Chapter 3

LITERATURE REVIEW

The literature review aims to explain the concepts of health insurance, financing, and premium of health insurance, user's fees and utilization health care services in order to make them understanable so that we can use them to answer the following questions: What is insurance coverage? What is HI good for? Why do people choose HI? Is HI important? What are user's fees (user charges).

Experiences from other countries, previous studies and comments on health insurance and the VHI program in Vietnam will be mentioned in order to show the advantages, and solutions that are relevant to Vietnam.

3.1 Concepts of Health Insurance

Health insurance is a system in which prospective consumers of care make payments to a third party in the form of an insurance scheme, which, in the event of future illness, will pay the provider of care for some or all of the expenses incurred. In other words, health insurance is a means of providing members of a defined community with some protection against the cost of health services. Hsiao (1992) described health insurance as a means to pool the risks. When risks are pooled across a population, unpredictable losses can be transformed to predictable losses; and with cross-subsidisation of resources from the healthy to the sick, from the rich to the poor, from small family to large family with a number of dependants achieved, individual security is improved.

The concept of health insurance benefits is describe as health services provided to insured persons which are delivered, paid or reimbursed in full or in part by the third-party-payment, that is payment for health care services incurred by a defined group of protected persons, made by government and health insurance companies, on their behalf (Ron, Abel-Smith and Tamburi, 1990).

Health insurance is a way of realising social justice, because it is based on solidarity and co-operation between the well and the ill, the rich and the poor, and employers and employees (Abel-Smith,1986).

The basic issues of health insurance are: Who will be covered? What will be covered? How will the plan be financed? How much will patients pay? (Sharp, Register and Leftwich, 1994). The goals of health insurance organised by government can be summarised as follows:

(1) To ensure everyone has access to adequate health care and an equal opportunity of access to basic health care for people at equal risk. In terms of equity, the broader objective of full equality is usually phrased in the health care context as equal treatment for equal need. Expanding population coverage is one of the equity goals. The larger a scheme's population coverage, the more equitable a scheme is. The possible growth of coverage means that a scheme has the potential to increase the number of beneficiaries if financing is available.

(2) To eliminate the financial burden connected with the acquisition of health services.

(3) To control and limit rising health care costs, in order to avoid a moral hazard both in terms of a consumer moral hazard and a provider moral hazard, and in order to achieve efficiency by doing the best way to provide health care services (Donaldson and Gerard, 1993).

Puntularp (1995) explained that in developing countries, health insurance has a major role in mobilising funds from private sources for health care services. Other options may not be suitable for low-income groups which HI is intended to cover (informal workers, agriculture workers), for example, taxation and user charges, because they have such low incomes. Besides that, HI can have the disadvantage of adverse selection if more people with higher risk of illness join the scheme and people with lower risk do not. It can also have a moral hazard since treatment costs are paid by the insurers while patients become less price-conscious. The viability of introducing this system, and its success, depends on the level of economic development, including income of the population, the socio-cultural conditions and

co-operation between the MOPH and health-related organisations. Finally, it depends on how health management can operate in such a way that it leads to efficiency and equity. Because they lack that foundation, although more than half of all developing countries have introduced health insurance into their countries, it covers only a small number (5-30%) of the population.

3.2 Insurance Coverage

Categories of insurance coverage related to percentage of each category (Gooding, Sandra Smith, et al. , 1996). Some countries choose voluntary membership as a route to wider coverage. Access to the insurance system is offered on a voluntary basis, this removes the problems related to registration of members, since only persons who apply for membership are registered. Offering voluntary membership may entice certain population groups to join, particularly those groups who are not presently covered by an insurance scheme and those who may be dissatisfied with the existing quality of health care services (Charles Normand and Axel Weber, 1994).

3.3 Utilisation, Demand and Premium for Health Insurance

Phelps (1993) mentions that people seem to dislike risk. The pervasive purchase of insurance of many types offers concrete evidence of this dislike. People willingly (and often) pay insurance companies more than the average loss they confront, in order to eliminate the chance of really risky (large) losses. We can describe people who behave this way as being risk averse. Risk aversion arises from a simple additional assumption, that the marginal utility of income, while positive, gets smaller and smaller as a person's income gets larger. The difference between the certainty equivalent and average income is called the risk premium. It represents the maximum that a risk-averse person would be willing to pay to avoid this risk. The consumer behaviour when confronted with uncertain risky financial events stands at the heart of the economist's way of thinking about such decisions. Economists presume that people act to maximise expected utility. When they do so, they buy insurance against risky events.

