Knowledge: a multidisciplinary e-journal
ISSN: 2581-3471

Website: https://www.knowledge-ejournal.in

Constraints in Implementation of Health Insurance Policies for the betterment of Health Care Protection: A Case Study at Alipore Sadar, Sub-division, South 24 Parganas, West Bengal

Deepshikha Mutsuddi, Assistant Professor,
Department of Geography, Maheshtala College, West Bengal.
Email: deepshikha.geo@gmail.com
and
Amitajyoti Bagchi, Associate Professor,
PG Department of Geography, Vivekananda Women College, West Bengal.
Email: amitjbagchi@gmail.com

Abstract

"Health is Wealth" gives expression to overall health status, economic prosperity and human development of a community. The population of developing countries depend much upon informal resources of health care. Due to the fear of high health care expenses and it's impoverishment impact people take self-medication or traditional resources for healing. These self-medications are very risky, mostly non-scientific and often of poor qualities for short-term beneficial treatment in compare to professional care. Presently Government of developing countries have started allocating higher percentage of their funding towards healthcare-sector by launching various Health Insurance Schemes in order to provide healthcare protection towards low income group of people in particular. But lack of awareness amongst common people creating obstacles for the successful launching of the Health Insurance Schemes. High income groups are suffering from high financial burden for costlier treatment due to huge out-of-pocket payment for outpatient. So in the developing countries the Health Insurance in case of both Private and Government Insurance Schemes are not effectively benefitting the insured beneficiaries and are unable to provide full health protection security to the population.

Introduction

Health is the level of functional or metabolic efficiency of a living-organism. It is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. There are three determinants of an individual health, a) Life Style – the aggregation of personal decision, b) Environmental – all matters to the human body, c) Bio-Medical – all aspects of health, physical and mental developed with the human body as influenced by genetic make-up. Health have an essential role in modern economic growth and a healthy workforce is recognized as the key to economic growth and sustainable development. Health problem, health deterioration due to several cause and health care are worldwide issue. Human health is one of the "pre-requisite" for socio-economic development of an area, hence it should be nurtured and also be protected through health insurance coverage. Health insurance addresses a major area of public concern. It is an insurance against the risk of incurring medical expenses among individuals. Health policies provide monetary protections for hospitalization expenses. So having health insurance is important because coverage helps people get timely medical care and improves their lives and health.

Study Area

South 24 Parganas an area about 9960 Sq. Kms. has intra specific morphological variation which indeed made South 24 Parganas a complex district stretching from metropolitan Kolkata to the remote riverine villages of Sundurbans up to the mouth of Bay of Bengal. I have chosen Alipore Sadar sub-division of South 24 Parganas district covering 427.28 Sq. Kms. For my study area. This sub-division lies between 22.53° N and 88.33° E and consists of three municipalities (Maheshtala, Budge Budge and Pujali) and five Community Development Blocks (CDBs) (Thakurpukur, Maheshtala, Budge Budge I & II and Bishnupur I & II). This 5 CDBs contain 36 Census Towns and 45 Gram Panchayets. Besides this a large parts of Kolkata Municipal Corporation falls under this sub-division. As Alipore Sadar sub-division cover the urban area surrounding metropolitan Kolkata, urban fringe area and also include extreme remote villages and typical rural areas, so lots of variation in respect of economy, standard of living can be observed which lead to variation in awareness of healthcare and simultaneously variation consciousness, acceptability, adaptability and implementation of different health insurance coverage.

