Annex 2

HEALTH INSURANCE IN INDIA: CURRENT SCENARIO

Introduction

The health care system in India is characterised by multiple systems of medicine, mixed ownership patterns and different kinds of delivery structures. Public sector ownership is divided between central and state governments, municipal and *Panchayat* local governments. Public health facilities include teaching hospitals, secondary level hospitals, first-level referral hospitals (CHCs or rural hospitals), dispensaries; primary health centres (PHCs), sub-centres, and health posts. Also included are public facilities for selected occupational groups like organized work force (ESI), defence, government employees (CGHS), railways, post and telegraph and mines among others. The private sector (for profit and not for profit) is the dominant sector with 50 per cent of people seeking indoor care and around 60 to 70 per cent of those seeking ambulatory care (or outpatient care) from private health facilities. While India has made significant gains in terms of health indicators - demographic, infrastructural and epidemiological (See Tables 1 and 2), it continues to grapple with newer challenges. Not only have communicable diseases persisted over time but some of them like malaria have also developed insecticide-resistant vectors while others like tuberculosis are becoming increasingly drug resistant. HIV / AIDS has of late assumed extremely virulent proportions. The 1990s have also seen an increase in mortality on account of non-communicable diseases arising as a result of lifestyle changes. The country is now in the midst of a dual disease burden of communicable and noncommunicable diseases. This is coupled with spiralling health costs, high financial burden on the poor and erosion in their incomes. Around 24% of all people hospitalized in India in a single year fall below the poverty line due to hospitalization *(World Bank, 2002).* An analysis of financing of hospitalization shows that large proportion of people; especially those in the bottom four-income quintiles borrow money or sell assets to pay for hospitalization *(World Bank, 2002)*

This situation exists in a scenario where health care is financed through general tax revenue, community financing, out of pocket payment and social and private health insurance schemes. India spends about 4.9% of GDP on

health *(WHR, 2002).* The per capita total expenditure on health in India is US$ 23, of which the per capita Government expenditure on health is US$ 4. Hence, it is seen that the total health expenditure is around 5% of GDP, with breakdown of public expenditure (0.9%); private expenditure (4.0%). The private expenditure can be further classified as out-of-pocket (OOP) expenditure (3.6%) and employees/community financing (0.4%). It is thus evident that public health investment has been comparatively low. In fact as a percentage of GDP it has declined from 1.3% in 1990 to 0.9% as at present. Furthermore, the central budgetary allocation for health (as a percentage of the total Central budget) has been stagnant at 1.3% while in the states it has declined from 7.0% to 5.5%.

Table 1. *Socioeconomic indicators*

Land area	2% of world area
Burden of disease (%)	21% of global disease burden
Population	16% of world population
Urban : Rural	28:72
Literacy rate (%)	65.38
Sanitation (%)	Rural – 9.0; Urban – 49.3
Safe drinking water supply (%)	Rural – 98; Urban – 90.2
Poverty (%)	Below poverty line – 26 Rural – 27.09; Urban – 23.62
Poverty line (Rs.)	Rural – 327.56; Urban – 454.11

Table 2. *Achievements: 1951-2000*

	1951	1981	2000
Demographic changes			
Life expectancy	36.7	54	64.6 (RGI)
Crude birth rate	40.8	33.9 (SRS)	26.1 (99 SRS)
Crude death rate	25	12.5 (SRS)	8.7 (99 SRS)
Infant mortality rate	146	110	70 (99 SRS)

	1951	1981	2000
Epidemiology			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small pox (no of cases)	>44,887	Eradicated	
Guinea worm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries & hospitals (all)	9209	23,555	43,322 (95–96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors (Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing personnel	18,054	1,43,887	7,37,000 (99-INC)

In light of the fiscal crisis facing the government at both central and state levels, in the form of shrinking public health budgets, escalating health care costs coupled with demand for health-care services, and lack of easy access of people from the low-income group to quality health care, health insurance is emerging as an alternative mechanism for financing of health care.

Health Insurance

Health insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called *premium*.' In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals

and households. Given the appropriateness of this definition in the Indian context, this is the definition, we would adopt. The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

(1) Voluntary health insurance schemes or private-for-profit schemes;

(2) Employer-based schemes;

(3) Insurance offered by NGOs / community based health insurance, and

(4) Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).

