

MEDICAL POLICIES FOR THE MASSES

- The surging need for pan-population health insurance

A policy-driven mass movement towards health insurance for all would not only augment the quality of life of the average citizen but also provide economies of scale, which would in turn lower medical costs, says, B.S.R.Rao

'Extremely unsatisfactory.' The term was used in a recent newspaper report quoting an IRDA official, to describe the progress and growth in the health insurance sector over the past few years. No careful observer of the Indian health insurance scene will put forward a note of dissent. The available information on the penetration of health insurance in the country paints a dismal picture. A number of factors might account for this situation. An understanding of some of the aspects might help in making policies to ensure swift progress of health insurance in our country.

The primary function of health insurance is undoubtedly the reduction of uncertainty. *Ceteris paribus* – individuals prefer to reduce their financial risks and are willing to pay for it. From the society's point of view, health insurance is a problem in the allocation of relatively scarce resources.

As Kenneth Arrow points out, the provision of insurance as such has a "positive scarcity." That is, the reduction of risk bearing – or the ability of people not to be troubled by chance events implied in availability of insurance – is an economic good. It is, to an extent, "free goods" in the sense that if all medical costs a nation incurs are pooled, ideally, there would be "very little uncertainty about the aggregate", save catastrophic events like epidemics. Though some people are ill and some healthy, the statistical variability of the risks is very small in a large population. For a society as a whole, there is very little risk in health.

However, individually there exists a very large risk; there is a small probability that a 'statistical' individual is very ill and a very large demander of medical services. It is, therefore, not easy for a nation to provide insurance fully against medical risks.

(1) In a purely competitive market, resource allocation is efficient, as the market price of goods equals the cost of producing those goods. It follows that no person can be made better off without making someone in the economy worse off. Economics, however, recognises that the general rule that an efficient price system leads to maximisation of the welfare of society requires quite a few qualifications. In this context, three qualifications are highly relevant:

(1) The first pertains to incomplete or nonexistent market resulting in incorrect pricing of the goods or services – the price to the buyer is not equal to the seller's cost. Examples are pollution and traffic congestion, besides medical care. A brief discussion of this issue is attempted later in this article.

(2) The second pertains to inequitable or skewed distribution of income. In the case of medical benefits, it is clear that people with lower incomes (or inadequate incomes) are denied the required medical benefits and services.

(3) People are not necessarily aware of their own interests. As such, public policy must be designed to make people aware of what they should do or to provide them more of what they ought to get or give less of what they should not have than what they desire to have. Examples include curbing or denying the supply of narcotics and alcohol. Another example is tobacco, where the manufacturer needs to make a statutory warning on the danger to health posed by its consumption. In the case of medical care, there appears to be an overestimation of its value.

Besides the above three qualifications, in the medical care market, part of the demand is induced by the supply forces (supply induced demand), violating one of the equilibrium conditions, namely that the demand and supply functions must be independent of each other.

We may now revert to the first issue, that is, the failure of the market to correctly price the goods or service. In the case of medical care, the problem of correct pricing arises from uncertainty surrounding medical care. Writers on the subject specifically refer to two dimensions of uncertainty. The first is the random character of the incidence of illness (in the statistical sense) – uncertainty of incidence of illness – as one does not know when one gets sick, one does not know when one needs medical care. As a result, individuals have a problem of risk in connection with illness and the need for medical care.

In a price system, such risk finally assumes the form of financial uncertainty. If the individual has funds to spend on medical care, his finances may be adversely affected. In the extreme case, in countries where healthcare costs are high, the individual may get financially crippled. In the alternative situation, where the individual is unable to fund medical care, he may have to suffer the inevitable health consequences. A health insurance policy is of good service in such cases.

A second kind of uncertainty, which is equally important or even more so, is one that a health insurance policy will not be able to provide for. The individual does not have information as to what kind of treatment is needed and, furthermore, the probability of success of the treatment. This type of uncertainty is peculiar to the medical care market. The issue is further complicated by the fact that medical care market is characterised by the presence of the problem of asymmetric information. In the face of the existence of the phenomenon of asymmetric information, the price system fails to ensure an efficient allocation of resources.