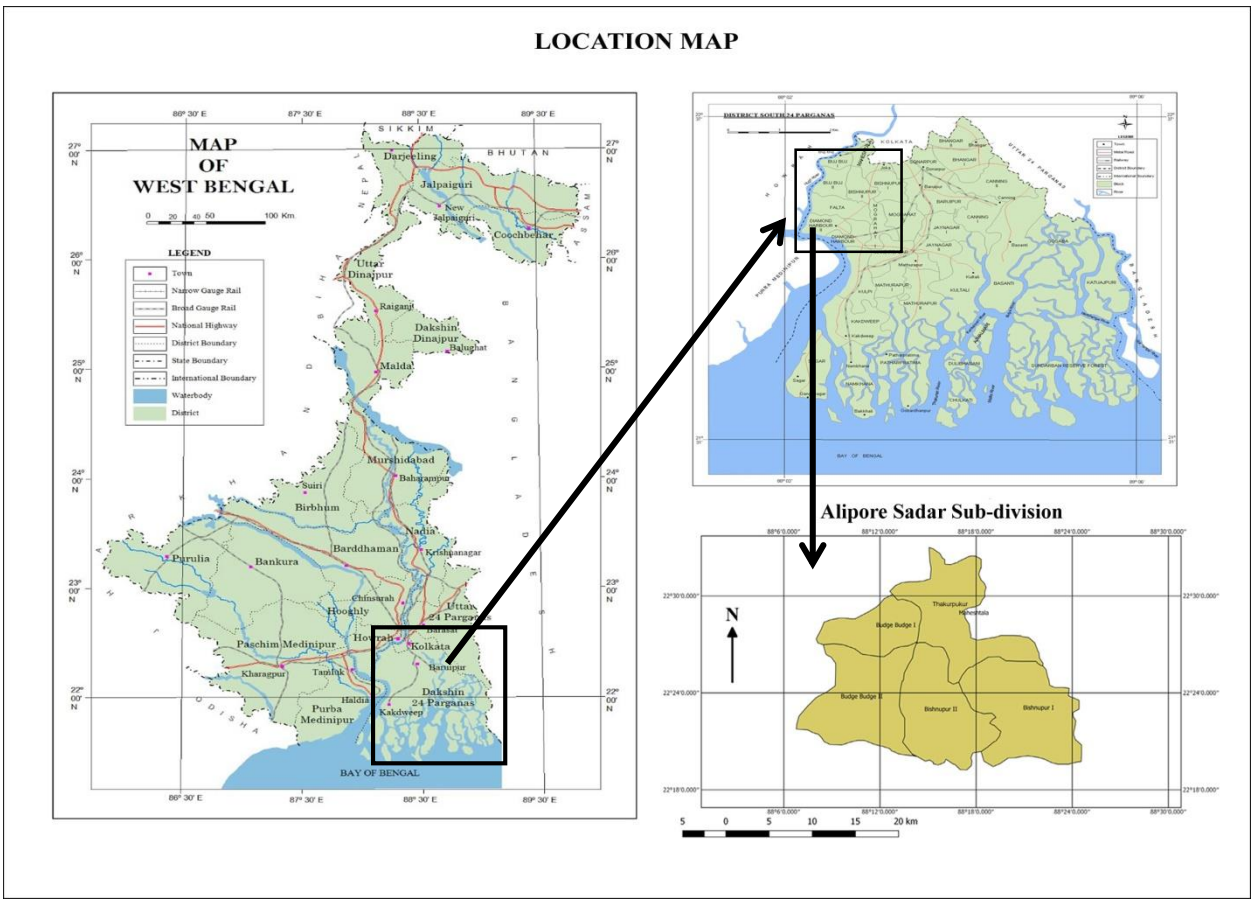

Figure 1 , location map of the study area.

Objectives

1) To study the health and health insurance coverage in the study area.
2) To study health insurance in respect of public health demand and variation of these criteria in regard to of different economic status.
3) To find scope for improvisation of health protection through health insurance schemes
4) To find limitations and drawbacks of the health insurance coverage.