Voluntary health insurance schemes or private-for-profit schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer's income.

In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and the Life Insurance Corporation (LIC) of India provide voluntary insurance schemes. The Life Insurance Corporation offers *Ashadeep Plan II and Jeevan Asha Plan II*. The General Insurance Corporation offers Personal Accident policy, *Jan Arogya policy*, *Raj Rajeshwari policy*, *Mediclaim policy*, *Overseas Mediclaim policy*, *Cancer Insurance policy*, *Bhavishya Arogya policy* and *Dreaded Disease policy (Srivastava 1999 as quoted in Bhat R & Malvankar D, 2000)*

Of the various schemes offered, Mediclaim is the main product of the GIC. The Medical Insurance Scheme or Mediclaim was introduced in November 1986 and it covers individuals and groups with persons aged 5 – 80 yrs. Children (3 months – 5 yrs) are covered with their parents. This scheme provides for reimbursement of medical expenses (now offers cashless scheme) by an individual towards hospitalization and domiciliary

hospitalization as per the sum insured. There are exclusions and pre-existing disease clauses. Premiums are calculated based on age and the sum insured, which in turn varies from Rs 15 000 to Rs 5 00 000. In 1995/96 about half a million Mediclaim policies were issued with about 1.8 million beneficiaries (Krause Patrick 2000). The coverage for the year 2000-01 was around 7.2 million.

Another scheme, namely the *Jan Arogya Bima* policy specifically targets the poor population groups. It also covers reimbursement of hospitalization costs up to Rs 5 000 annually for an individual premium of Rs 100 a year. The same exclusion mechanisms apply for this scheme as those under the Mediclaim policy. A family discount of 30% is granted, but there is no group discount or agent commission. However, like the Mediclaim, this policy too has had only limited success. The *Jan Arogya Bima* Scheme had only covered 400 000 individuals by 1997.

The year 1999 marked the beginning of a new era for health insurance in the Indian context. With the passing of the Insurance Regulatory Development Authority Bill (IRDA) the insurance sector was opened to private and foreign participation, thereby paving the way for the entry of private health insurance companies. The Bill also facilitated the establishment of an authority to protect the interests of the insurance holders by regulating, promoting and ensuring orderly growth of the insurance industry. The bill allows foreign promoters to hold paid up capital of up to 26 percent in an Indian company and requires them to have a capital of Rs 100 crore along with a business plan to begin its operations.Currently, a few companies such as Bajaj Alliance, ICICI, Royal Sundaram, and Cholamandalam among others are offering health insurance schemes. The nature of schemes offered by these companies is described briefly.

- **Bajaj Allianz**: Bajaj Alliance offers three health insurance schemes namely, Health Guard, Critical Illness Policy and Hospital Cash Daily Allowance Policy.
  - The Health Guard scheme is available to those aged 5 to 75 years (not allowing entry for those over 55 years of age), with the sum assured ranging from Rs 100 0000 to 500 000. It offers cashless benefit and medical reimbursement for hospitalization expenses (pre- and post-hospitalization) at various hospitals across India (subject to

exclusions and conditions). In case the member opts for hospitals besides the empanelled ones, the expenses incurred by him are reimbursed within 14 working days from submission of all the documents. While pre-existing diseases are excluded at the time of taking the policy, they are covered from the 5th year onwards if the policy is continuously renewed for four years and the same has been declared while taking the policy for the first time. Other discounts and benefits like tax exemption, health check-up at end of four claims free year, etc. can be availed of by the insured.

- The Critical Illness policy pays benefits in case the insured is diagnosed as suffering from any of the listed critical events and survives for minimum of 30 days from the date of diagnosis. The illnesses covered include: first heart attack; Coronary artery disease requiring surgery: stroke; cancer; kidney failure; major organ transplantation; multiple sclerosis; surgery on aorta; primary pulmonary arterial hypertension, and paralysis. While exclusion clauses apply, premium rates are competitive and high-sum insurance can be opted for by the insured.
- The Hospital Cash Daily Allowance Policy provides cash benefit for each and every completed day of hospitalization, due to sickness or accident. The amount payable per day is dependant on the selected scheme. Dependant spouse and children (aged 3 months – 21years) can also be covered under the Policy. The benefits payable to the dependants are linked to that of insured. The Policy pays for a maximum single hospitalization period of 30 days and an overall hospitalization period of 30/60 completed days per policy period per person regardless of the number of confinements to hospital/nursing home per policy period.

