# CHAPTER III

# LITERATURE REVIEW

## 3.1 Concept of Health Insurance

Health insurance is a system in which prospective consumers of health 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. It involves a highly complex combination of incentives to providers, consumers, and third party fund holders. Health insurance is a risk-pooling or risk- sharing system. It is a means of financial protection against the risk of unexpected and expensive illness.

The health insurance benefits are described as health services given 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, Smith and Tamburi, 1990).

When risks are pooled across a population, unpredictable losses can be transformed to predictable losses, and cross-subsidization of resources from the healthy to the sick, from the rich to poor, from small families to large families with a number of dependents is achieved, thus improving the individual security.

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, benefits covered, 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 risk share resources are pooled. Thus, the financial viability of the joint undertaking becomes high (Ron,Smith and Tamburi, 1990).

Voluntary Health Insurance (VHI) 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 precondition to implement VHI is that should cover a large enough number of insured, that the income of the target population group should be high enough to pay regular premiums, and that "the availability and stability of a relevant health care infrastructure" (Ron, Smith and Tamburi, 1990).

Health insurance based on the fund-pooling and risk-sharing principles is increasingly recognized as the best financing option. However, for the majority of countries in the Region, the idea of health insurance concept is a relatively new concept, and there are limited policy frameworks and legal provisions to introduce health insurance right away.

### 3.2 Determinants of Health Insurance Participation

**(1) Income.**

The utilization of health services under a health insurance program tend to show that those people with higher income participated more in health insurance than poor people (Hongvivatana and Suphachit , 1999). On the other hand, most rich people like to make use of private health facilities to get better treatment (Tin, 1993).

Percentage of participation in health insurance by rich people was higher than by poor people aince the poor do not have the capacity to pay the premium of Health Insurance (Hongvivatana and Suphachit , 1999). The study also indicates that larger families size

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Educational attainment and employment sector are factors that are related to the length of uninsured periods (Swartz, 1993). Short periods without health insurance are less likely than longer periods to adversely affect access to health services (Ayanian, 2000).

People lack coverage regardless of education, age, or state of residence. Employment and geographic factors are central because private insurance is closely tied to employment, and eligibility for public programs is partly determined by work and income criteria (Custer and Ketsche, 2000).

More than one-quarter of all uninsured adults have not earned a high school diploma, and almost four out of every ten adults who have not graduated from high school are uninsured. Coverage varies over the life cycle, and the average individual's chances of being uninsured trace a curve across the life span, from a lower-than-average likelihood for minor children (Swartz, 1993).

**(3) Sex**

One of the most obvious differences in health indicators between men and women is life expectancy. As noted earlier, women are expected to live on an average 5.8 years longer than men. The longer life expectancy for women may appear at first to contradict claims that women face difficulty accessing health care, however, the reasons for women's longevity can be explained by many factors, and may not necessarily indicate better health status (Miles and Parker, 1997).

Women appear to experience more disease and disability than men throughout most of their lifespan. Men tend to develop more serious illnesses much earlier in life and die from them at an earlier age, whereas women are 11 times more likely to have acute or short-term illnesses. The contradiction of lower mortality but higher morbidity has been the subject of much investigation. While there is no clear explanation, several factors have been attributed to longer life expectancy (Fronstin, 2000).

Women tend to live longer than men because they take more preventive measures in avoiding poor health. Sociologists have argued that women more readily admit that they are sick and consult with physicians more often. Women are also less likely to adopt unhealthy lifestyle behaviors; including smoking, alcohol consumption, and illegal drug use (Fronstin, 2000). In addition, high rates of death from coronary heart disease in men have been attributed to high stress occupations.

Women are also less likely to die from accidents, including automobile accidents, and firearm homicide. Higher accident rates among men may be attributed to exposure to jobs or other activities where the risk of death or injury is higher (Fronstin, 2000). There are gender disparities in coverage, reflecting the different experiences of adult men and women in the workplace and with public policies. Although men are more likely than women to be uninsured, women have a lower rate of employment-based coverage because women are more likely to obtain coverage through individual policies and public programs; their insurance status tends to be less stable, with more opportunities for gaps in coverage (Miles and Parker, 1997).

It is considered that the sex variable is related to health insurance programs and the utilization of health services. In this group females are considered to make more use of health care facilities. It was reported that pregnant women in the villages where the health insurance project was implemented, had antenatal care; tetanus toxic were also delivered by health personnel in the health facility ( Kusol Lerjariya S, 1987).

**(4) Age**

It was also noted that youngsters and adults did not participate just because they think that they do not fall sick frequently, and the economic status of population affects the decision to join the health insurance (Hongvivatana and Suphachit , 1999).

People who are 65 and older have a minimal likelihood of being uninsured because Medicare provides virtually universal coverage to that age group. Marriage and the

rearing of infants and young children both decrease the chances, on average, that an adult will be uninsured. Sources of coverage and health status, as well as participation in the work force, also affect one's chances of lacking coverage (Ayanian, 2000).

**(5) Health Education**

Basic health education on control and prevention of certain specific disease conditions like malaria, tuberculosis, leprosy, and HIV/AIDS, are given to the rural people through commune and village health workers. This is widely done through immunization and education on sanitation. The likelihood of being insured increases as the level of health education rises; these suggest that health is directly related to the level of education.

Fronstin (2000) explained the high rates of accidents among men with the fact that men take activities that involve high risks. This would mean that if men have a higher level of health education, they would understand the risk they are exposed to and join health insurance. This would apply to chronic diseases as well.

**(6) Perception**

The decision to utilize health services and health insurance depends on people's psychological behaviors. Practically people need to know the benefits when taking part in any program (Ayanian, 2000). Most of the people taking part in health insurance in rural areas were persuaded to accept the health insurance project by the health volunteers and health personnel.

Some people did not participate in health insurance because no one took contact with them. The participation of health insurance depends on the attitude towards the scheme and health services provided by the public health facilities. It was also noted that people prefer not to join health insurance or visit the health center or the hospital because the quality of health services is not satisfactory.

Most people liked to see a medical doctor in the health center or hospital .The reason for joining the health insurance was the satisfactory quality of health services, whereas people

who were dissatisfied with the services of health centers or hospital did not participate in the health insurance program (Hongvivatana and Suphachit , 1999)

### 3.3 Experiences from Other Countries

In the case of Thailand the Community Health Insurance (CHIS) schemes have a regulated procedure to seek health care services with the first contact at the public health grass-roots level, which is a good method for Cambodia to learn. 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 Cambodia currently consists of school children.

The Voluntary health insurance schemes (VHIS) in Thailand, commonly known as the Health Insurance Scheme, were 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 Care Fund reimbursed medical expenses to health centers, district and provincial hospitals on an actuarial basis.

The Ministry of Public Health (MOPH) informally subsidized 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 1000 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 utilization 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 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 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).