HOW WELL DOES THE EMPLOYEES' STATE INSURANCE SCHEME PROTECT AGAINST CATASTROPHIC HEALTH PAYMENTS IN TAMIL NADU, INDIA?

CREHS

POLICY BRIEF
JUNE 2011

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The authors are part of the Consortium for Research on Equitable Health Systems (CREHS) and funded by the Department for International Development, UK.

This policy brief is based on a research report, "How Equitable is Employees' State Insurance Scheme in India? A Case Study of Tamil Nadu." The report is available on the CREHS website http://www.crehs.lshtm.ac.uk

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METHODS USED

- A survey of about 900 Scheme members (called "Insured Persons") was conducted in the Chennai region between August 2007 and March 2008
- Analysis of data from the Scheme on the number and types of services accessed was undertaken
- Survey respondents were chosen from four different sectors: textiles, engineering, food and beverages and leather
- Ten industrial units were chosen based on their willingness to participate
- Respondents were selected based on the employees who were present and whose names were listed as per their identification number
- Systematic random sampling was used to select every 5th person from the first stage
- A detailed questionnaire was developed and administered which explored: demographics and socio-economic characteristics; household assets owned by the members; contributions to the Scheme; health seeking behaviour; the place of care used as out-patients and in-patients; direct medical expenditure, non-medical expenditure and indirect care seeking costs

INTRODUCTION

Around 70% of total health expenditure in India is made up of out-of-pocket payments and around 30% of households spend more than 10% of their income on health. The importance of health insurance as a mechanism to provide financial protection is well grounded in both theory and experience. This research looked at the effectiveness of the Employees' State Insurance Scheme (the Scheme) at protecting beneficiaries from out-of pocket expenditure on healthcare. Nearly 13% of the total beneficiaries of the Scheme are located in Tamil Nadu. About 8 million out-patient cases and 0.34 million in-patient cases were treated in Scheme facilities in 2007-2008 at a cost of Rs.854 million.

The Scheme was introduced in India in 1955 in order to provide financial protection to those in the lowest income groups in the industrial/manufacturing sector. Based on the principle of pooling risks and resources, it provides medical facilities to beneficiaries and cash compensation for loss of wages or earning capacity while in service. Under the Scheme employees contribute 1.75% of their wages towards premium payments. Employees earning less than Rs. 50 per day are exempted from contribution towards premium payments. Employers contribute 4.75% of the wages of eligible employees. The State Government also makes a contribution. Medical care is delivered either through facilities owned by the Scheme or through designated, or empanelled, outside providers.

Typically, insured employees and their dependents are attached to a particular dispensary closest to their residence. The medical staff act as gatekeepers to higher level institutions, which are either hospitals that are directly owned by the Scheme or private hospitals with which the Scheme has an agreement to provide care at a negotiated price ("empanelled hospitals").

The coverage, quality and overall effectiveness of the Scheme suffer from poor public perception. Studies also show that the system suffers from long recruitment procedures and a low level of satisfaction among users. This research assessed the effectiveness of the Scheme in Tamil Nadu based on the perceptions of insured persons, the degree of financial protection provided and the levels of utilisation of Scheme facilities.

KEY FINDINGS

The majority of beneficiaries seek care outside the insurance plan from private facilities at a relatively high personal cost.

A total of 2001 out-patient consultations took place during the 30 days preceding the survey. Only 67 (3%) of these utilised Scheme facilities; 406 patients (20%) chose to visit private facilities and the remainder self medicated, visited a pharmacist or did not seek care. Of the 169 insured patients who required in-patient care only 60 (35%) used Scheme facilities while the remainder, 109 (64%), visited private facilities.

Despite the overall low utilisation of the Scheme facilities it is important to note that they were used more by those in the lower socioeconomic quintiles than those in higher quintiles, see Figure 1.

