance by Education, Occupation and Income

The first of the four sources of financing would be own fund or current income which may be called out of pocket, second, borrowing from relatives and friends, which may vary depending upon the network one has. The third preference would be for disposing of asset or property. The fourth one is getting assistance from NGOs, which is not common for all the complaints.

Education confers many advantages on the individuals and it provides allocative efficiency as claimed by human capital theory. We tried to find the variation in the source of finance and the level of payment and the level of education of health service seekers.

Table 2 indicates that around four fifth of illiterates the slightly higher percentage among groups having primary and secondary levels of education financed their healthcare expenditures through out of packet funds. Only persons with higher education have met their entire medical expenditure from their own pocket source. Perhaps their educational status itself is an index of their better economic status. In other words, higher educated respondents met their entire cost of healthcare treatment out of pocket, while four fifth of all other level educated met the expenditure from out of pocket source and a few through selling of assets.

Table 2: Source of Finance by Education, Occupation and Income

Classification		Out of pocket/ savings	Sale of asset	Barrowing from relative/friends	Assistance from NGOs/Pvt/Govt	Total
Literacy Level	Primary	198 (85.34)	2 (0.86)	26 (11.21)	6 (2.59)	232 (100)
	Secondary	114 (84.44)	4 (2.96)	14 (10.37)	3 (2.23)	135 (100)
	Degree	17 (100)	0 (0)	0 (0)	0 (0)	17 (100)
	Illiterate	259 (80.68)	4 (1.25)	53 (16.51)	5 (1.56)	321 (100)
Occupation Group	Agriculturist	152 (93.3)	1 (0.6)	9 (5.5)	1 (0.6)	163 (100)
	Agri. Labour	233 (82.0)	3 (1.1)	41 (14.4)	7 (2.5)	284 (100)
	Non. Agri. Labour	41 (74.5)	1 (1.8)	12 (21.8)	1 (1.8)	55 (100)
	Self-employed	77 (82.8)	2 (2.2)	11 (11.8)	3 (3.2)	93 (100)
	Salaried	60 (77.9)	2 (2.6)	14 (18.2)	1 (1.3)	77 (100)
	Rural artisan	25 (75.8)	1 (3.0)	6 18.2)	1 (3.0)	33 (100)
Income Group	Low (Below Rs.24,000)	286 (83.38)	3 (0.87)	47 (13.70)	7 (2.05)	343 (100)
	Middle (Rs. 24,001 to Rs. 60,000)	249 (81.6)	7 (2.3)	42 13.8)	7 (2.3)	305 (100)
	High (Above Rs.60,000)	53 (93.0)	0 (0)	4 7.0)	0 (0)	57 (100)
Total		588 (83.4)	10 (1.4)	93 13.2)	14 (2.0)	705 (100)

* Figures in parentheses indicate percentages

The proportion of patients who paid the bill by disposing of their assets was around 1.5 per cent in the case of illiterates and primary level literates and in the case of secondary level educated patients it was around three per cent. However, except patients with higher education, 10 to 15 per cent of all others borrowed to meet their cost of treatment. Around one to four per cent of our sample received support or assistance from NGOs.

Occupational group to which one belongs may have a role in the attitude towards life and their behaviour. Here we can look at the pattern of source of financing the healthcare expenditure among the occupational groups. We have classified the sample into to six occupational groups. Nine out of every ten agriculturists or farm families met their healthcare expenditure from out of pocket or savings, while about four fifth of agricultural labour and self employed category met it through the same source. Three fourth of the other occupational groups also relied on the same. So with a difference of five per cent to ten per cent all the occupational groups met their expenditure from out of pocket or savings.

The dependency on borrowing varied among the occupational groups – five per cent in the case of farmers and nearly one fifth (22 per cent) in case of non-agricultural workers. Other occupational groups varied between these two ends. Sale of asset to finance healthcare expenditure was resorted to by about three per cent of artisans and salaried class.

In receiving assistance from NGOs and others it was the self-employed and artisans who ranked higher than other occupational groups.

For analysing the way the different income groups financed their healthcare expenditure, we classified the respondents in to low, middle and high income groups depending upon their annual income in the range upto Rs.24,000, Rs.24,000 to Rs.60,000 and above Rs.60,000 per year respectively. It is found that about 49 per cent of respondents were in low-income group, around 44 per cent in middle income and only seven per cent in high-income group.