Besley (1990) argued that the main function of an insurance contract is to reduce the risk faced by the person who buys it. Such contracts typically operate in terms of an agreement by the insurance company to pay something to the insured in the event of a particular outcome, in exchange for the payment of an insurance premium. In the case of health insurance, the two parties in the contract are the patient and the insurance company, and there are two conditions upon which insurance payments can be made to depend: one is the state of health and the other is expenditure upon health care. This kind of contract ties health insurance directly to the demand for health care.

The Problem of Moral Hazard of Health Insurance

The moral hazard of health insurance is the increased risk of payout for insurance firms that results from behavioural changes caused by the insurance coverage itself.

Insurance mechanisms often alter the economic constraint on both patients and health care providers. Since treatment costs are paid by the insurers, patients become less price-conscious and providers become less economically and morally restrained, charging higher prices as well as requiring frequent visits by patients. This condition causes over-consumption and over-treatment. The impact of moral hazard depends not only on demand factors, but also on the availability of supply and the response of providers. Under reimbursement insurance there may be incentives to increase consumption of health care, both from health care provider and consumer. The ways to avoid that problem, as applied to consumers, are the methods of a deductible, coinsurance and co-payment. The way to encourage providers is by controlling health care cost and making necessary regulations to limit the abuse of health care services provision (Besley, 1990).

Sharp, Register and Leftwith (1994) explained the price elastic demand for health care services when the sellers in the health care industry decrease prices, and

the price elasticity of demand is equal to the percent change in quantity demanded divided by the percent change in price.

Premium for health insurance

"Premium is the amount or instalment paid for an insurance scheme, under which the total expenditure for benefits and administration of a given period are met out of the income (from contributions and other sources) of the same period" (Ron, Abel-Smith and Tamburi, 1990)

Normally insurance schemes do not accumulate reserves except for contingency reserves. If insurance policies are actuarially fair, premiums paid will equal health care expenditure incurred, which assumes that insurance companies make no profit. The more people who are covered the smaller the marketing cost will be per person, an economy which may then be fed back to consumers in reduced premiums (Donaldson and Gerard, 1993). In the health insurance system, health care is basically financed by advance or premium payment by the population. The premium may be set for individuals or for families. In principle, the premium reflects the average total cost (per person or per family) of the health care covered by the insurance. The premium must effectively be collected from the population and this demands considerable administrative effort. Thirdly, the evaluation of health care costs and variations in the volume of care mean that premiums must be regularly adjusted (Carrin, 1995).

3.4 Utilization of Health Care Services

The utilization of health services can be expressed in terms of the annual number of consultations, the annual number of inpatient admissions as well as the annual number of hospital days/ person.

Utilization of health services by consumers with varying levels and types of insurance coverage means the lower use of health services by the uninsured relative to

the insured. There is mixed evidence with regard to the effect of insurance coverage on the appropriate utilization of health services (Gooding, Sandra Smith et al, 1996). The relationship between insurance coverage and appropriate usage of the health care services by consumers is not clear. In particular, the difference in appropriateness of health services use by consumers with and without insurance and with different types of health insurance can be analysed. Health insurance coverage can affect health care services utilization directly by encouraging or discouraging health services use, and indirectly by encouraging or discouraging use of alternative sources of care.

3.5 Health Insurance Financing

"Most people agree that health insurance contribution is a considerable source of additional financing of health care for most developing countries if they want to achieve health for all. Introducing health insurance is essentially a problem of political salesmanship. The health insurance option makes it possible to restore an awareness of connections between participation by individuals and groups in health care financing on the one hand, and services rendered on the other and it is not realistic to expect the rural population to pay the whole cost of its health services in insurance contributions; that means, health-for-all programs will have to be paid for almost entirely by countries' own resources" (Abel-Smith, 1986)

Hsiao (1992) argued that private health insurance has not found its way to developing countries because it is unfeasible. But voluntary health insurance could face the difficulty of covering all people in a developing country, and the financing strategy is only a means to achieve these objectives, such as extending as much as possible the membership of that program.

