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HEALTH INSURANCE FOR THE POOR IN INDIA

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Foreword

The paper "Health Insurance for the Poor in India" was prepared to give an overview on the topic. Earlier draft of the paper was presented at ICRIER in a workshop organised under the project "New institutional and Economic Approaches to Health Insurance for the Poor in India" on 17th March, 2003. This revised paper incorporates comments made by the workshop participants.

In general, health insurance is not well developed in India. A major part of total health spending in the country takes the form of private, out-of-pocket spending which is clearly regressive in nature. There is a clear need for developing health insurance mechanism, especially for the low-income people who need it the most. A number of health insurance experiments are currently being tried for the low-income people in India. This paper gives a perspective on the topic.

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Health Insurance for the Poor in India*

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Abstract

Community based health insurance (CBHI) is more suited than alternate arrangements to providing health insurance to the low-income people living in developing countries. The universal health insurance scheme, launched recently by the Prime Minister of India, is only one of the forms that CBHI can take. While analysing the proposed scheme, we examine alternate forms of CBHI schemes prevalent in the country. The development of private health insurance market in the country will not leave the poor unaffected. Insurance sector reform can affect the poor through its effect on the provision of health services (i.e., cost, quality and access) used by the low-income people as well as through its access to financing of health care. In this paper we also explore how insurance sector reforms alter health insurance prospects facing the poor in India, and what changes on the health front affecting the poor have happened or are likely to happen as a result of insurance sector reforms. We conclude that in diverse settings of India all forms of CBHI have a role to play and therefore need to be encouraged by the government through appropriate interventions. Formal insurance providers can also be reigned to serve low-income population. At the same time, developments in formal health insurance market need to be guided so as to minimise cost escalation of health care provision.

Key Words: Health Insurance; Low-income people; poverty; risk and insurance; insurance schemes.

JEL Classification: I1, I3, G1

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1 Introduction

Health care financing in India can be considered almost unique in several respects. *One*, the share of public financing in total health care financing in the country is considerably low--just around 1% of GDP compared to the average share of 2.8% in low- and middle-income countries or even relative to India's share in disease burden.[2] *Two*, the beneficiaries of this limited public health financing are not only the poor as one would expect in a limited public spending to be, but also the well-off section of the society.[3] *Third*, over 80% of the total health financing is private financing, much of which takes the form of out-of-pocket payments (i.e., user charges) and not any prepayment schemes.[4] Reliance on out-of-pocket payments is not only inefficient and less accountable than other methods of financing, it is also iniquitous to the poor on whom the disease burden falls disproportionately more, who are more susceptible to disease and who are much likely to be pushed into poverty trap (Gumber 1997, Visaria & Gumber 1994). The World Bank (2002) estimates that one-quarter of all Indians fall into poverty as a direct result of medical expenses in the event of hospitalisation.[5] One of the important challenges facing the Indian health policy experts is: how to convert

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[2] While India contains one-sixth of the world population, its share in Disability-adjusted Life Years (a measure in which two-third weightage is given to mortality and one-third to morbidity, is used to quantify disease burden) make up 21 per cent of the global total. About one-quarter of world's annual maternal deaths occur in India and 19% of total under five child mortality (Naylor et al. 1999). The South Asia region contains the largest number of people living in poverty among developing regions, and faces a high burden of disease and under-nutrition associated with poverty. The largest country of this region, India, received negligible external assistance (0.7%) in 1990, unlike other countries of this region for whom external assistance is an important component of health spending, accounting for more than 10% of expenditures. In Sub-Saharan Africa as well external funding constitutes an important source of health financing (Schieber and Maeda 1997).

[3] A significant proportion of government spending on health goes into supporting teritary care whose beneficiaries are mainly the non-poor. In the order of priority, public funding needs to be allocated primarily for promotive and preventive health care which benefits the poor the most. Another feature of public health spending is that total states' spending on health, which accounts for three-fourth of the total public health spending, is more regressive than central government spending.

[4] WHR (2000) estimates private spending in India to be 87% of total health spending. Of this, 84.6% is out-of-pocket expenditure, lower only to Cambodia, the Democratic Republic of Congo, Georgia, Myanmar and Sierra Leone (see Misra et al. 2003).

[5] The World Bank (2002) comes up with some other startling observations: that, on average, the poorest quintile of Indians is 2.6 times more likely than the richest to forego medical treatment in the event of illness; that more than 40 percent of individuals who are hospitalised in India in a year borrow money or sell assets to cover the cost of health care; that hospitalised Indians spend more than half of their total annual expenditure on health care.

predominantly private out-of-pocket spending into health insurance premium whereby this amount is collected from a much larger group of insured individuals rather than from the limited number households affected by illness. Another important challenge is: how to provide health insurance to the people who cannot afford to pay (full) premium. Before digging deep into the issues involved let's look at the broad health care financing options.

