Original article

Effectiveness of health insurance and its impact on rural health development

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Background: Providing health insurance or health security for poor people continues to be one of the most important unresolved policy issues for the world. Most rural and informal sector workers in the world do not have any form of health insurance. And in most developing countries, the rural and informal sectors constitute the bulk of the population.

Emerging and reemerging new diseases Medical service are being expensive in the recent years because of the advancement of new technologies and increasing demand for quality of care, changing life styles and poor health accessibility in the rural areas.

Methods: A non experimental descriptive exploratory research design was followed. The population of this study consisted of all those people who were involved in the Health Insurance Scheme launched by various organizations. 105 household was taken from Kirtipur Municipality.

Results: 96.2% of total 105 respondents have getting accessibility through existing Health Insurance scheme and most of them 42.9% have got free bed at the time of admission in the hospital, 43.8% free operation charge, 74.3% have got free health check up and 4.8% have got free lab tests.

Conclusion: Health Insurance Scheme is important indicators of quality services delivered by the scheme. Patient satisfaction is an important factor for willingness to pay. Quality of service is one of the determining factors for rural people to join the Health Insurance Scheme. On the basis of the study finding, it was concluded that awareness program on Health Insurance Scheme should be conducted for the community people, is necessary for the people and premium rate of existing HIS to be lowered, coverage area of the Scheme to be increased for making effective Health Insurance Scheme.

Key word: Rural, Health Insurance

Introduction

Providing health insurance or health security for poor people continues to be one of the most important unresolved policy issues for the world. Most rural and informal sector workers in the world do not have any form of health insurance. And in most developing countries, the rural and informal sectors constitute the bulk of the population[2].

The socioeconomic conditions of Nepal, a rural, agricultural economy with low human development and presence of endemic poverty, have made the health sector a priority for sustained economic development. Equitable access to quality health care to meet the needs of the poor and reduction in poverty by achieving of the Millenium Development Goal (MDG) are the key concerns of the health policy. Delivery of Essential Health Care Packages (EHCP) to all regardless of the ability to pay, availability of the health needs beyond EHCP, regulation of the private health market/sector within the context of decentralization, and public-private/NGO partnership are important features of the health sector reform strategy. Government of Nepal has acknowledged this within the context of 20/20 implementation and the declaration to provide essential health care package. Nevertheless, the problem of financing of the health sector is a matter of serious concern to the

government since there are indications of paucity of resources in general[1].

In India, for example, estimates suggest that 90% of India's families earn their livelihood from the unorganized sector, contributing 40% of the nation's GDP (Jhabvala and Subrahmanya 2000). However, they are poor, most of them are not in employer-employee relationships, they do not have any form of insurance or security (e.g. maternity benefits, retirement, health insurance), nor do they have representative organizations that might help them fight for these benefits (Ahmad et al. 1991, Gumber & Kulkarni 2000). The poor are particularly vulnerable to the lack of health security. Studies show that the poor spend a greater percentage of their budget on health related expenditures (this varies between 6-8% in various studies see Sheriff et al 1999). The burden of treatment is particularly devastating for major health issues, and particularly when they seek "in-patient" care (hospitalization). Further, the high incidence of sickness (morbidity in technical terms) cuts into their budget in two different ways, i.e. they need to spend large amounts of money for treatment and are unable to earn money while under treatment. In fact, healthcare costs are one of the primary reasons for rural indebtedness and poverty (Gumber 1997). However, a common perception is that the poor are too poor to buy health insurance. While it might be true for the poorest of the poor who struggle for survival every day, it need not be true for those living close to the poverty line (Martin et al. 1999, Zeller and Sharma 1998). Moreover, there is substantial evidence that if provided with the opportunity, the poor would be willing to pay for health insurance. A recent study by Gumber and Kulkarni (2000) suggest that the rural respondents in Gujarat were willing to pay an annual premium of Rs. 80 and Rs. 95 for coverage for hospitalization, chronic ailment, and specialist consultation and an additional 16% if there was coverage of transport costs, medicine costs and diagnostic charges. However, a large number of the existing schemes for poor people still involve part or full subsidies by the governments of various countries. Several obstacles stand in the way of providing health insurance to the rural poor and informal sectors (Van Ginneken 1999). First, the rural and informal sector is not a homogenous category, so it is difficult to organize them.