➢ **ICICI Lombard**: ICICI Lombard offers Group Health Insurance Policy. This policy is available to those aged 5 – 80 years, (with children being covered with their parents) and is given to corporate bodies, institutions, and associations. The sum insured is minimum Rs 15 000/- and a maximum of Rs 500 000/-. The premium chargeable depends upon the age of the person and the sum insured selected. A slab wise group discount is admissible if the group size exceeds 100. The policy covers reimbursement of hospitalization expenses incurred for diseases

contracted or injuries sustained in India. Medical expenses up to 30 days for Pre-hospitalization and up to 60 days for post-hospitalization are also admissible. Exclusion clauses apply. Moreover, favourable claims experience is recognized by discount and conversely, unfavourable claims experience attracts loading on renewal premium. On payment of additional premium, the policy can be extended to cover maternity benefits, pre-existing diseases, and reimbursement of cost of health check-up after four consecutive claims-free years.

- **Royal Sundaram Group**: The *Shakthi* Health Shield policy offered by the Royal Sundaram group can be availed by members of the women's group, their spouses and dependent children. No age limits apply. The premium for adults aged up to 45 years is Rs 125 per year, for those aged more than 45 years is Rs 175 per year. Children are covered at Rs 65 per year. Under this policy, hospital benefits up to Rs 7 000 per annum can be availed, with a limit per claim of Rs 5 000. Other benefits include maternity benefit of Rs 3 000 subject to waiting period of nine months after first enrolment and for first two children only. Exclusion clauses apply *(Ranson K & Jowett M, 2003)*
- **Cholamandalam General Insurance**: The benefits offered (in association with the Paramount Health Care, a re-insurer) in case of an illness or accident resulting in hospitalization, are cash-free hospitalization in more than 1 400 hospitals across India, reimbursement of the expenses during pre- hospitalization (60 days prior to hospitalization) and post- hospitalization (90 days after discharge) stages of treatment. Over 130 minor surgeries that require less than 24 hours hospitalization under day care procedure are also covered. Extra health covers like general health and eye examination, local ambulance service, hospital daily allowance, and 24 hours assistance can be availed of. Exclusion clauses apply. **Employer-based schemes**

Employers in both the public and private sector offers employer-based insurance schemes through their own employer-managed facilities by way of lump sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual irrespective of actual expenses, or covering them under the group health insurance policy. The railways, defence and security forces, plantations

sector and mining sector provide medical services and / or benefits to its own employees. The population coverage under these schemes is minimal, about 30-50 million people.

Insurance offered by NGOs / community-based health insurance

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits.

Community-based schemes are typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources *(International Labour Office Universities Programme 2002 as quoted in Ranson K & Acharya A, 2003).* Such schemes are generally run by trust hospitals or nongovernmental organizations (NGOs). The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with the for-profit insurers for the purchase of custom designed group insurance policies. However, the coverage of such schemes is low, covering about 30-50 million (*Bhat, 1999*). A review by Bennett, Cresse et al. *(as quoted in Ranson K & Acharya A, 2003)* indicates that many community-based insurance schemes suffer from poor design and management, fail to include the poorest-of-the-poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes.

Table 3 provides an overview of some non-profit social insurance schemes. Some of the schemes are described below *(Ranson K & Jowett M, 2003).*

Table 3. *Non-profit social insurance schemes in India*

Name	Location	Members	Type of insurance
1. ACCORD/ ASHWINI Health Insurance Scheme	Tamil Nadu (Gudalur)	7 356 (1997)	Health Insurance (with NIA)
2. Aga Khan Health Services3	Gujarat (Sidhpur)	40 000 (1997)	Health insurance
3. Apollo Hospital Association (AHA)	Tamil Nadu (Madras)	10 000 (1995)	Health Insurance (with GIC)
4. ASSEFA (Association of Sarva Sewa Farms)	Tamil Nadu (Madurai)	N.N.	Cattle Insurance Health Insurance
5. Cooperative Development Federation (CDF)	Andhra Pradesh (Hyderabad)	26 000	Death Relief Fund (Life Insurance)
6. Goalpara Cooperative Health Society	West Bengal (Shantiniketan)	1 247 (1997)	Health Insurance
7. Kottar Social Service Society (KSSS)	Tamil Nadu (Kanyakumari)	34 000	Health Insurance
8. Mallur Health Cooperative	Karnataka	7 000 Health	Insurance
9. Mathadi Hospital Trust	Maharashtra (Bombay/Mumbai)	150 000	Health Insurance
10. Medinova Health Card Scheme	West Bengal (Calcutta)	35 000	Health Insurance
11. Navsarajan Trust	Gujarat	10 000	Health Insurance (with NIA) Accidental Insurance (with LIC) Nutrition Legal Aid Drugs Fight Against Corruption
12. New Life	Tamil Nadu	N.N.	Health Insurance
13. Organization for Development of People (ODP)	Tamil Nadu (Mysore)	1 137	Health Insurance Accidental Insurance (with NIC)