In financing of health services a country may, in principle, choose between public financing through general taxation or private financing through health insurance. Public financing is justified where equity concern overrides efficiency objective. Where the opposite is true, reliance is often placed on the private insurance market. Equity considerations in private insurance market can generate inefficiency and market failure as it involves tradeoff between desired distribution and the distorted incentives that accompany such redistribution. Therefore, where equity is the prime consideration it can best be achieved under public financing. In practice no health financing system is either purely public or private. Countries where private health insurance dominates, some public financing can still be observed. Similarly, some private insurance can be seen even in a public funded health system. All insurance systems, public or private, must strike a balance between economic efficiency and equity.

The choice between public health financing or private insurance is hardly available to countries like India because of their governments' limited ability to marshal sufficient resources to finance health spending, and also because the nature of employment (where majority of workers are self-employed, or do not have a formal employer or steady employment) is such as to provide little scope for payroll taxes. Given this, heavy reliance on private spending is necessary for financial reasons, notwithstanding the declared policy of the state to provide *universal, comprehensive primary health services* to the entire population. Private spending may also be desirable on efficiency grounds. But the form that bulk of private spending takes need to change from out-of-pocket payments to private insurance.

Insurance or pooling of risks through prepaid schemes has a number of advantages. Besides being more equitable, it is one of the significant drivers of improvement in the healthcare provision by encouraging investment and innovation. Also, it helps improve the quality and efficiency of public health care system by continually benchmarking it. Private insurance has certain pitfalls too such as leaving out the low-income individuals who may not be able to afford premium, denying coverage to people who are sick, and limiting the coverage for high-cost conditions or services. In a country like India where public health care suffers from poor management, low service quality, weak finances, and lack of responsiveness to patients' needs and demands, development of health insurance is likely to bring improvement in public health care system. Even the private health sector in India that has grown in an undirected fashion, with virtually no effective guidance on the location and scope of practice, and without effective standards for quality of care or public disclosure on practices and pricing (World Bank 2002). Development of health insurance will necessitate improvement in private sector as well. The pitfalls associated with private health insurance can be reduced through appropriate regulation. To the extent that certain per cent of population can be covered through private health insurance, development of health insurance will tend to reduce the need for government financing of secondary and tertiary care. This would help government to develop and maintain smaller and well targeted system of health care financing to serve people who would not have access to private insurance, and to address public health priorities such as immunisations that are quasi-public goods (Srinivasan 2001).

Before launching any major health initiative, there ought to be a well articulated vision of health care system for the country, and public health policy must be devised to realise that vision. Ideally, certain basic health services, including inpatient care, must be made available to every member of the society. These services must be paid through insurance, which means that every member must have health insurance cover or at least have *access* to health insurance, with government subsidising insurance premium, in full or in part, for those who cannot afford it. For the upper-and middle-income people, private health insurance market with effective and sound regulation can take care of

health financing. However, with the development of private insurance market, only half the country's population can at best be reached. The other half, which consists of low-income population (30% of the population below the poverty line and add to it another 20% living dangerously close to this line) is likely to remain outside the ambit of private health insurance unless there is an explicit social obligation in this respect which can come only from insurance regulator. For the low-income people, who are the main focus of this paper, neither government provided nor market mediated arrangement is appropriate. Community based health insurance (CBHI) because of its certain features such as, the voluntary participation of the people, not-for-profit objective in organising the scheme, scheme management by the community itself, and some degree of risk pooling, is more suited to insuring the poor (see section 2). The CBHI schemes themselves can take different forms.[6] The forms that are prevalent in India are discussed in the paper.

The paper is structured as follows: in the next section (section 2) we discuss different forms of Community Based Health Insurance (CBHI) schemes prevalent in India, and critically examine 'universal health insurance scheme" launched in the country recently.[7] Development of private health insurance in the country too will have a bearing on the access to health care services by the poor. In section 3 we discuss the factors that are holding back the development of private health insurance in the country, and in section 4 we discuss how the development of private health insurance market could possibly affect the poor. Section 5 concludes the paper.

2 Health Insurance for the poor

For the low-income people, insurance was never considered to be an option in the past. They were assumed to be too poor to save and pay premium. Hence, the government assumed the responsibility of meeting health care needs of the poor. One could argue that

[6] Some community based health initiatives do not involve any risk pooling. They provide easy credit or renegotiate medical fee with the providers on behalf of the members of a scheme. Since such initiatives do not provide any insurance we do not refer to these in this paper.

[7] The phrase 'Community Based" was removed from the proposed scheme when the scheme was actually launched.

if government pays for the poor anyway, why think of insurance at all? Instead, why does government not continue providing free health services to the poor, as in the past? Well, the strategy of free public health provision has not worked well in most states. Shrinking budgetary support to the public health services, inefficiency in provision, and unacceptably low quality of these services is reflective of this. Even in states like Tamil Nadu where public health care provision is reasonably developed, and may even get better as the decentralisation process deepens, there are reasons for introducing health insurance. *First,* it is being increasingly realised that even low-income people can make small periodic contributions, which can add up to a significant amount, thereby taking some financial burden off from the already strained state revenues. *Second,* the insured individuals would have an option of going to either public or private service provider, which in turn would generate competition among providers for better services. *Finally,* health insurance can be used to promote certain desirable behaviour. For example, the Aarogya Raksha scheme of Andhra Pradesh links family planning to health insurance.