Second, they are geographically dispersed. Third, there are no employers or it is difficult to identify employers. Fourth, providing health insurance to this section of the population is a daunting task, because rural and unorganized workers often need employment, income and social security simultaneously, which is hard to provide. As a result, for example, overall health insurance coverage is low in India (Gumber 2002). Estimates suggest that less than 10% of people in India have access to health insurance, and a majority of them belong to organized sector (Gumber 1998, Ellis et al 2000). Obviously,

the demand for health care for the rural and unorganized sector has largely been unmet.

Commercial insurance companies so far have showed little interest in providing health insurance for rural farmers and workers in the informal sector because of potentially low profitability and high risk. It is non-government organizations (NGOs) and charitable institutions (not-for-profit) that have played an important role in the delivery of affordable health services to the poor. However, the coverage of these schemes have been very limited, and the record has been mixed. A recent review of 83 NGO provided health

Insurance schemes for the informal sector suggest issues of poor design and management, affecting their sustainability (Bennett, Creese and Monasch 1998). We reviewed several initiatives and experiments, which, despite the problems, provided us valuable experience and lessons[3]. Emerging and reemerging new diseases Medical service are being expensive in the recent years because of the advancement of new technologies and increasing demand for quality of care, changing life styles and poor health accessibility in the rural areas. Thus, getting money during illness is very difficult and one has to pay high interest rate in lending in the rural area. Many families have to sell their land, house and other property to pay the cost of health care and they crumbled down below the poverty line.

It has become difficult for the government to care to the growing health needs of the people from its limited resources. Moreover, ever increasing population and changing health care seeking behavior of people have exerted more and more pressure on government to explore alternative sources of health care financing. Health insurance; with its underlying principals of pooling of risks and resources among the healthy and sick and among the rich and poor is considered to be one of the possible health care financing mechanisms for Nepal.

Community health insurance has got higher priority and ranked as Pi in the MoH programmers. Thus, priority will be given in resource allocation, release and implementation of the programme. Many developed and developing countries have successfully adopted health insurance programme to improve their people's health hazard suffering life.

The government is actively fostering the development of these health insurance systems in urban as well as rural areas. The purpose of those programme was No one should be barred from health services, and treatment due to lack

of money, low income or poverty. It is a shame that people have to beg for health care, as it is their birth right."

The His Majesty government of Nepal (HMGN); ministry of health has a plan to adopt alternative health financial schemes to make up the health services expenditures. As a result they have brought a "in 2000 (MOH 2000). The government has also highlighted the program for implementing the community based health insurance as a pilot programmed in the country.

Many developed as well as developing countries of the world have successfully adopted health insurance as an integral part of their health care financing system. In the context of Nepal, health insurance has not yet occupied a genuine place in the country's health system, despite the government's stress in the policies and plans (e.g. National health policy, Long-term health plan, Ninth and tenth plan. Nevertheless, community based health insurance scheme is not entirely alien in Nepal in the sense that it is being experienced in some areas only.

Materials and Methods

This study was carried out in Kirtipur Municipality, Kirtipur where health insurance programme was lunched by Model hospital and health cooperative organization. The survey was conducted each household during November 2006. A total no. of 560 households were selected but only 105 respondents have involve in health insurance scheme. Door to door survey was conducted and information were collected with the help of a semi structured questionnaire and pre tested proforma and the data was compiled and analyzed with application of statistical tests wherever necessary.

Results

This chapter deals with the finding of the study obtained from analysis and interpretation of the data, the responses from 105 beneficiaries who were involved in Health Insurance Scheme. Data have been analyzed according to the objectives of the study. The collected data were compiled and tabulated in dummy tables, manually, following which analysis and interpretation was commenced on the basis of frequency, percentage mean and standard deviation.