Name	Location	Members	Type of insurance
14. Pragati Thrift and Credit Society	–	410	Death Relief Fund
15. Raigarh Ambikapur Health Association (RAHA) Medical Insurance Scheme	Madhya Pradesh (Raigarh District)	75 000	Health Insurance
16. Saheed Shibsankar Saba Samity (SSSS)	West Bengal (Burdwan)	6 800	Health Insurance
17. Seba Cooperative Health Society	West Bengal (Calcutta)	3 000 families	Health Insurance (with GIC)
18. Self Employed Women's Association (SEWA)	Gujarat (Ahmedabad)	40,000	Integrated Insurance Scheme Health Insurance Life Insurance (with LIC) Accident (with NIA) Asset Insurance Maternity Benefit
19. Kasturba Hospital Scheme, Sewagram	Maharashtra (Wardha District)	19 457 (1997)	Health Insurance
20. Social Work and Research Centre (SWRC) (defunct?)	Rajasthan (Ajmer)	20 000	Health Insurance
21. Society for Promotion of Area Resources Centre (SPARC)	Maharashtra (Bombay/Mumbai)	1 200 couples	Health Insurance Accident Housing (with OIC)
22. Students Health Home	West Bengal (Calcutta)	550 000	Health Insurance
23. Tribhuvandas Foundation	Gujarat (Anand)	800 000	Health Insurance
24. Trivandrum District Fishermen's Federation (TDFF)	Kerala (Thiruvananthapuram)		Craft & Gear Fund (loan basis) Contingency Fund (death, accidents, loss of work)

Name	Location	Members	Type of insurance
25. Urmal Rural Health and Research Development Trust (defunct?)	Rajasthan (Bikaner & Jodhpur)	N.N.	Health Insurance
26. Voluntary Health Services Medical Aid Plan	Tamil Nadu	160 000	Health Insurance

Source: Patrick Krause (2000), 'Non-profit Insurance Schemes for the Unorganized Sector in India', Social Policy Division 42, Working Papers No. 22 e, GTZ

Some examples of community-based health insurance schemes are discussed herein.

- **Self-Employed Women's Association (SEWA), Gujarat**: This scheme established in 1992, provides health, life and assets insurance to women working in the informal sector and their families. The enrolment in the year 2002 was 93 000. This scheme operates in collaboration with the National Insurance Company (NIC). Under SEWA's most popular policy, a premium of Rs 85 per individual is paid by the woman for life, health and assets insurance. At an additional payment of Rs 55, her husband too can be covered. Rs 20 per member is then paid to the National Insurance Company (NIC) which provides coverage to a maximum of Rs 2 000 per person per year for hospitalization. After being hospitalized at a hospital of one's choice (public or private), the insurance claim is submitted to SEWA. The responsibility for enrolment of members, for processing and approving of claims rests with SEWA. NIC in turn receives premiums from SEWA annually and pays them a lumpsum on a monthly basis for all claims reimbursed. (Ranson K & Acharya A, 2003).
- Another CBHI scheme located in Gujarat, is that run by the **Tribhuvandas Foundation (TF),** Anand. This was established in 2001, with the membership being restricted to members of the AMUL Dairy Cooperatives. Since then, over 1 00 000 households have been enrolled under this scheme, with the TF functioning as a third party insurer.
- **The Mallur Milk Cooperative** in Karnataka established a CBHI scheme in 1973. It covers 7 000 people in three villages and outpatient and inpatient health care are directly provided.