Methodology

The study has been conducted in two parts. The Non-Analytical part with the data of 2018-2019 include the study of health status, economy and essentiality, implementation, relevance of health insurance coverage. The Analytical part include economically and environmentally acceptable new and innovative technology with the help of statistical tools, cartographic depictions and GIS techniques to develop the health status of the district. Materials used were primary data tools (field visits and semi-structured interviews) and secondary data tools (data from hospitals, Census of India 2011, Human Development Report 2018, different articles, Govt. publications). Statistical Analysis, spatial mapping and analysis are done by using GIS software. The attributes are then layered to ascertain spatial relationship. Finally, the geographical database has been used for GIS analysis to identify the impact of health insurance on providing health security and protection. Health treatment and improvements variable with respect to economic status has also been also depicted through GIS mapping techniques.

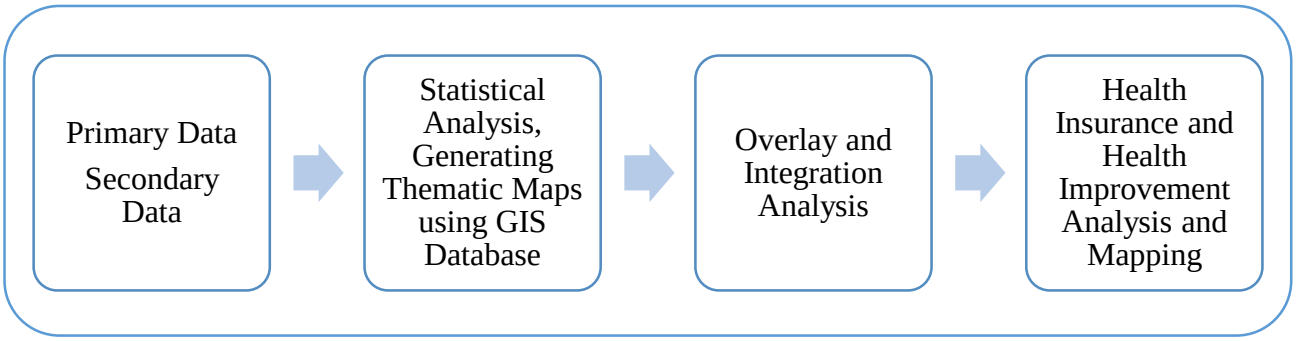

Figure 2 : Schematic Diagram showing the Study Approach.

Table 1 Rural and Urban Population of Alipore Sadar Sub-division

CD Blocks	Urban Population	Rural Population	Total Population
Thakurpukur Maheshtala	86023	90180	176203
Bishnupur I	27980	204385	232365
Bishnupur II	75552	138979	214531
Budge Budge I	83335	29573	112908
Budge Budge II	56880	135254	192134
			n=928141

Source: Census of India, 2011

The differential rural and urban population of Alipur Sadar sub-division is shown in Table 1. Here it is found that Thakurpukur-Maheshtala block urban and rural population is almost of equal level where as in the block Budge Budge I urban population is greater than rural population but in Budge Budge II reverse is the situation. Bishnupur I has lower urban population and it is very low in Bishnupur II block. Alipore Sadar sub-division is consisted of both urban and rural population almost at equal term. The economic status of this population irrespective of their existence at urban and rural areas needs to be understood from the point of view of their healthcare and health insurance.

Table 2 Economic Status medical expense and health insurance condition of Alipore Sadar Sub-division.

Income Group	Average Income (INR/Annum)	Family Expenditure (INR/Annum)	Medical Expenditure (INR/Annum)	Health Insurance Coverage	Health Insurance Investment (INR/Year)	Treatment without Health Insurance		Treatment with Health Insurance		Health Improvement after treatment	
						Affected Population	Medical Expenditure (INR)	Affected Population	Medical Expenditure (INR)	Population with Health Insurance	Population without Health Insurance
High	Above 1200000	1000000	100000	300000 Approx.	20000 Approx.	75	200000	382	500000	211	205
Medium	350000 – 500000	500000	50000	100000 Approx.	7000 Approx.	211	50000	238	50000	223	215
Love	50000 – 150000	100000	25000	10000 Approx.	-	237	10000	183	15000	206	185
Very Low (BPL)	Below 50000	50000	5000	5000 Approx.	-	377	500	97	12000	260	235
						n = 900		n = 900			