Ron, Abel-Smith and Taburi (1990) wrote:

(1) One of the ways to achieve flexibility in financing policy of health insurance schemes is changing contributions to meet changing demands for health

care, and health insurance schemes will generally find it easier to finance or to introduce new programs than governmental ministries.

(2) The MOPH and health insurance are related because, in developing countries, health insurance may be a semi-autonomous organisation, it needs subsidisation from government to different degrees. Normally, it accounts only for a minor part of annual revenue which expected to cover current health care costs and administrative costs.

(3) The level of contribution required depends on a set of variables, such as the quality of health care services, income of the population in the target group, the subsidy from government and social and market conditions relevant to health care in general, such as education, age, family size... In terms of management, financial control is achieving a balance between revenue and expenditure, even in VHI schemes run by public organisations. It is necessary to limit as much as possible the over spenders and overusers of system. It also has to constrain the administrative cost around 8-10 % of revenue. In terms of strategy to extend the membership of scheme, the emphasis is on improving quality of care, but it takes time and challenges in both premium and cost containment. So, another solution is to use flexibility in financing policy.

3.6 Types of Health Insurance

Many kinds of health insurance are applied nowadays, but mainly they are divided into two types, compulsory and voluntary health insurance.

Compulsory health insurance is a health insurance program in which legislation defines the population and benefits covered, the conditions of eligibility, and the sources of funds of the scheme. Health insurance is a form of social security, so it is also called social insurance. It is financed by imposing mandatory insurance payments on employed workers as a percentage of their wages, and by imposing on their employers a similar or somewhat higher payroll tax. Government may, in some instances, also contribute to the scheme. When legislation makes membership compulsory for a large section of the population, low and high risks are shared and

resources are pooled. Thus, the financial viability of the joint undertaking becomes high (Ron, Abel-Smith and Tamburi, 1990).

Voluntary health insurance is a health insurance program in which affiliation to the scheme is not determined by legislation. Membership of VHI is not mandatory and people who are willing and able to pay premiums join the scheme. The main pre-condition to implement VHI is that it should cover a large enough number of insured the income of the target population group should be high enough to pay regular premiums, and “the availability and stability of a relevant health care infrastructure” (Ron, Abel-Smith and Tamburi, 1990).

3.7 Experiences from other countries

Donaldson and Gerard (1993) mentioned that a public insurance system could be administered by a monopolistic agent such as a regional government, or national government. One of the best-known systems of public health insurance is that existing in Canada. There, consumers pay a uniform premium for hospital and medical care. Some elements of costs, such as capital expenditure, are financed from tax revenues. The two points from those experiences can be well applied in Vietnam, where VHI is a public system with a uniform premium, and where part of the costs are subsidised from tax revenue.

In the case of Thailand, from which Vietnam can learn, the VHI scheme has a regulated procedure to seek health care services with the first contact at the public health grass-roots level. The target population was expanded from coverage of the near poor to include the middle income class in rural areas. Also, the School Health Insurance program can promote accessibility to health services among primary school children. One-fifth of the population of Vietnam currently consits of school children. The Voluntary Health Insurance Scheme (VHIS) in Thailand, commonly known as the Health Insurance Card Scheme, was first introduced in 1993. Households contributed a minimal membership fee to the Health Card Fund to cover access to care for a year. Beneficiaries have to make the first contact at a public health centre at

the sub-district level with access to higher level of care through a referral letter. At the end of the year, the Health Card Fund reimbursed medical expenses to health centres, district and provincial hospitals on an actuarial basis. The MOPH informally subsidised the Health Card Project as medical expenses were greater than reimbursement from the Health Card Fund. The target population was expanded from coverage of the near poor to include the middle income class in rural areas. At present, the price of a health insurance card is 1,000 baht per year for one family of not more than five members. The population coverage is 2.7 million or about 4.6% of the total population. The benefits provided are outpatient care for sickness and injuries, inpatient care and mother and child health services. There is no limitation in utilisation of services. The beneficiaries, however, can go only to health care provider units under the Ministry of Public Health. The first contact is the health centre or district hospital, and then patients have to follow a referral line for higher levels of care. School Health Insurance (SHI) in Thailand, has the objective to promote accessibility to health services among primary school students. The target population is 6.7 million or 11.5% of the total population. The benefits of this scheme are outpatient and inpatient care at public service units. In some areas, dental services are provided. The MOPH is in charge of all administration of this scheme (Piyarain and Janjaroen, 1994).

