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Mainstreaming health insurance for people with disabilities

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ABSTRACT

Many low- and middle-income countries have introduced public health insurance schemes to increase access to health care and provide financial protection against the costs of care for disadvantaged groups. Using national health household survey data from Vietnam and an appropriate two-part model, this paper examines the targeting effectiveness of public health insurance schemes and their impact on health care utilization for persons with disabilities. Results suggest that current community-based targeting methods are not effective, and that insurance mechanisms are an unsatisfactory buffer for inpatient-related costs to which persons with disabilities are prone. A higher level of disability targeting is recommended, both in terms of eligibility and benefits.

1. Introduction

To mitigate the impact of user-fees, persons with disabilities (PWDs) are increasingly being incorporated into public health insurance or waiver schemes for disadvantaged groups in low- and middle-income countries (LMCs). These 'mainstream' programs differ to discrete disability insurance programs that commonly exist in high-income countries, which are characterized by high levels of administration and resources. The effectiveness of mainstream public insurance schemes in ensuring equity for disadvantaged groups has not been extensively studied (Newbrander, Collins, & Gilson, 2000). This is particularly the case for PWDs (Handicap International and Christoffel-Blindenmission), and is especially concerning because they are often among the poorest of the poor and have high health care needs (WHO, 2011). Important questions remain about the ability of governments to identify beneficiaries and provide financial protection against costs of care for this vulnerable subpopulation.

Scheme eligibility criterion for PWDs is generally governed by severe disability given by incapacity to work, and living within a poor family with determination based upon some form of means test or poverty determination (Bitran & Giedion, 2003; Mitra, 2005). Eligibility is either determined at the community level, through committees of community representatives, or at the health facility or social welfare office (Newbrander et al., 2000). Schemes typically operate through the distribution of free health insurance cards *ex ante* or the granting of fee waivers and service exemptions at the point of contact at health facilities (Bitran & Giedion, 2003).

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The community based targeting model is common in LMCs due to its cost effectiveness and responsiveness to the living standards of households and social context (Conning & Kevane, 2002). The model also fits within with the current paradigm of disability which defines disability as social rather than individual construction (Shakespeare & Watson, 1997). However, community models are open to political capture and lack the expertise and survey tools to accurately identify poverty and disability status (Conning & Kevane, 2002). Additional problems have been identified in relying upon established community structures to target the most vulnerable and underprivileged groups in contexts where the lack of opportunities to participate in production-related activities may be deeply rooted in local social structures.

The ability of administrations in LMCs to accurately determine disability and poverty status is largely unknown. The experience of high-income countries demonstrates that it is difficult to determine work incapacity due to impairment, and the process involves lengthy medical assessment and background information (Carney & Hanks, 1994). PWDs may be well captured by schemes with a poverty eligibility criterion in LMCs irrespective of their ability to target disability, since PWDs are disproportionately poor. Alternatively, disability may be a more readily identifiable poverty criterion than income or other living standard measures in LMCs, which are typified by large informal labor markets.

The effect of public health insurance schemes on the utilization of health care for PWDs is similarly unclear. Through pooling risk across individuals, health insurance lowers the price of health care at the time of purchase. Such a reduction may lead to increased use of health care, an effect known as *ex post moral hazard* (Zweifel & Manning, 2000). Like other goods, the effect is dependent upon price and income constraints in addition to time and other constraints of seeking out health care. For PWDs, budgetary constraints may be considerable due to high health care needs resulting in high levels of spending, reduced income, and high travel costs (monetary and time) associated with accessing care (Haveman & Wolfe, 2000; WHO, 2011). Other constraints, reported in LMCs, may include environmental barriers to accessing health facilities, lack of medical services or technology, or discriminatory treatment of PWDs by health care staff (Kleinitz et al., 2012; WHO, 2011).

Second, health insurance may affect health care utilization by undermining preventative care efforts (*ex ante moral hazard*) such as insured people taking less preventative care, or engaging recklessly in behaviors endangering their health (Zweifel & Manning, 2000). Third, health insurance might increase utilization through supplier-induced demand in fee-for-service provider payment systems. This is particularly likely in LMCs which are characterized by piece-rate payment systems, weak regulatory frameworks, and low public funding of health care (Newbrander et al., 2000).

Using national household health survey data from Vietnam and an appropriate two-part model, this paper examines the targeting effectiveness of public health insurance schemes for PWDs and their impact on health care utilization. The policy relevance of this paper is that it applies a measure of severe disability as a suitable proxy for eligibility to non-contributory health insurance. This measure is distinct from contemporary international definitions of disability which are consistent with mild to moderate disability measures (Palmer & Harley, 2011). This study aims to contribute to the scant evidence-base on the effectiveness of social health protection programs in LMCs for which severe disability is an eligibility criterion.

Vietnam is an excellent case study due to its relatively advanced public health insurance system which relies upon a community based targeting model for the identification of policy beneficiaries and a fee-for-service provider payment system. The country has passed disability specific legislation which advocates the right to access affordable health care as equal to other rights (Socialist Republic of Viet Nam, 1998, 2010). Vietnam is an upper low income country with a GDP per capita of $1109 (2009 prices) and has a large disabled population: 12.9 million people, or 15% of the population, based upon the latest international definition of disability (General Statistics Office, 2006).

The rest of the paper is organized as follows. The next section provides a background on the public health insurance system in Vietnam with respect to PWDs. This is followed by a description of the data and key variables (Section 3), and an outline of the methodology and some econometric issues in estimation (Section 4). Empirical results are presented in Section 5, followed by a discussion and some concluding remarks.

2. The development of publicly funded health insurance schemes providing coverage to people with disabilities in Vietnam

In 1989, the Vietnamese government began to implement major reforms to the health sector. Broadly, the reforms involved privatization of medical services and the introduction (or considerable increase) of user fees in public services (Segall et al., 2002). Deregulation and legalization of private medical practice and pharmaceutical trade led to a rapid expansion of the private sector. By the early 1990s, there was a marked decline in the use of public health care, with the vast majority of out-of-pocket spending on pharmaceuticals (Gertler & Litvack, 1998; Witter, 1996).

In an effort to improve formal health care access and use, in 1992 the Vietnamese government introduced a compulsory health insurance (CHI) scheme for formal sector employees, 'meritorious persons' and policy beneficiaries (Ekman et al., 2008).[1] Policy beneficiaries included PWDs, orphans, the elderly (85 years above), and persons living with HIV/AIDS (Le et al., 2005; Regulation 67). Eligibility criteria for PWDs included severe disability, defined as incapacity to work, and without a source of income (Socialist Republic of Viet Nam, 1998). PWDs that incurred impairments through war were classified in a

[1] Note that fee waivers for target groups, including PWDs, were earlier mandated alongside the introduction of user fees at public facilities (Nguyen et al., 2002, 2009). However, the coverage and effectiveness of early exemption policies was greatly limited by inadequate funding and lack of local political commitment (Nguyen et al., 2009).