Table 1: Distribution of respondents by their residence Area

Residence Area	Number	Percentage
Panga ward No-9	35	33.3
Tyanglaphata ward no. -17	35	33.3
Kirtipur Nayabazar -	35	33.3
Total	**105**	**100**

Among 105 respondents, 35 respondents (33.3%) were from each residence area (Panga, Tyanglaphata, Kirtipur Nayabazar) *(Table 1).*

Table 2: Gender wise Distribution of Respondents According to Sex

Sex	Number	Percentage
Male	74	70.5
Female	31	29.5
Total	**105**	**100**

Majority of respondents (70.5%) were male, whereas, only 29.5 percent of respondents were female *(Table 2)*.

Fig. 1: Distribution of respondents according to occupation

The total respondents about 47.6% (50) were service holder, whereas only 13.3% were belonged to business. Among others, tailors, house –wife, driver were involved in this study *(Fig. 1).*

Fig. 2: Distribution of respondents as per education level

Majority of respondents (99.1%) were literate, whereas only 1 % was illiterate. Among literate majority of the (43%) had higher secondary and above level education, whereas only 27.6% respondents had primary level education *(Fig. 2)*.

Table 3: Distribution of Respondents According to Types of Family.

Types of Family	Number	Percentage
Nuclear	48	45.7
Joint	57	54.3
Total	**105**	**100**

Majority of respondents (54.3%) had joint family and minority of respondents (45.7%) had nuclear family *(Table 3)*.

Table 4: Type of the Insurance adopted by respondents

Type of Insurance	Number	Percentage
Hospital based	15	14.28
Community based	42	40
Health Cooperative based	38	36.2
Others	10	9.52
Total	**105**	**100**

Community based insurance done people are higher than other. People are more attractive to do insurance through community organization which show 40%. but hospital based insurance done people are less than community whereas through health cooperative based programme is more effective than alone hospital based programme. but table shows that jointly programme organized by health cooperative and hospital based programme is more effective than community based programme. combination of two organization is shows 53 respondents have done hospital and health cooperative insurance *(Table 4)*.

Table 5: Information on Health Insurance Scheme

Sources of information	Number	Percentage
News papers	9	8.58
Television / radio	11	10.47
Insurance Agents	15	14.28
Neighbor/peer	65	61.9
Others	5	4.77
Total	**105**	**100**

Almost all of the respondents had some kind of information on Health Insurance Scheme. Among them majority of the respondents (61.9%) were informed by neighbor /peer, only 14.28% were informed by Insurance Agents. remain of them were known about insurance news paper and television/ radio. 8.58% were informed from news paper and 10.47% were informed from Television/radio. only 4.77 respondents were know from others sources as Holing board, hospital and so on *(Table 5)*.

Table 6: Respondents Awareness: on Benefits Given by the Scheme

Benefits	Number	Percentage
Free Bed Charge	45	42.9
Free Op Charge	46	43.8
Free Dr Check up	78	74.3
Free Lab Tests	5	4.8
Awareness		
Mean	1.65	-
SD	1.09	-

Majority of respondents (74.3%) knew about benefits of Health Insurance Scheme including free Dr check up (74.3%), followed by free operation Charge 43.8%, whereas only 4.8% respondents knew about the free lab tests. Further, mean score obtained by them in average was 1.65 and the variance takes place by 1.09 *(Table 6)*.

Table 7: Increase in Health Care Expenses by the Health Insurance Scheme

Increasing health care expenses	Number	Percent
Yes	93	88.6
No	12	11.4
Total	**105**	**100**

Majority of respondents (88.6%) expressed their desire to increase the coverage of health care expenses by HIS in existing coverage. Whereas, only 11.42 % respondents did not want to increase the coverage *(Table 7)*.

Table 8: Respondents Response: Existing Premium rate of HIS:

Premium Rate	Number	Percent
Normal	80	76.2
Low	2	1.9
High	23	21.9
Total	**105**	**100**

Majority of the respondents (76.2) perceived the existing premium rate as normal, whereas, only 21.9% respondents perceived as a high rate *(Table 8)*.