Source: Primary days computed by Author (2018-2019

Table 2 is representing the income level (yearly), family expenditure (yearly), yearly health expenditure, Health Insurance coverage, annual health insurance investments, affected person having health insurance or non-insured population, expenses of treatment for insured and non-insured population. This table is indicating the average healthcare & treatment, health improvement scenario including health insurance coverage with respect of economic status divided into 4 economic groups, i.e. High, Middle, Low and BPL level.

Impact of Health Insurance on Health Care and Health Protection

According to David H. Peters (2002) a better healthcare is judged on the basis of the fulfilment of three basic objectives;

i) Improving the health status of the population by reducing mortality and morbidity rates
ii) Protecting the people against the financial risks of health problems
iii) Responding the citizen's demand and needs.

After taking into consideration among these three objectives the second objective appears to be most important issue because health insurance coverage provides opportunity to the common people to get relief from huge financial burden of health related examinations and treatment and recovery.

The concept of "Health Insurance" was proposed in the year 1694 by Hugh the elder Chamberlane from Peter Chamberlane family. In 19th Century "Accident Assurance" began to be available which operated much like modern disability insurance. During the middle to the late 20th Century traditional disability insurance evolved into modern health insurance programme. Human health is an essential asset for a society and its socio-economic growth, so human health should be nurtured and also be protected through health insurance coverage. Institute of Medicine (IOM) estimated that lack of Health Insurance Coverage was related to highermortality rate. Today most comprehensive Health Insurance programmes cover the cost of routine, preventive and emergency health care procedures and also most prescribed common drugs. The need for Health Insurance is many fold from operational situations like – 1) Uninsured people receive less medical care and timely care. 2) Uninsured people, i.e. die prematurely than insured persons. 3) It is a fiscal burden to uninsured people and their families at the time of emergency. 4) The benefits of expanding coverage outweigh the cost for added service should be increased like expanding coverage should

improve health, lengthen lives, reduce disability, help to control communicable diseases and should raise productivity. 5) Network hospitals and clinics improve access to medical care but do not fully substitute health insurance, i.e. proximity to network hospitals or clinics increases access to care only. 6) Health Insurance Schemes also provides important for tax saving benefits to tax payers.

In the matter of Health Treatment the Indian health system is considered as a high out-of-pocket payment. This inequitable form of economic investment in health services has two necessary consequences. Firstly financing is an important barrier for accessing health care services and secondly some people who need complicated health care, there become pray to excessive cost of treatment. Quite often for this purpose house and other assets are kept in mortgage. In rural arrears livestocks are sold for this purpose also. Borrowing money from private money-lenders at high interest rates is a common practice amongst rural population.