Conceptually, a society can be thought of as consisting of two groups of individuals, those who can afford to buy health insurance that promises certain "minimum" level of benefit, and those who cannot afford to buy the "minimum" benefit on their own and need some public subsidy. As mentioned above, development of private health insurance may take care of those who can afford to buy insurance. For those who cannot afford, alternate approaches with some public subsidy are suggested. However, while operationalising the idea, this conceptual distinction gets blurred. Government's attention gets confined only to those who are below the poverty line. While those below the poverty line definitely need to be covered with government support, the non-BPL population with low-income also need to be covered, with our without government support, since market insurance is likely to bypass this section as well. An important policy question here is: how best to target and reach this section of the population? One way is to *redefine* the BPL population so as to include low-income people as well. Another approach is to include non-BPL population also in the scheme meant for BPL population with lower level of subsidy.

Even though the government's approach is to support voluntary insurance rather than to expand the existing social insurance schemes, the following approaches may be suitable for the different sections of the society. For the upper and the middle income people social insurance and voluntary insurance are suggested to be the two dominant forms of financing health care. State's role is primarily to develop an appropriate legislative framework, to appoint independent regulator, and to formulate procedures and regulations to avoid well documented market failures (Misra et al. 2003). Even for low-income people who are employed in the formal sector, social insurance may be a better way of providing health protection. However, it is for the low-income people working in the unorganised sector and those below the poverty line that alternate approaches are needed.[8] One approach suggested in the literature, which is relatively straight forward, is to create a *sickness fund* for this section of society. The fund could be used to cover all hospitalisation expenses of such families in public facilities as well as designated private facilities. T N Krishna estimates the size of fund required to cover hospitalisation costs of 300 million BPL population. Assuming 4% of BPL population require hospitalisation every year and the cost per episode (at 1995-96 prices) is Rs. 2,100, the size of fund comes to Rs. 25,000 million per annum. Misra et al. (2003) revised this cost figure and arrived at Rs. 40,000 million required for covering hospitalisation cost per annum of the BPL population. If, instead of directly bearing the cost, government provides them health insurance the demand on government funds may come down significantly as insurance helps in some resource mobilisation from the people themselves (for comparison of costs see section 2.2).

Health insurance for the poor can take different forms. It could be community based (examples to follow) or non-community based (like Jan Arogya policy of the government).[9] Community Based Health Insurance (CBHI) can itself take several forms.

[8] Even for the low-income people, a long-term view may to integrate them with the system meant for the rest of the population. But this does not conflict with the need for exploring alternate arrangements that can work for them in the short and medium term.

[9] Jan Arogya policy is offered by the non-life public insurers. The scheme, started in 1996, is targetted at low-income population. At the nominal premium of Rs. 70 an adult individual up to 45 years can get the benefit of up to Rs. 5,000 in case of hospitalisation. The premium is Rs. 90 for an individual above 45 years and Rs. 50 for a dependent. An adult member can insure maximum of two dependents.

Two types of CBHI schemes that are observed in India are: where an NGO acts as an intermediary between a formal insurance provider and the insured community (for example, SEWA in Ahmedabad, ACCORD in Nilgiris) and where the NGO itself provides insurance to the target community. In the latter case, where an NGO itself insures the target population, the NGO may itself be the health service provider (for example, Sewagram Hospital) or may have an arrangement with the health service provider (for example Tribhuvandas Foundation).[10] (For other major differences between these CBHI schemes see the Table 1). All these forms currently exist in the country but only in small pockets. These forms need to be explored. Each of these forms may be relevant depending on the local conditions that vary considerably across regions. For as diverse a country as India there can be no Pan India model. Indeed, CBHI schemes could be designed in a number of ways, depending on the socio-economic characteristics of the target population, health profile of the population, and the health risks prevalent in the region. Even within states different schemes could be designed for different districts. This calls for scientific approach with begins with good experimentation, and fine-tuned subsequently as experience accumulates. The decentralisation process initiated in the country with the 73rd and 74th Constitutional Amendment aimed at promoting local bodies (Panchayati Raj Institutions (PRIs) in the rural areas and Nagar Palikas in the urban areas) has raised hopes of being able to reach the poor through community based initiatives with some subsidy to those who cannot afford the costs (Gumber & Kulkarni 2001).

Table 1: Important differences in CBHI Arrangements

Type of Arrangement	**NGO is an Intermediary**	**NGO is a Manager**	**NGO is a Provider**
Examples	SEWA/ACCORD	Tribhuvandas Foundation	Sewagram/VHS
Type of risks covered	Inpatient Care & Non-Health Risks	Inpatient Care	Inpatient and Outpatient Care
Pre-existing/Chronic Conditions	Excluded	May not be excluded	Not Excluded

[10] Ranson (2002) identifies these three schemes prevalent in India. For review of these schemes see Ranson 2002.