- A similar scheme was established in 1972 at **Sewagram**, Wardha in Maharashtra. This scheme covers about 14 390 people in 12 villages and members are provided with outpatient and inpatient care directly by Sewagram.
- The **Action for Community Organization, Rehabilitation and Development (ACCORD),** Nilgiris, Tamil Nadu was established in 1991. Around 13 000 *Adivasis* (tribals) are covered under a group policy purchased from New India Assurance.
- Another scheme located in Tamil Nadu is **Kadamalai Kalanjia Vattara Sangam (KKVS),** Madurai. This was established in 2000 and covers members of women's self-help groups and their families. Its enrolment in 2002 was around 5 710, with the KKVS functioning as a third party insurer.
- **The Voluntary Health Services (VHS),** Chennai, Tamil Nadu was established in 1963. It offers sliding premium with free care to the poorest. The benefits include discounted rates on both outpatient and inpatient care, with the VHS functioning as both insurer and health care provider. In 1995, its membership was 124 715. However, this scheme suffers from low levels of cost recovery due to problems of adverse selection.
- **Raigarh Ambikapur Health Association (RAHA**), Chhatisgarh was established in 1972, and functions as a third party administrator. Its membership in the year 1993 was 72 000.

Social Insurance or mandatory health insurance schemes or government run schemes (namely the ESIS, CGHS)

Social insurance is an earmarked fund set up by government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income (and hence ability to pay) rather than related to health risk. The benefit packages are standardized and contributions are earmarked for spending on health services

The government-run schemes include the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS). (See Table 4)

Table 4. *Public insurance schemes*

	ESIS (Employees State Insurance Scheme)	CGHS (Central Government Health Scheme)
Contribution	Employees: 4.75% of wages. Employers: 1.75% of wages. All contributions are deposited by the employer. State governments contribute a minimum of 12.5 %on ESIS expenditures in their respective States (Garg 1999b, p. 30). See also section 59A (Govt. of India, 1999g, pp. 51-52)	Pay/pension Contribution (Rs/month) (Rs/month) < 3,000 15 3001–6000 40 60001–10000 70 10001–15000 100 > 15000 150 The bulk of resources (85%) come from general revenues of the Central Government (Garg 1999b, p. 34)
Reimbursement	Does not allow reimbursement of medical treatment outside of allotted facilities. For example, the Employees State Insurance Act 1948 states that entitlement to medical benefits does not entitle the insured to 'claim reimbursement for medical treatment. except under regulations' (Govt. of India, 1999g, p. 50) and ESI (General) Regulations, (Govt. of India, 1999g, p. 156)	1. Reimbursement of consultation fee, for up to four consultations in a total spell of ten days (on referral) 2. Cost of medicines 3. Charges for a maximum of ten injections. Reimbursement for specified diseases or ailments
Entitlement	Depending on 'allotment' as per the ESI Act 1.Outpatient medical care at dispensaries or panel clinics, 2. Consultation with specialist and supply of special medicines and tests in addition to outpatient care; 3. Hospitalization, specialists, drugs and special diet. 4. Cash benefits: Periodical payments to any insured person in case of sickness, pregnancy, disablement or death resulting from an employment injury.	1. First-level consultation and preventive health care service through dispensaries and hospitals under the scheme 2. Consultation at a CGHS dispensary / polyclinic or CGHS wing at a recognized hospital. 3. Treatment from a specialist through referral, emergency treatment in private hospitals and outside India.
Eligibility	Employees (and dependants) working in establishments employing ten or more persons (with power) or twenty or more persons (without power) and earning less than Rs. 6 500 per month. (Garg 1999a, p.85)	Employees of the Central Government (excepting railways, Armed Forces pensioners and Delhi Administration), pensioners, widows of Central Government employees, Delhi Police employees, Defence employees and dependants residing in 24 specified locations (See Govt. of India, various publications)

Reproduced from Mahal A (2001), 'Assessing Private Health Insurance in India: Potential Impacts and Regulatory Issues', Discussion Paper Series, No. 16, National Council of Applied Economic Research, New Delhi. p. 35

Central Government Health Scheme (CGHS)

Since 1954, all employees of the Central Government (present and retired); some autonomous and semi-government organizations, MPs, judges, freedom fighters and journalists are covered under the Central Government Health Scheme (CGHS). This scheme was designed to replace the cumbersome and expensive system of reimbursements *(GOI, 1994).* It aims at providing comprehensive medical care to the Central Government employees and the benefits offered include all outpatient facilities, and preventive and promotive care in dispensaries. Inpatient facilities in government hospitals and approved private hospitals are also covered. This scheme is mainly funded through Central Government funds, with premiums ranging from Rs 15 to Rs 150 per month based on salary scales. The coverage of this scheme has grown substantially with provision for the non-allopathic systems of medicine as well as for allopathy. Beneficiaries at this moment are around 432 000, spread across 22 cities.