Our data revealed that the high-income group met their healthcare expenditure mostly from out of pocket or savings (93 per cent) and a small portion (7 per cent) by borrowing. However, the other two income groups met four fifth of the expenditure through own source and about 13 per cent depended on borrowing. Further a small portion (2.5 per cent) footed the bill for their healthcare treatment by disposing of their assets and with the support of NGOs.

Social Group and Pattern of Financing Healthcare Expenditure

In all socio-economic analysis and discussion the population is classified based on the social group to which they belong viz., socially deprived or SC/ST, backward class and other social groups. These classifications have their effect on their choice and pattern of expenditure. Hence it assumes importance in the discussion of preferences of social groups and the corresponding expenditures.

Table 3: Source of finance by Social Group of Household and the Type of Family

Classification		Out of pocket/ savings	Sale of asset	Barrowing from relative/friends	Assistance from NGOs/Pvt/Govt	Total
Social Group	SC/ST	138 (76.2)	2 (1.1)	36 (19.9)	5 (2.8)	181 (100)
	BC	440 (85.8)	8 (1.6)	56 (10.9)	9 (1.8)	513 (100)
	Others	10 (90.9)	0 (0)	1 (9.1)	0 (0)	11 (100)
Type of Family	Nuclear	456 (82.3)	8 (1.4)	79 (14.3)	11 (2.0)	554 (100)
	Joint	132 (87.4)	2 (1.3)	14 (9.3)	3 (2.0)	151 (100)
Total		588 (83.4)	10 (1.4)	93 (13.2)	14 (2.0)	705 (100)

* Figures in parentheses indicate percentages

It is evident from our data presented in Table 3 that three fourth of SC/ST group, marginally higher than four fifth of backward class people and nine out of every ten of other groups met their healthcare expenditure out of own savings or income. SC/ST group depended double that much of the BC and other groups on borrowing. SC/ST and BC depended on other sources of financing more or less equally while the other social groups have not faced this situation. In other words, relatively better economic condition enabled other social group households compared with BC and SC to meet the expenses out of pocket while relatively lesser proportion of SC/ST relied on the same (out of pocket) source.

In respect of type of family and source of financing of healthcare expenditure it is found that more number of joint families depend on own source than nuclear families while more nuclear families resorted to borrowing than joint families. If out of pocket expenses are considered as preparedness, then joint families provided more security than nuclear families in meeting household expenditures.

Knowledge on Health Insurance

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

The results show that life insurance schemes are popular in rural areas. In fact, people have relatively good knowledge of life insurance schemes rather than saving schemes. But none of the sample respondents had been covered by health insurance schemes. Only 2.4 per cent of total sample rural households have known about health insurance. Even some of the life insurance policyholders also were not aware of the availability of health insurance programmes.

Willingness to pay for health insurance rural areas

The preceding discussion implies that there is a significant willingness to participate in health insurance programmes of households that may not necessarily look very promising to the insurance companies – either from their ability to pay status or from their risk of illness status. However, it is contended here that with careful planning, it should be possible to use this willingness to the advantage of the insurance companies, so that the outcome is beneficial to both the insurer and insured. Lower premium rates are an essential pre-requisite for this. But that can only happen if those who are least willing to participate are brought into the net of insurance programmes. In India, the middle class is the largest expanding class. Without getting them and the high-income households into the pool, it is unlikely that private insurance will be tenable, from both the business as well as equity point of view.

III. Conclusion

Unlike other areas of spending, health treatment is neither regular nor predictable. Moreover, in the Indian context with poor environmental and general standards of living, all household members are likely to require health treatment although women, children and the elderly are likely to suffer more due to poor health. Unlike other categories of expenditure, spending on health treatment is often unavoidable, since illness may lead to lack of active life and work. However, the amount spent may widely vary and may be determined by the nature of the illness, the type of treatment provided, the system of healthcare chosen and the healthcare service provider. Often people report sickness suddenly and there are incidences like accidents, which warrant emergency treatment.

Most of the people stated they are willing to join and pay for the health insurance scheme. However, the probability of willingness to join was found to be greater than the probability of willingness to pay. Indeed, socio-economic factors and physical accessibility to quality health services appeared to be significant determinants of willingness to join and pay for such a scheme.

We end with an analysis of the future prospects of health insurance in a country with an expected middle class of 500 million middle class consumers in the next 8 years. The discussion suggests that insurance companies in India should take serious note about the people's willingness to pay for health insurance scheme.

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