Membership Size	Medium to Large	Small to Medium	Medium to Large
Availability of Benefit	After certain period	At time of discharge	At time of utilisation
Administrative Costs	Moderate	Low	Low
Subsidy	External	External	Internal/External
Group Formation	Occupation/Geography Based	Occupation/Geography Based	Geography Based

Source: Ranson (2002) and Own Compilation

The real benefit of CBHI lies in keeping the transaction costs low, in the design of scheme suited to the community needs, in influencing health behaviour through health education, and in influencing the supply of health care. Popularising insurance among low-income people requires conveying the idea, canvassing for it, collecting premium, and verifying claims and then reimbursing these claims. In case of formal providers, all these functions typically take up significant part (at least 20 per cent) of the premium amount. In CBHI schemes such costs can be kept low, say to 5-6 per cent. This is because many of these tasks can be performed by the community members themselves. Besides, in poor communities financial barrier is only one of the barriers to accessing health care. Often, there are many non-financial barriers that must also be overcome through the design of schemes which ought to take into account characteristics of the community. All these aspects can best be handled if the scheme is community based. Additionally, the problems of adverse selection and moral hazard that arise due to informational asymmetries too can be reduced by making use of local knowledge that is readily available among people living in close communities. CBHI scheme is more appropriate in reducing informational asymmetries. CBHI schemes also help in influencing provision of health services. By its very nature, CBHI scheme can be designed to meet health care needs that are specific to a community. By this reckoning, Jan Arogya type of policy, which is not tailored to the needs of the target community, cannot be hoped to be very successful. There is no community participation in the scheme, and this type of policy is also more prone to abuse. Generally, CBHI scheme is organised through an NGO that is conversant with the target community. A CBHI scheme where an NGO mediates between community members and the formal insurance provider seems to combine the

participatory feature with the efficiency aspect characteristic of the formal insurance provider. However, some forms of CBHI also have important limitations. For example, where an NGO itself provides insurance (acts like an insurer) the ability of the NGO to have a pool of well diversify risk is limited. This in turn restricts the ability of NGO to cover or insure variety of risks facing the target population. Moreover, where CBHI schemes are critically dependent on external funding, extending the reach of these schemes then depends on the amount of such funding available. Furthermore, the insurance schemes launched either by national or state-level governments when elections are in sight tend to be populist or vote-catching ploy. Since such schemes have to be renewed every year, these tend to be dropped once the elections are over. It is to be seen if universal health insurance scheme belongs to this category.

2.1 Insurance reforms and health insurance prospects for the poor

Where an NGO itself provides insurance to the target community, insurance sector reforms do not directly affect formation of such schemes, though appropriate regulatory changes designed to encourage such grouping may positively affect their formation.[11] The scope for introducing such changes is greater now than prior to liberalisation. Where insurance reforms do affect is in non-community based scheme (where the government directs public insurance companies to offer a product to the poor with or without some subsidy from the government) as well as in NGO mediated CBHI scheme (where an NGO ties-up with the formal insurance provider in ensuring certain benefit package to the targeted poor, e.g. SEWA type arrangement). Both these types of schemes were more likely when insurance was a public monopoly. Now with the introduction of competition, for-profit companies will voluntarily serve only those segments and introduce those products that are profitable in descending order of magnitude to the company. Typically, providing insurance to the poor is not profitable

[11] A well known international expert on health insurance, William Hsiao, who examined IRDA regulations commented that these regulations are written only for for-profit organisations and doesn't recognise the fact that insurance could also be provided by not-for-profit organisations such as NGOs involved in CBHI schemes. Not-for-profit organisations play an important role even in market economies like that of the US.

and insurance companies are unlikely to take up this moral obligation on their own volition. Furthermore, even public insurers that have mostly entered into such commitments may no longer be willing to do so as competition in the market intensifies. The regulator imposed uniform obligation across all formal insurers can then improve the prospects of NGO-mediated CBHI or non-community based scheme for the low-income people. The current social and rural sector obligation imposed by the Insurance Regulatory and Development Authority (IRDA) is on the insurance business in general and does not specifically apply to health insurance. Furthermore, this obligation does not require insurance companies to subsidise premium. This obligation is just to ensure that some amount of insurance activity also moves to rural areas and doesn't remain confined to big cities and towns.

In the past, public insurer cross-subsidised the policies meant for the disadvantage sections of the society. Now, for cross-subsidy to work properly, a uniform social obligation needs to be imposed on all insurance companies and not only on public insurers. Such an obligation would then come from the regulator and not from the government. The regulator, for example, could mandate all insurance companies to offer "basic" benefit package covering maternal, preventive, catastrophic and chronic care at standard prices to the poor, especially in rural areas with some subsidy from the government. In this case, the regulator may limit exclusions, mandate guaranteed renewal, and make accreditation of service provider public. Here too NGOs can play a crucial role as an intermediary between the private insurers and the community. Whether having a cross-subsidy obligation uniformly on all insurance companies is the best (most efficient) way of reaching the poor is an open question. Generally, subsidy that comes from general revenue of government is the most progressive.

Moreover, if prepayment schemes run by charity hospitals are also brought under the insurance regulator's supervision, this can give a boost to such managed care arrangements. If the legal constraint becomes a real obstacle for the expansion of managed care oriented health insurance the indemnity model may de facto get

encouragement, resulting in cost escalation and reduction in the potential market for private insurance (Ferreiro 2000).