The CGHS has been criticized from the point of view of quality and accessibility. Subscribers have complained of high out-of-pocket expenses due to slow reimbursement and incomplete coverage for private health care (as only 80% of cost is reimbursed if referral is made to private facility when such facilities are not available with the CGHS).

Employee and State Insurance Scheme (ESIS)

The enactment of the Employees State Insurance Act in 1948 led to formulation of the Employees State Insurance Scheme. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits, preventive and promotive care and health education. Medical care is also provided to employees and their family members without fee for service. Originally, the ESIS scheme covered all power-using non-seasonal factories employing 10 or more people. Later, it was extended to cover employees working in all non-power using factories with 20 or more persons. While persons working in mines and plantations, or an organization offering health benefits as good as or better than ESIS, are specifically excluded. Service establishments like shops, hotels, restaurants, cinema houses, road transport and news papers printing are now covered. The monthly wage limit for enrolment in the ESIS is Rs. 6 500, with a prepayment contribution in the form of a payroll tax of 1.75% by employees,

4.75% of employees' wages to be paid by the employers, and 12.5% of the total expenses are borne by the state governments. The number of beneficiaries is over 33 million spread over 620 ESI centres across states. Under the ESIS, there were 125 hospitals, 42 annexes and 1 450 dispensaries with over 23 000 beds facilities. The scheme is managed and financed by the Employees State Insurance Corporation (a public undertaking) through the state governments, with total expenditure of Rs 3 300 million or Rs 400/- per capita insured person.

The ESIS programme has attracted considerable criticism. A report based on patient surveys conducted in Gujarat *(Shariff, 1994 as quoted in Ellis R et a, 2000)* found that over half of those covered did not seek care from ESIS facilities. Unsatisfactory nature of ESIS services, low quality drugs, long waiting periods, impudent behaviour of personnel, lack of interest or low interest on part of employees and low awareness of ESI procedures, were some of the reasons cited.

Other Government Initiatives

Apart from the government-run schemes, social security benefits for the disadvantaged groups can be availed of, under the provisions of the Maternity Benefit (Amendment) Act 1995, Workmen's Compensation (Amendment) Act 1984, Plantation Labour Act 1951, Mine Mines Labour Welfare Fund Act 1946, *Beedi* Workers Welfare Fund Act 1976 and Building and other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996.

The Government of India has also undertaken initiatives to address issues relating to access to public health systems especially for the vulnerable sections of the society. The National Health Policy 2002 acknowledges this and aims to evolve a policy structure, which reduces such inequities and allows the disadvantaged sections of the population a fairer access to public health services. Ensuring more equitable access to health services across the social and geographical expanse of the country is the main objective of the policy. It also seeks to increase the aggregate public health investment through increased contribution from the Central as well as state governments and encourages the setting up of private insurance instruments for increasing the scope of coverage of the secondary and tertiary sector under private health insurance packages. The government envisages an increase in health expenditure as a % of GDP from existing 0.9% to 2.0 % by 2010 and an

increase in the share of central grants from the existing 15% to constitute at least 25% of total public health spending by 2010. The State government spending for health in turn would increase from 5.5% to 7% of the budget by 2005, to be further increased to 8% by 2010.

The National Population Policy (NPP) 2000, envisages the establishment of a family welfare-linked health insurance plan. As per this plan, couples living below the poverty line who undergo sterilization with not more than two living children would be eligible for insurance. Under this scheme, the couple along with their children would be covered for hospitalization not exceeding Rs 5 000 and a personal accident insurance cover for the spouse undergoing sterilization. The Institute of Health Systems (IHS), Hyderabad has been entrusted the responsibility of operationalizing the mandate of the NPP 2000. The initial scheme proposed by the HIS was discussed at a workshop in June 2003. The consensus at the meeting was that the scheme, needed further improvement prior to its implementation even as a pilot project.