Those beneficiaries who chose to use private providers rather than ones designated by the Scheme on average paid more for the out-patient and in-patient services that they accessed, see Tables 1 and 2. Not only was the cost of treatment high but the transportation cost and other medical expenditures incurred were higher for those who sought out-patient care from the private sector. When it came to in-patient care the beneficiaries who visited the Scheme facilities incurred more indirect

expenditure compared to those sought care from the private facilities. This is because there are few Scheme owned facilities and empanelled hospitals and the beneficiaries had to travel long distances to access them.

Reasons given for not using the Scheme facilities for out-patient care included: a lack of access, long waiting times, inconvenient opening hours and dissatisfaction with the quality of treatment. Beneficiaries were deterred from accessing in-patient care for the same reasons but also because of: a perception of low quality drugs, long waiting periods, the insolence of Scheme personnel, unusual delays in reimbursement of money spent on treatment outside the scheme, lack of or low interest by employers and a poor awareness of the Scheme procedures.

Poor access to the Scheme facilities was due to inconvenient opening times and geographical inaccessibility. Opening hours did not always coincide with beneficiaries' working hours. About 40% of the sample population reported not having an out-patient facility within a 10 km radius of their residence. Almost 60% reported that in-patient facilities were also not present within a 10 km radius. Eligible family members, who lived apart from the Scheme member, had to travel long distances to the provider designated by the Scheme. Private providers, on the other hand, are widely distributed across the state and tend to have more flexible hours and shorter waiting times.

Figure 1: Utilisation of the Scheme, by socioeconomic group

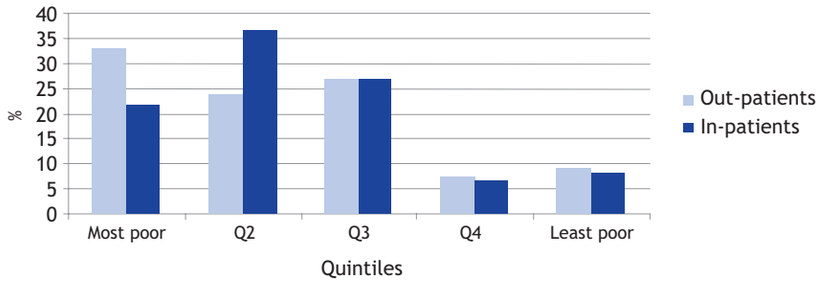

Table 1: **Out-patient expenditure per visit in the Scheme facilities and private facilities, by socioeconomic group (figures are in Rs.)**

Quintiles	Direct Medical Expenditure	
	Category 1*	Category 2**
1 (lowest)	30.00	635.96
2	Nil	249.37
3	152.50	1015.95
4	550.00	329.39
5 (highest)	500.00	1279.86
Total	322.50	705.64

Table 2: **In-patient expenditure per episode in the Scheme facilities and private facilities, by socioeconomic group (figures are in Rs.)**

Quintiles	Direct Medical Expenditure	
	Category 1*	Category 2**
1 (lowest)	2250.00	3031.25
2	1750.00	8605.56
3	3400.00	4462.50
4	4750.00	1500.00
5 (highest)	3136.36	4892.31
Total	2250.00	5431.13

* Category 1: Beneficiaries who visited the Scheme facilities first and obtained free services but might have also been referred by physicians to private facilities for certain services are reimbursed.

** Category 2: Beneficiaries who visited private facilities on their own without referrals from the Scheme providers and who are therefore not reimbursed.

CONCLUSION AND POLICY RECOMMENDATIONS

- The government could improve access to healthcare by constructing more Scheme facilities or adding more private facilities to the panel of recognised hospitals where beneficiaries can get treatment.
- The basic infrastructure of the existing facilities could be improved to provide a higher quality of service; this includes making basic diagnostic equipment available, providing nursing personnel, improving laboratory services and making conditions more sanitary.
- A multiple card system could be introduced so that the beneficiaries can use a convenient facility whenever required. This would particularly help those employees whose family members or dependents do not live with them. It would mean that employees and their families could hold a number of cards so that even if they lived apart each could use the most convenient health facility.

This document is an output from a project funded by the UK Department for International Development (DFID) for the benefit of developing countries. The views expressed are not necessarily those of DFID.

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