Moreover, the efficacy of medical care is clouded by the specialisation of information essentially or exclusively on the supply side. If a patient approaches a doctor, he advises him on what is to be done: either refers him to a diagnostic centre or to a specialist, or recommends an operation or prescribes expensive drugs. Demand for medical services is

no longer fully controlled by the receiver of the services or the person actually using them, but by someone else, presumably in the interests of the patient. The medical professional may not consider the patient's financial resources while advising the course of treatment, or the patient's willingness to trade off health against other things, or trade off one aspect of health against another.

There is no guarantee that the physician's judgment about the available alternatives in treatment is superior to the patient's judgment. Even if the motives are genuine, the interplay of decisions gets complicated when financial considerations enter.

Turning to the issue of distribution of wealth and income under the traditional economic model, competition is supposed to ensure that resources are being used efficiently. While allocation of resources in a society may be efficient, it may not be just or fair. Modern economics, in general, does not concern itself with what is right or fair. No concern is spent on whether or not the overall distribution of wealth or income is justified. However, a society, while addressing itself to distributional issues, may choose to tax the rich to provide for the poor. If that happens, it is the result of social choice and not necessarily based on social justice. Social justice is derived from a set of principles concerning what a person ought to have as a right; it is not a matter of preferences.

Adopting John Rawls' system of justice, we can say that a society is better off only when it makes its least well-off people better off. In other words, a society should devote its resources to increasing the primary goods possessed by the most disadvantaged people. According to Rawls, primary goods are defined as "rights and liberties, powers and opportunities, income and wealth". Self-respect is considered another primary goods, but Rawls does not, of course, list it as one of the primary goods. Many analysts, however, do not agree with this decision of Rawls. Ronald Greene is of the view that access to healthcare is not only a social primary good, but possibly one of the most important such goods because disease and ill-health interfere with our happiness and undermine our self-confidence and self-respect.

Lester Thurow opines: "Society's interest in the distribution of medical care springs, not from unspecified externalities ... but from individual – societal preferences that 'human rights' include equal right to healthcare." Many analysts advocate "equal access for equal need" in regard to healthcare because this principle provides individuals with the opportunity to use needed health services.

It has always been accepted that poverty should not prevent one from having at least a minimum level of medical care. Arrow observes that the acceptance of this principle is compelling when generational implications are taken into account. "Children should not suffer for the poverty of their parents. At least they should grow up and have a fair chance."

Given this background, we should answer a policy question: should health insurance be made compulsory? While there are people who believe that there should be no compulsion in regard to health insurance on grounds such as the general principle of free

choice, freedom for a person to take chances if he prefers, and greater knowledge by an individual about his own circumstances, there are many arguments in favour of compulsory health insurance, of which the following two reasons are noteworthy:

1) The first argument is based upon the economies of scale that can be reaped by the society by making health insurance compulsory. Group policies are so much cheaper than individual policies.

2) The second reason is adverse selection. If individuals are allowed to choose the level of health insurance they desire, those who believe they are healthier and believe they will continue to be healthier will opt out of the system. It is an instance of asymmetric information or informational inequality. The result is creation of inefficiency in the operation of the system.

There is, therefore, a strong case for having compulsory health insurance. To avoid intolerable financial costs in such a case, suitable policy measures are warranted. First, imposition of some part of the cost on the patient or co-payment is required. It may be fixed at 20 to 25 per cent. For very costly treatment 100 per cent coverage is desirable. The demand for medical treatment is not insatiable. Some analysts suggest a relatively small deductible to eliminate small claims coupled with a co-payment rate of 20 to 25 per cent, which goes down to zero if annual medical expenditure adds up to a ceiling amount.

Second, we may attempt increasing the supply of medical care for the purpose of controlling cost of care. This expansion must be accompanied by an appropriate distribution of medical care facilities all over the country. This will reduce the travel costs and inconvenience involved for patients if the facilities are concentrated in metros, cities and big towns.

Finally, there must some direct control of costs involved for providing medical care and its use.

The policy measures suggested above are tentative and extensive research needs to be conducted to evaluate their efficacy and usefulness.

***Dr. B. S. R. Rao is Professor and Dean,
International Institute of Insurance
and Finance, Hyderabad.***