In keeping with the recommendations of the Tenth Five Year Plan and the National Health Policy (NHP) 2002, the Department of Family Welfare is also proposing to commission studies in eight states covering eight districts, to generate district-specific data, which is essential for conceptualization of a reasonable and financially viable insurance scheme.

The current plan – the Tenth Five Year Plan (2002-07) - also focuses on exploring alternative systems of health care financing including health insurance so that essential, need-based and affordable health care is available to all. The urgent need to evolve, implement and evaluate an appropriate scheme for health financing for different income groups is acknowledged. In the past, the government has tried to ensure that the poor get access to private health facilities through subsidy in the form of duty exemptions and other such benefits. Social health insurance for families living below the poverty line has been suggested as a mechanism for reducing the adverse economic consequences of hospitalization and treatment for chronic ailments requiring expensive and continuous care.

In the budget for the year 2002-2003, an insurance scheme called *Janraskha* was introduced, with the aim of providing protection to the needy population. With a premium of Re 1/- per day, it ensured indoor treatment up to Rs 3 000 per year at selected and designated hospitals and outpatient treatment up to Rs 2 000 per year at designated clinics, including civil hospitals, medical colleges, private trust hospitals and other NGO-run

institutions. A few states have started implementing this scheme under pilot phase.

In the budget for the period 2003-2004, another initiative of community-based health insurance has been announced. This scheme aims to enable easy access of less advantaged citizens to good health services, and to offer health protection to them. This policy covers people between the age of three months to 65 years. Under this scheme, a premium equivalent to Re 1 per day (or Rs 365 per year) for an individual, Rs 1.50 per day for a family of five (or Rs 548 per year), and Rs 2 per day for a family of seven (or Rs 730 per year), would entitle them to get reimbursement of medical expenses up to Rs 30 000 towards hospitalization, a cover for death due to accident for Rs 25 000 and compensation due to loss of earning at the rate of Rs 50 per day up to a maximum of 15 days. The government would contribute Rs 100 per year towards the annual premium, so as to ensure the affordability of the scheme to families living below the poverty line. The implementation of this scheme rests with the four public sector insurance companies.

The government also offers assistance by way of Illness Assistance Funds, which have been set up by the Ministry of Health and Family Welfare at the national level and in a few states. State Illness Assistance Funds exist in Andhra Pradesh, Bihar, Goa, Gujarat, Himachal Pradesh, Jammu and Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Mizoram, Rajasthan, Sikkim, Tamil Nadu, Tripura, West Bengal, NCT of Delhi and UT of Pondicherry. A National Illness Assistance Fund (NIAF) was set up in 1997, with the scheme being reviewed in January 1998. Through this, three Central Government hospitals and three national-level institutes have been sanctioned Rs 10 00 000 each at a time from the NIAF to provide immediate financial assistance to the extent of Rs 25 000 per case to poor patients living below the poverty line and who are undergoing treatment in these hospitals / institutions. Thereafter the scheme has been extended to few other institutes across the country and provides Rs 25 000 – Rs 50 000 per case.

Health insurance initiatives by State Governments

In the recent past, various state governments have begun health insurance initiatives. For instance, the Andhra Pradesh government is implementing the *Aarogya Raksha* Scheme since 2000, with a view to increase the utilization of permanent methods of family planning by covering the health risks of the

acceptors. All people living below the poverty line and those who accept permanent methods of family planning are eligible to be covered under this scheme. The Government of Andhra Pradesh pays a premium of Rs 75 per acceptor. The benefits to be availed of, include hospitalization costs up to Rs. 4000 per year for the acceptor and for his / her two children for a total period of five years from date of the family planning operation. The coverage is for common illnesses and accident insurance benefits are also offered. The hospital bill is directly reimbursed by the Insurance Company, namely the New India Assurance Company.

The Government of Goa along with the New India Assurance Company in 1988 developed a medical reimbursement mechanism. This scheme can be availed by all permanent residents of Goa with an income below Rs 50 000 per annum for hospitalization care, which is not available within the government system. The non-availability of services requires certification from the hospital Dean or Director Health Services. The overall limit is Rs 30 000 for the insured person for a period of one year.