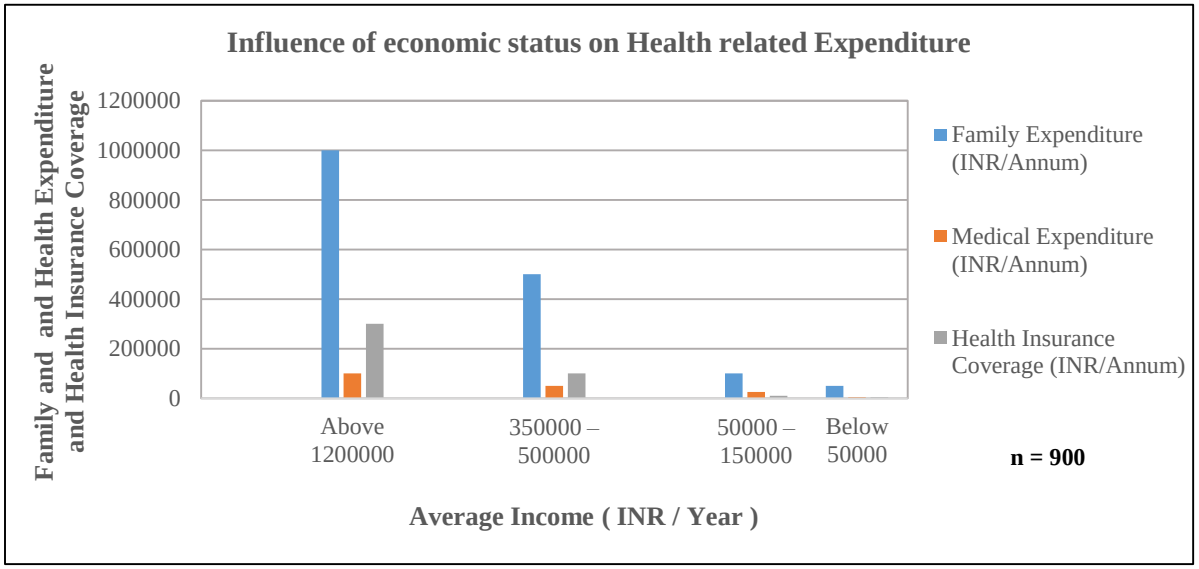

Figure 3 : Influence of economic status on Health related Expenditure

Source : Primary Data 2018-19

In Figure 3, variation in family expenditure, medical expenditure, health insurance coverage, health insurance investment is shown in terms of average yearly income of high, middle, low and

BPL level income group of people. From this graph it is clearly observed that high income Group is having high health insurance coverage and are capable to afford high amount of premium for their health protection but this average amount and premium amount gets reduced in the next 3 economic group and it is almost negative in the case of BPL level income group. But Govt. Health Insurance Schemes like ESIS, CGIS, UHIS, RSBY etc. are launched to provide health security and health insurance benefit to the lower income group.

So Health Insurance can play a role like an umbrella to protect the economy of a family and provide proper healthcare and services at the time of need and balance the economic and physio-mental condition of the family. So Health Insurance coverage can act as a tool for not only providing physical-mental-economic security to a family but that also has an influencing effect on the socio-economic development and growth of a society. Health insurance has a high positive impact on HDI and GDI of a country.

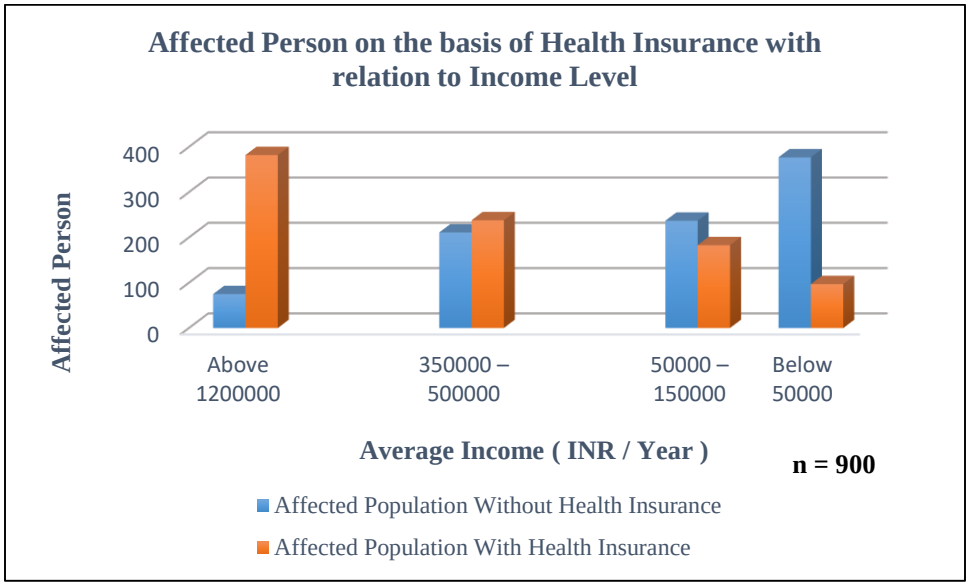

Figure 4.a : Affected person on the basis of Health Insurance with relation to income level

Source : Primary Data 2018-19

Figure 4a shows health status and economic status of Alipore Sadar sub-division, South 24 Parganas. In case of non-insured percentage of treatment done is less among high income group.