Table 9: Affordability of the Current Premium

Affordability	Number	Percentage
Yes	93	88.6
No	12	11.4
Total	**105**	**100**

Out of 105 respondents, majority of the respondents (88.6%) were able to afford the current premium rate whereas,

only11.4% respondents expressed that, and they could not afford the current premium *(Table 9).*

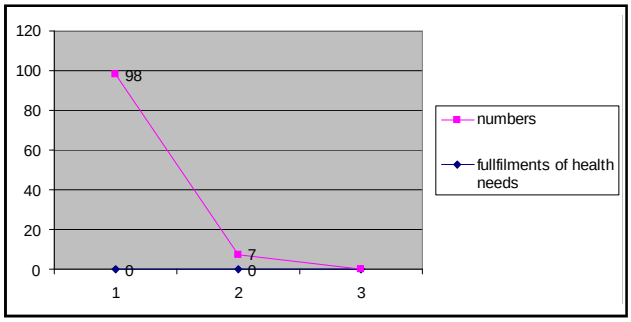

Fig. 3: Fulfillment of health needs of community

In regard to fulfillment of health need of community people as shown in table 16, the majority of the respondents (93.3%) expressed that their needs were full filled.

Discussion

His Majesty Government of Nepal (HMGN) has plan and implement Health insurance program. Community health insurance has got higher priority and ranked as p1 (priority1) (MoH, Guideline for community Health Insurance Government of Nepal) in the MoH program, so it is in lined with government's health policy.

In fact, there are couple of community based health insurance scheme being operated in the NGO and semi government or academic sector but till now there is no such study has been conducted to see the effectiveness of health insurance scheme.

Assessment of consumer's satisfaction is necessary as an indicator of effectiveness of existing health insurance scheme in order to expand the scheme and improve of health status of people in urban Nepal as well as rural.

However, any meaningful policy/strategy formulation to promote health insurance scheme in the country is badly constrained by dearth of information regarding scheme so, it is necessary to assess awareness of community people where it is implemented. There are three models of His presently under operation in Nepal: The hospital based micro- social health insurance scheme, community health post based insurance scheme and health co-operation models

Social science report 27 a study in Sudan shows that health Insurance has positive implication for utilization of public health services and provision of equal access to health services, the study recommend that insurance coverage to be expanded to all segment of the population, extra financial resources to be injected into health sectors in order to reduce the negative effect of the insurance such as adverse selection and moral hazard and rationalization of resources should be enhanced and more incentives should be provided to the staff.

Provision of public sector health services is basically financed from taxes and user fees. Both are regressive, as the taxes are mainly indirect (VAT) and the user fees are a fixed amount, meaning that the poor pay relatively more than the rich, if and when they make use of public services at all. There are virtually no insurance schemes in place. People pay around $10 per capita out-of-pocket per annum. A pilot with community health insurance is planned for this year. Public services are mostly used by the middle income groups, while the rich go to the private sector and the poor don't go at all. The ongoing Nepal Living Standard Survey will give more information on utilisation of health services in the rural areas.

Data from different sources have been analysed to get a grasp on the relationship between poverty and health and reveal great disparities in both health outcomes and intermediate indicators. Differences between the richest and poorest income quintiles in attended delivery, antenatal care, immunization coverage, malnutrition, total fertility rate and use of modern contraceptives are 2-10 fold. Infant and child mortality rates are much higher in rural areas and in particular in the mountains, coinciding with income differentials. A relation between the educational level of the mother (often in itself income related) and major health indicators has also been clearly established, as well as a relation between health care seeking behaviour and poverty. Geographical focus of reaching the poor should be on the Mid-and Far-West Regions, where 22% of the population live, who have the worst health indicators of the country and where hence great health gains can be made.

Conclusion

Since the purpose of this study was to find out the effectiveness of HIS among community people where program was implemented. Effectiveness included awareness and satisfaction of community people towards HIS. While assessing existing extent of awareness, the majority of the respondents 62.9% had moderate level of awareness where as 35.2% respondents had adequate awareness and only 1.9% respondents had inadequate level of awareness similarly while assessing the existing extent of satisfaction none of the respondents were poorly satisfied HIS majority of respondents 96.2% were highly satisfied and only 3.9% respondents were moderately satisfied with existing HIS the study also highlighted the major factors that affected for effective HIS major areas where need more attention in order to make effective HIS in future.

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