In the future, the experience of Singapore should be applied to Vietnam by establishing the family savings fund which can be used to pay for the medical expenses a family members, that is a shared responsibility in looking after the welfare of family members, and to avoid incurring medical expenses. Faced with mounting costs of the medical services, the Ministry of Health of Singapore started to look at various options for changing the health financing system. The problem was to keep the balance between demand and supply capacity. With growing affluence and greater health consciousness, many people want more and better services, so Singapore's family savings scheme (MEDISAVE), established in 1983, attempts to impose savings and to restructure the system of health care financing. In addition to promoting individual responsibility for maintaining good health, it also aims to build

up financial resources so as to provide the means to pay for medical care during illness.

The savings are regularly set aside by the transfer of 6% of earnings into a personal Medisave account. Funds can be withdrawn from the Medisave account to pay for hospital charges and some outpatient procedures. Medisave also can be used to pay for the medical expenses of family members, so there is a shared responsibility in looking after the welfare of family members, and to avoid incurring medical expenses (Donaldson and Gerard, 1993).

3.8 Previous Studies and Comments on HI and VHI Program in Vietnam

Carrin, Murray and Sergent (1993) commented in Towards a Framework for Health Insurance Development in Haiphong, Vietnam, that in Vietnam an endeavor is made to introduce health insurance at a national scale, and province and district levels will have a large say in the development of health insurance. In Haiphong, the VHI scheme established there basically provides for health insurance against costs of hospital services. Haiphong needs further health insurance development planning and study, in order to reach the objective of extending the membership of the VHI program.

In terms of management, Vietnam is to be congratulated for having established so quickly an administrative system for the scheme which has succeeded in enrolling so many insured persons and making payments to the providers. Also, health insurance has not led the ministry of finance consciously to cut the health budget. The introduction of health insurance has improved the drug supply position. Some of the extra drugs bought for health insurance are being used to supply the poor when stocks have run out. The key to maintain the health insurance in Vietnam is reduced supplies at lower cost, more rational prescribing, and a way of keeping the premium down while still going a long way to meet the most important needs on a family basis for the VHI card is a solution to extend the membership of VHI program in Vietnam and in Haiphong in particular (Abel-Smith, 1993). Because of that, one of

the objectives of VHI in Vietnam is to increase access to health insurance, by defining health insurance premiums that are attractive for the voluntary insured (Ron, 1995).

In summary, Carrin, Murray and Sergent (1993) suggested as follows :

(1) A in other countries, health insurance in Vietnam is a means of pooling risks among the insured population and operates on the principle of redistribution of financial resources. Simultaneously, health insurance helps to finance the health care delivery system in Vietnam.

(2) Management of a health insurance scheme must be clear as to which services it will cover and what it will reimburse. It needs to work closely with other parties, particularly hospitals.

(3) It is necessary to establish an appropriate premium for the VHI scheme in Haiphong. The premium much be set in anticipation of estimated health expenditures.

The total amount of premiums must be based on the expected health care expenditures incurred by the insured. The costs are tied to the costs of operating a hospital. The health insurer must have access to those cost data.

(4) The payments by the health insurer must be structured in a way that encourages the hospitals to meet efficient and effective targets. The health insurer should not be required to simply reimburse the hospital for whatever costs it incurs. In this respect, the feasibility of adopting flat payment mechanisms needs to be investigated.

(5) The components of the costs of a health insurer are the membership size, the utilisation rate of the membership, the costs of hospital services and the administrative costs related to the management of the health insurance scheme.

(6) Accrual accounting, annual budgets, the preparation of annual financial statements and regular (at least quarterly) reporting to management and the government is an essential part of good management.