The availing of treatment is very less among the low income group because in most of the cases low income population are unaware about the health insurance schemes and on other side they are neglecting their health condition for financial causes. Only when severe illness occurs they become bound to do the treatment urgently without caring about any health insurance facilities.

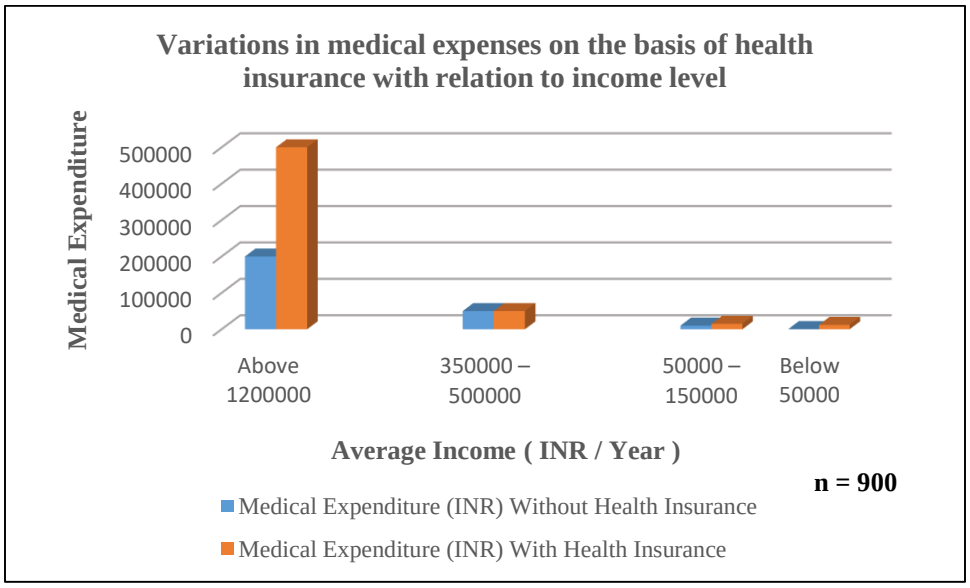

Figure 4.b) : Variations in medical expenses on the basis of health insurance with relation to income level

Source : Primary Data 2018-19

Figure 4b shows the amount of medical expenditure incurred by both insured and non-insured persons. As medical expenditure becomes high among non-insured because in non-insured cases out of pocket payment has to be beared by the patient party. So high income group of people try to make the treatment done through health insurance coverage. This is particularly advantageous for the expensive treatment and healthcare. For this reason medical expense is higher among high income group as they can enjoy health insurance coverage and they don't neglect their health and does regular health treatment consciously. But on the other hand people belonging to low income or BPL level group show reluctance in the matter of meeting medical expenditure. They don't even feel the need to go for medical insurance. This reveals the fact they are not properly guided to avail

different Health Insurance Schemes of Government and for this reason the families of lower income group are deprived from the benefit of such insurance schemes.