2.2 Community Based Universal Health Insurance Scheme

Prior to the announcement of the proposed community based universal health insurance scheme by the finance minister of India, various states governments were contemplating to launch a health insurance scheme for its poor population. State governments intensified their efforts when a similar announcement by the central government a year ago (in the budget 2002-03), didn't take off. Without sufficient knowledge base, the state governments were trying to enter into an arrangement with the providers of medical services, public insurance companies and the target community whereby insurance companies would reimburse treatment costs of the target community and the governments would subsidise the premium to the insurance company for the insurance sold to the target community. Some state governments had thought of paying the premium through their general revenues while others had planned to cross-subsidise premium by bringing state government employees also under Mediclaim policy (Punjab and West Bengal governments were thinking alone these lines).[12] With the recent announcement (in the budget 2003-04) made by the finance minister to launch "community based universal health insurance" scheme for the low-income people, state governments have put off their plans.

Before analysing the scheme launched recently, let's first look at some of its important features. The scheme comes in three different flavours: (i) Re 1 per day per year for an individual (ii) Rs. 1.5 per day per year for a family of up to five members, and (iii) Rs. 2 per day per year for a family of upto seven members. Given this, the bias towards family enrolment, as opposed to individual enrolment, is obvious. What are the benefits provided? Well, in case of hospitalisation the scheme provides medical expenses

[12] This is based on the draft of the scheme circulated in the workshop on "Health Insurance in India" jointly organised by the Ministry of Health and Family Welfare (MHFW) and the World Health Organisation (WHO) in Delhi in January 2003.

upto Rs. 30,000 per family,[13] and if an earning member falls sick the scheme also provides for the loss of livelihood at the rate of Rs. 50 per day upto maximum of 15 days, and in case of death of the earning head of the family due to personal accident Rs. 25,000 is to be given to the nominee.

In all these flavours the government provides a subsidy of Rs. 100 which remains fixed whether it is an individual who buys insurance or a family of five or of seven.[14] While the scheme is open to anybody who wants to participate in it, the subsidy is given only to the BPL families. Moreover, the scheme is designed to cover not a poor individual/family on Indian streets but those who are members of some group or the other such as cooperative societies, bidi workers, handloom weavers etc. In other words, the proposed scheme is a group insurance scheme with membership of at least 100 families.[15] The scheme is not designed to cover the entire BPL population, at least not in the initial phase. If the scheme survives and does not get extended to include other BPL families, state governments would then need to think of reaching those poor who are not a part of any occupation-based or any self-help group for which the scheme is currently intended.

Some other salient features of the scheme are (i) individuals between the age of 3 months and 65 years can join the scheme (ii) total hospital expense that can be reimbursed under the scheme for any one illness can be up to Rs, 15, 000, with a cap on the amount payable for different types of hospital expenses (iii) a number of illnesses/situations are excluded, for example maternity insurance is not included, and (iv) claims will be settled either by an intermediary called third party administrators (TPAs) or by the insurance companies themselves.

The way in which the scheme is designed, it cannot be termed as a community based scheme. The scheme is so designed as to keep the transaction costs low. But here

[13] In case of family membership, the benefit is on floater basis which means that the total reimbursement of Rs. 30,000 can be availed either individually or collectively by the family members.

[14] In case a BPL individual participates in the plan, the total premium would be Rs. 365 per year, of which he would pay only Rs. 265, with the balance Rs. 100 paid by the government as subsidy.

[15] It is learnt that the policy is now available even to a group of 10 families.

too the presence of TPAs limits the scope of reduction in transaction costs. Because the scheme lacks "community character" the other potential benefits of community based scheme cannot be reaped. Furthermore, a universal standard package of costs and benefits, takes away the needed flexibility in designing a scheme appropriate to local conditions.

The scheme is expected to cover 10 million families that are below the poverty line in the first year. The government subsidy is capped at Rs. 1000 million. Assuming all 10 million families get covered, the resource mobilisation that can be effected is in the range of Rs. 3650 million to Rs. 7300 million, with considerable variation in the claims liability[16]. An important point to note is that the scheme is designed on the assumption that even the poor can contribute some payment towards their health security and the amount that is sought to be mobilised is significant. If this scheme is to be made available for the entire BPL population of about 300 million, the extent of resource mobilisation that could be effected is quite significant indeed. Assuming average family size to be 5. There would be 60 million poor families (assuming 300 BPL population). If each family pays premium of Rs. 540 (i.e., Rs. 1.5 X 365) per year, the total premium amount would be Rs. (540 X 60) 32,400 million. Of this amount the government contribution by way of subsidy (of Rs. 100 per family) would be Rs. 6000 million. So, the amount that could be mobilised from the BPL population would be around (Rs. 32,400 million - Rs, 6,000 million) Rs. 26,400 million. If we compare this figure with the amount estimated by Rajiv et al. of Rs. 40,000 million, around 65 per cent of the funds can be mobilised from the people themselves! However, there is a catch here. These estimates only pertain to hospitalisation costs whereas the costs involved in case of health insurance are higher as it also provides for wage loss.