A pilot project on health insurance was launched by the Government of Karnataka and the UNDP in two blocks since October 2002. The aim of the project was to develop and test a model of community health financing suited for rural community, thereby increasing the access to medical care of the poor. The beneficiaries include the entire population of these blocks. The premium is Rs 30 per person per year, with the Government of Karnataka subsidizing the premium of those below poverty line and those belonging to Scheduled Castes/ Scheduled Tribes. This premium entitles them to hospitalization coverage in the government hospitals up to a maximum of Rs 2 500 per year, including hospitalization for common illnesses, ambulance charges, loss of wages at Rs. 50 per day as well as drug expenses at Rs 50 per day. Reimbursements are made to an insurance fund which has been set up by the NGO / PRI with the support of UNDP.

The Government of Kerala is planning to launch a pilot project of health insurance for the 30% families living below the poverty line. The scheme would be associated with a government insurance company. Currently, negotiations are under way with the IRA to seek service tax exemption. The proposed premium is Rs 250 plus 5% tax. The maximum benefit per family would be Rs 20 000. The amount for the premium would be recovered from the drug budget (Rs 100), the PRI (Rs 100) and from the beneficiary (Rs 62.50)

while the benefits available would include cover for hospitalization, deliveries involving surgical procedures (either to the mother or the newborn). Instead of payment by the beneficiary, Smart Card facility would be offered. This scheme would be applicable in 216 government hospitals.

Concerns, Challenges and the Way Ahead

The preceding sections of this paper present the health insurance scenario in India. Given the situation, there are few issues of concern or barriers towards implementing a social health insurance scheme in India. These are enumerated below along with the possible way ahead.

India is a low-income country with 26% population living below the poverty line, and 35% illiterate population with skewed health risks. Insurance is limited to only a small proportion of people in the organized sector covering less than 10% of the total population. Currently, there no mechanism or infrastructure for collecting mandatory premium among the large informal sector. Even in terms of the existing schemes, there is insufficient and inadequate information about the various schemes. Data gaps also prevail. Much of the focus of the existing schemes is on hospital expenses. There continues to be lack of awareness among people about health insurance. In spite of existing regulation in some States, the private sector continues to operate in an almost unhindered manner. The growth of health insurance increases the need for licensing and regulating private health providers and developing specific criteria to decide upon appropriate services and fees. Health insurance per se, suffers from problems like adverse selection, moral hazard, cream-skimming and high administrative costs. This is coupled with the fact that in the absence of any costing mechanisms, there is difficulty in calculating the premium. There is also a need to evolve criteria to be used for deciding upon target groups, who would avail of the SHI scheme/s and also to address issues relating to whether indirect costs would be included in health insurance. Health insurance can improve access to good quality health care only if it is able to provide for health care institutions with adequate facilities and skilled personnel at affordable cost.

Given this scenario, the challenge, then, for Indian policy-makers is to find ways to improve upon the existing situation in the health sector and to make equitable, affordable and quality health care accessible to the

population, especially the poor and the vulnerable sections of the society. It is in a way inevitable that the state reforms its public health delivery system and explores other social security options like health insurance. Implementing regulations would be one, but by no means the best mechanism to contain provider behaviour and costs. This can only be done by developing mechanisms where government and households can together pool their funds. This could be one way of controlling provider behaviour.

There is an urgent need to document global and Indian experiences in social health insurance. Different financing options would need to be developed for different target groups. The wide differentials in the demographic, epidemiological status and the delivery capacity of health systems are a serious constraint to a nationally mandated health insurance system. Given the heterogeneity of different regions in India and the regional specifications, one would need to undertake pilot projects to gather more information about the population to be targeted under an insurance scheme and develop options for different population groups. Health policy-makers and health systems research institutions, in collaboration with economic policy study institutes, need to gather information about the prevailing disease burden at various geographical regions; to develop standard treatment guidelines, to undertake costing of health services for evolving benefit packages to determine the premium to be levied and subsidies to be given; and to map health care facilities available and the institutional mechanisms which need to be in place, for implementing health insurance schemes. Skill-building for the personnel involved, and capacity-building of all the stakeholders involved, would be a critical component for ensuring the success of any health insurance programme.

The success of any social insurance scheme would depend on its design, the implementation and monitoring mechanisms which would be set in place and it would also call for restructuring and reforming the health system, and developing the necessary prerequisites to ensure its success.

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