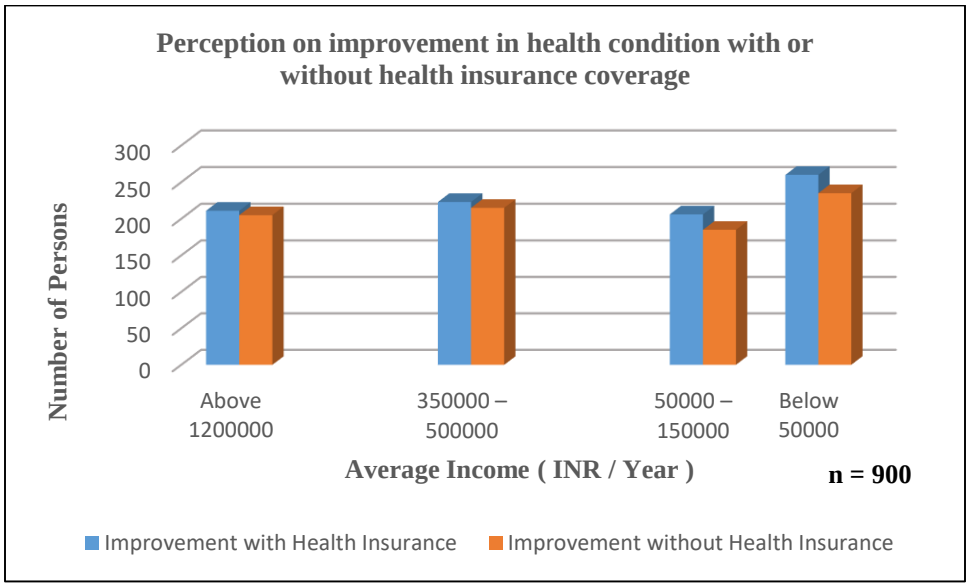

Figure 5 : Perception on improvement in health condition with or without health insurance coverage

Source : Primary Data 2018-19

Figure 5, indicating a similar scenario of both high to low income groups. Health improvement status is high among people who are benefitted with health insurance coverage and low in case of non-insured people. But it is depicting that either treatment is not done properly without health insurance coverage or due to huge financial burden patient are not availing the full treatment as a result percentage of health improvement are reducing.

Conclusion

In this study the impact of health insurance on out of pocket payments and financial risk protection for healthcare services has been shown. A regional and economic disparity has been observed in health expenditure especially in case of out of pocket payment in the study area. The objective of any health insurance coverage is to reduce the expenditure of healthcare services and enhance the utilization of healthcare facilities so that an equity can be achieved in the healthcare system. At the same time different Govt. Health Insurance Schemes are provided to give financial protection

against inpatient expenditure and improve utilization of inpatient services through cashless facilities especially for the low income and BPL income group of people. The Government schemes are made to provide financial support to the ailing people and their families and to make the patients free from distress like selling of assets and household property or to go for borrowing money from local money lenders to meet medical expenditure. The analysis shows that the average medical expenditure is less incases of both inpatient and outpatient who are benefitted by health insurance coverage but medical expenditure is high among the non-insured population. But in most of the cases of patient having Health Insurance coverage needs to be admitted in hospital for availing the Health Insurance benefits. So the benefits of Health Insurance are not been provided to the outpatient (patients who are not hospitalized). So in this matter though the patient have health insurance coverage still "out of pocket" payment are done which leads to a financial burden for the outpatient.

After analyzing the primary and secondary data it can be stated that health insurance contains the out of pocket spending particularly by the poor people. For BPL people the Govt. of India launched "Rastriya Swastha Bima Yojona" (RSBY) on 1st April 2008. Again the Govt of West Bengal started the "Nischay Yan" Scheme under the "Janani Shishu Suraksha Karyakram" (JSSK) on 1st June 2011 particularly for the people residing in the rural areas so that the expecting women can be shifted to the nearby hospitals free of cost. The "Swastha Sathi" Scheme was officially launched by Chief Minister of West Bengal on 30th December 2016 for employees on full time, casual and part time basis. Recently in August 2018 Govt. of India have launched a health insurance scheme named "Ayushman Bharat" for low level income group of people. Though many Govt. and Private health insurance schemes have been launched to provide health security to low income group people but survey reveals that Govt. health insurance schemes are largely ineffective to serve the purpose fully. The main reason for the ineffectiveness is lack of awareness amongst the insured persons. They have poor understanding about the benefit of the schemes and their modalities. Although the schemes are highly potential but the effectiveness of the schemes are heavily constrained by its ineffective implementation at various level. Beside this many poor people by not belonging to BPL category are deprived of the benefit of such schemes. The procedure of selection of BPL families is often flawed and put many families out of the list. They are then deprived from availing health insurance schemes. It has been also observed that to avoid the