In principle, both public and private insurance companies can participate in the scheme. In reality, participation of private insurance companies seems unlikely, especially when there are other more lucrative areas still to be tapped. Prior to

[16] The range is worked out based on assumption that either the entire 10 million policies are bought by individuals (10 million X Rs. 365= Rs. 3650) or by a family of seven individuals (10 million X Rs. 730=Rs. 7300).

liberalisation, when insurance was a public monopoly, launch of such a scheme would have made perfect sense. Indeed, two health insurance products—Mediclaim and Jan Arogya—were launched at that time, and we are all too aware of the dismal record of these products. Now with competition at the market place, wouldn't encumbering public insurers put them at a disadvantage? Even though the subsidy is being paid by the government to cover for any possible shortfall, it is unlikely to attract even the public insurance companies. One, claims liability under the scheme is open ended whereas the government subsidy is capped. Two, the public insurers showed total disinterest, even scorn, when similar scheme "Janraksha" was announced in the budget 2002-03. Little surprise why the scheme failed to take off the ground![17]

Health insurance scheme for the poor should take care of not just the inpatient or hospital care, as designed in the proposed scheme, but also of the outpatient care. It is often suggested that insurance be provided only for inpatient care and that outpatient care be left outside the ambit of insurance. The reasons given are: that people can, by and large, afford out-patient care because it is relatively inexpensive; it is the inpatient care that pushes them into poverty trap; that administratively it is difficulty to include out-patient care; and, that out-patient care would lead to cost escalation. Ideally, both in-patient care and outpatient care be covered, and the decision of whether or not a patient needs hospitalisation be professionally made and should not be a function of whether or not the patient has health insurance cover. For this reason the UNDP sponsored experiments on community based health insurance, launched recently, have addressed the

[17] Under Janraksha scheme, an individual after paying Re. 1 per day was entitled the benefit of upto Rs. 30,000 per year for indoor treatment in designated hospitals, and up to Rs. 2,000 for outpatient treatment in designated clinics.

issue of outpatient care as well.[18] Community character of CBHI schemes is used to tackle the problem of outpatient care as well. (For other issues in design of CBHI schemes see Ranson and Jowett 2003). However, with the launch of universal health insurance scheme, it is not clear how this would affect the prospects of an NGO negotiating a health insurance package for and on behalf of a target community with the public insurance companies.

In the current debate on health security for the poor, health insurance is made out to be panacea for all the ills facing the poor. Health insurance, no doubt, has emerged as an important financing tool as it promises to mobilise some resources from the people themselves i.e., those who buy insurance. But health insurance, which strengthens demand side, makes sense only when the supply of health care is reasonably well developed. Where this is not so, health insurance is meaningless. The supply of health care in the rural and remote areas of country is far from satisfactory. Although public health care centers are pervasive, these centers have degraded overtime in most states due to lack of funds, accountability and so forth. Any attempt at introducing health insurance for the poor must also be accompanied by revival of health care facilities at these centers.[19] The need for stepping up public health spending is endorsed by many expert studies. Unfortunately, the launch of the scheme is not accompanied by either an increase

[18] Recently, UNDP has sponsored at least three different kinds of community based health insurance experiments in the country, two of which are in Karnataka and one in W. Bengal. One common feature in all three experiments is that the issue of outpatient care too has been addressed. It is addressed not through insurance but through (soft) credit. The second common feature is that health insurance arrangement is with the formal (public) insurance provider. The main difference between the two experiments in Karnataka is in the mediator. In one case an NGO is the mediator, and in the other case it is the local government that mediates between the people and the insurer. In both these experiments, public health facilities used. At present only people below poverty line are covered in these experiments. But these can be upscaled to include ABL population also but without any subsidy. All aliments are covered but there is a cap on the maximum number of days a person can be hospitalised. In case of illness the person is given wage loss. In the West Bengal experiment, because of the absence or dsyfunctional public health facilities, the arrangement is with the private health care providers. In this scheme members of the scheme have to pay only part of the costs (make co-payments) instead of full costs paid by non-members for most treatments.

[19] These centers should be managed professionally with emphasis on recovering at least their operating costs. In certain regions these centers may not break-even due to thin or limited demand. In such regions government has a social role in supporting non-viable health centers. The welfare function of the government needs to be separated from the health care provision.

in public health expenditure or any commitment to reorient the public health system, and this seems to suggest lack of seriousness in providing health security to the poor (Sankar and Kathuria 2003). Finally, both the provision and access to health care services should be a part of a bigger health strategy which includes other public health programs such as safe drinking water, sanitation, family planning etc. as each of these are important determinants of health outcomes. In other words a comprehensive approach is needed.

With the view to understand how the development of private health insurance in the country is likely to impact the poor, we now turn to the factors that are currently affecting its development.

3 Private Health Insurance in India

Unlike most OECD countries where private/social health insurance is the main source of health care financing, in India, and more generally in developing countries, most private insurance is a supplementary service. Health insurance, whether social and private, whether formal or informal, is extremely limited in India. Existing health insurance schemes in India are mandatory schemes, private (voluntary) schemes, employer based insurance, and the schemes in the NGO/voluntary sector. All these schemes put together cover about 110 million people or about 11 percent of the population (Garg 2000). This number falls far short of the private health insurance potential that is estimated anywhere between 400 and 500 million people. What is holding back the realisation of this potential?

Although a number of private insurance companies have entered after the liberalisation of the insurance market in 2000, no significant change in health insurance has been observed either in terms of new health insurance products or in terms of the volume of business. The two health insurance products namely Mediclaim for the general public and Jan Arogya for the poor, launched prior to the liberalisation, have not shown

any significant growth either in terms of volume of business or in the number of policies sold post liberalisation (see Table 2 and Table 3)[20].

Table 2: Mediclaim Policy

	1997-98	1998-99	1999-00	2000-01	2001-02
No. of Persons Insured	2783862.0	3534417.0	4894129.0	5623864.0	7784491.0
Premium (Rs. In Lakhs)	21569.6	27173.5	38040.7	51898.2	74204.5
Claims (Rs. in Lakhs)	18612.4	21810.3	33226.1	47152.8	62038.6
Claims Ratio %	86.3	80.3	87.3	90.9	83.6

Table 3: Jan Arogya Bima Policy

	1997-98	1998-99	1999-00	2000-01	2001-02
No. of Persons Insured	139354.0	313643.0	686685.0	348413.0	348912.0
Premium (Rs. in Lakhs)	115.3	2880.0	6569.0	6800.3	9079.3
Claims(Rs. in Lakhs)	97.1	2882.4	7978.0	6689.0	8818.2
Claims Ratio %	84.3	100.1	121.4	98.4	97.1

Source: Annual Reports of the (non-life) public insurance companies.

The new general insurers have introduced slight variations of the existing Mediclaim and the new life insurers have introduced some health riders to their life policies. However, their volume of business is negligible (GOI 2002). Why has the scope of existing health insurance schemes remained limited? Two important reasons cited are: (i) poor product design, and (ii) lack of vigorous marketing of the products to sensitise the public of the need for health insurance. The existing health insurance schemes are indemnity based products wherein the payment to the health provider is first made by the sick individual and this amount is later reimburse (partly or fully) by the insurance company to the insured individual. A large section of population who cannot afford such large payments at the time of illness, even if these payments are reimbursed later, does not feel attracted to this type of insurance. Furthermore, the scheme provides for reimbursement only in case of hospitalisation, and not for out-patient care, and for

[20] Also, life insurance companies offer insurance against certain terminal or major diseases as riders to their life insurance products.

allopathic treatment and not for treatment as per alternate system of medicine.[21] Reimbursement of hospital expenses exposes the policyholders to the "service" of insurers which is far from satisfactory. Coming to the second reason, when the public is not much aware of the need for health insurance, vigorous marketing of schemes becomes essential for popularising the scheme. Finally, health insurance is not demanded for its own sake but for reducing financial barrier to health services. In rural and remote areas where supply of health services particularly inpatient facilities is weak, demand for insurance naturally gets constrained.[22]

More generally, why has health insurance business remained underdeveloped in India? Why no reputed global health insurance company has entered the market? Impediments to the establishment and development of private health insurance stem directly or indirectly from government policies regarding insurance, and health care sector (GOI 2002). The most important impediments arise from the supply side i.e., from the side of health care providers. Lack of standards for diseases and treatment procedures (and where these standards and procedures exists, their adoption is lacking); absence of rating and credentialling of the providers; non-existence of centralised database, standardisation of billing, claims and proposal forms are some of the problems facing the health care industry.[23]

On the insurance regulation side too there are some issues affecting the development of the market. For example, the minimum capital norm for exclusive health insurers is deemed to be lower than what is currently prescribed. Similarly, solvency margins and reinsurance requirement appropriate to health insurance which is less volatile than property and casualty insurance are deemed to be different from those applicable to other lines of general insurance business. Currently, such requirements that

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[21] According to the WHO Report about 70 percent of population in India uses Indian System of Medicine and Homeopathy.

[22] For more about the design of and weakness in Mediclaim see Bhat and Reuben 2002.

[23] Development of insurance requires spare capacity of medical facilities. In India where the pressure on these facilities is already high, additional facilities are needed to ease this pressure (Rangachary 2001). However, in the budget 2003-04 the finance minister announced a number of sops for the health care sector precisely with the intention of encouraging investment in this sector.

apply to general insurance business apply to health insurance as well.[24] Similarly, there are no minimum capital requirement and solvency norms for health care providers interested in establishing and running managed care schemes.[25] Besides, current Mediclaim policy that distorts the balance between price adequacy and coverage, restricts the ability of competitors to come up with more balanced products.

Once the entry barriers are removed, additional regulations need to be put in place for the smooth functioning of health insurance business. Even though, insurance regulations meant to ensure fairness, efficiency, and financial accountability in health insurance are similar to those applicable to general insurance business, health insurance business always involves additional regulations. These relate to meeting social objectives of access, adequate benefits, and consumer responsiveness. Typically insurers tend to develop a number of underwriting and pricing practices to avoid accepting high risk people. This kind of market segmentation is economically efficient but may be considered socially unacceptable. Often regulators ensure that equal access is available to the payers of health care, that companies cannot exclude high-risk individuals or costly preexisting conditions. Moreover, health insurance contracts are typically more complex than other insurance contracts. Regulators need to ensure that consumers understand the provisions of the contracts and that contracts are written in a manner understood by the buyers.[26]

Since health insurance is closely linked to health care provision, interventions required to correct these problems call for a coordination with other arms of the government such as the Ministry of Health and Family Welfare, and bodies like Medical Council of India, the regulators.[27] Finally, government's role in promoting or impeding

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[24] For example, statutory requirement to cede 20 percent of risks underwritten for reinsurance also applies to health insurance.