financial burden of the treatment, the intensity of neglecting the health is higher mostly among all income groups of non-insured population. This leads to prolong and worsened health problem in future days resulting higher and prolong financial burden to the family members, even lives are lost, families are ruined.

Thus this analysis also supports the fact that along with the BPL category families low, middle and even higher income group also face the problem of higher health care burden. So "Universalization of Health Insurance" is not only essential but it should be provided to both inpatient and outpatient depending on the genuinity and severity of the health condition. To cater with huge financial pressure of the patient a premium can be charged from the beneficiaries according to their income level so that Govt. could remain financially sustainable in order to provide health security through health insurance schemes. The present Govt. is willing to move National Health Assurance Mission (NHAM) in sustainable manner to make the health insurance universal in nature for all income level groups which can enhance the growth of HDI and GDI of a Country. While introducing and implementing any Health Insurance Scheme emphasis should be given to economically poor section. The procedure of selection of genuine BPL families and low income group should be done properly and if possible before providing Health Insurance Scheme facilities verification of income group should be measured in various levels so that corruption can be avoided. Then only genuinely needy population could get the benefit of Health Insurance Coverage through proper channel within proper time.

References

Bajpai, N., Jeffrey, D. S., Ravindra, H. D. (2010). *Improving Access and Efficiency in Public Health Services: Mid-term Evaluation of Indias National Rural Health Mission*. The Earth Institute, Columbia University, Sage Publication India Pvt. Ltd.

Besley, T.(1989). The Demand for Health Care and Health Insurance. *Oxford Review of Economic Policy,* 5(1):21-33.

Devadasan, N. et al. (2013). Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. *Health Research Policy and Systems,* 11(29), 11-29.

Ekman, Bjorn. (2007). The impact of health insurance on outpatient utilization and expenditure: evidence from one middle-income country using national household survey data, *Health Research Policy and Systems,* 5:6. (http://www.health-policy-systems.com/content/5/1/6

Government of India, Ministry of Health and Family Welfare (2010). Annual Report to the People on Health, New Delh

Iyengar, S. and Dholakia, R. H. (2011). Access of the Rural Poor to Primary Healthcare in India, W.P. No. 2011-05-03, Indian Institute of Management Ahmedabad (IIM-A), India.

Shankar, P., Manmeet, K. and Rajesh, K. (2012). Universal Health Insurance in India:
Ensuring Equity, Efficiency, and Quality, *Indian Journal of Community Medicine*, 37(3): 142–149.

Shukla, A. (2005). National rural health mission--hope or disappointment? *Indian Journal of Public Health,* 49(3):127-132.

Sukumar V., Juyal, S. and Mehdi, A. (2010). Healthcare Delivery and Stakeholders Satisfaction under Social Health Insurance Schemes in India: An Evaluation of Central Government Health Scheme (CGHS) and Ex-servicemen Contributory Health Scheme (ECHS), Working Paper 252, Indian Council for Research on International Economic Relations (ICRIER), New Delhi.

Venkat, R. A. and James, W. B. (2009). *Public-Private Partnerships in Health Care in India: Lessons for developing countries*. Routledge. Taylor and Francis Group. London & New York.

Wagstaff, A. (2002). Measuring equity in health care financing: reflections on and alternatives to WHOs fairness of financing index. *Health Economics*, 11(2): 103115.