[25] One of the experts from the medical profession observed that IRDA is encouraging insurance companies to enter health segment but medical providers are not being encouraged to provide insurance.

[26] For more details on regulatory issues see Mahal 2000.

[27] Actually there are two types of regulatory issues involved: one is regulation of health care services and the other is regulation of entities involved in health insurance business.

private health-related investment is a key element in the growth of private health financing and delivery. Unless these issues are dealt with one cannot expect any significant development to take place in health insurance business in the country.

4 Impact on the poor[28]

Developments on the health insurance front will not leave the poor unaffected. Even though private for-profit insurance companies are not expected to voluntarily provide health insurance cover to the poor, the poor may still be affected on account of the influence that development of health insurance will have on the supply of such services. Furthermore, the poor may also directly benefit if insurance regulations are specifically designed to achieve redistribution and equity objectives. At the minimum the government must ensure that (i) the liberalisation of insurance market provides value for money for the direct beneficiaries (ii) the poor are not adversely affected by the liberalisation (Peters et al. 2000). However, the government can definitely aim higher by ensuring that the poor too benefit from the developments in health insurance.

The likely impact of developing voluntary insurance on the poor is far from clear. There are both potential *benefits* and *risks* associated with it. Development of health insurance would influence supply of health services both in terms of its quality and price. It would also influence the extent of public funds available for subsidising the poor. The potential benefits and risks are formally listed below:

Potential Benefits:

- If the introduction of evidence-based medicine trickles down to other providers that are used more often by the poor, the poor could benefit from the improvement in quality in the private sector;

- If public subsidy to the non-poor who join health insurance decreases, greater public resources may be available for providing subsidy to the poor

Potential Risks:

[28] This section is based on the findings and recommendation made during the World Bank organised national seminar on private health insurance in November 1999. These are reported in Ferreiro (2000), Peters, D. et al. [a] and Peters, D. et al. [b].

- The gap between the poor access at present and the required access may increase with cost escalation;

- As the non-poor make a switchover from public to private hospitals there is a risk of political support for public financing getting reduced which would impact the poor by excluding them quality care from private market or by deteriorating quality and weakening support for public services (Peters et al. 2002)

The poor might benefit from the expansion of private providers if the supply of health care expands due to increase in affordability resulting from health insurance. However, if prices grow faster than delivery capacity, cost escalation may even expand the existing gap between the poor and the required access to health care. All this is unpredictable, since it depends on the supply response of health care and the model of health insurance implemented in the country. Regarding the latter, it is clear that an indemnity/fee-for-service system will unavoidably result in a severe cost escalation whereas a managed care which coordinates financing and delivery of healthcare would probably be capable of maintaining costs under control. Managed care by containing of unnecessary treatment helps in containment of costs and thereby makes health insurance more affordable to larger number of people; provides incentives for improving healthcare delivery; promotes preventive care such as medical check ups, immunisation and so on. Since fee-for-service approach to payment of health providers tends to escalate costs the government should encourage managed care models.

The pro-poor recommendations made in the World Bank organised national seminar on the topic are: (i) reduce the public subsidy to the wealthy by charging full cost recovery to the insured who use private insurance (ii) define minimum package of services cover that include preventive, maternity, and catastrophic cases (iii) encourage informal community financing schemes, for example, managed care schemes through NGOs with less regulation and lower capital deposit requirements.

5 Conclusions

Health insurance is emerging to be an important financing tool in meeting health care needs of the poor. Neither market mediated nor government provided insurance is an

appropriate way of reaching the poor. Community Based Health Insurance (CBHI) is more suitable arrangement for providing insurance to the poor. Development of private health insurance in the country has both potential risks and benefits in improving the access of the poor to health services. Appropriate regulatory changes can minimise the risks and turn potential benefits into concrete gains for the poor. However, currently even the private health insurance market lacks development for the want of proper regulatory decisions both on the supply of health services and on the demand for health insurance.

CBHI, which is more appropriate insurance arrangement for the poor, could take different forms and each of this form may be suitable depending on the characteristics of the target population, their health profile, and health risks to which the community is exposed. Indeed, for a country as diverse as India there can be no Pan India model and all different forms need to be explored. The scheme announced in the last budget and recently launched by the Prime Minister of India seems promising provided the insurers find it attractive enough to partake in the scheme. The liberalisation of insurance market has made this less likely, as competition in the market place will turn the focus of companies in most profitable lines of business. However, a regulatory requirement to this effect may then be a possible way out. The proposed scheme being a group insurance scheme is not meant to cover the entire BPL population. Also, it excludes outpatient care. As experience accumulates, the scheme can be fine-tuned and expanded to cover all low-income people. But increased public health spending and reforming of public health facilities is a must for the success of these community based health initiatives.

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