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Health insurance: still a long way to go

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THIS paper has threefold objectives: (*a*) to discuss the background and the need for a health insurance scheme; (*b*) to examine the different health insurance schemes including Community Based Universal Health Insurance Scheme (CBUHIS) and the most recent one proposed by the National Commission for Enterprises in the Unorganized Sector (NCEUS); and (*c*) to summarize broad lessons from existing health insurance schemes to foreground the broad contours of the most desirable insurance scheme in the Indian context. We argue that despite a dire need for a health insurance scheme for the poor both in the rural and urban areas, it remains a daunting task notwithstanding efforts of the government, NGOs, and the corporate sector.

The unorganized sector in India is sizeable and still growing, simultaneously with accelerated gross domestic product (GDP) growth rate. Besides contributing about 60% to the country's GDP, it offers livelihood to almost 90% of the workforce characterized by wide heterogeneity, mass poverty, and miserable living conditions. Workers in the unorganized sector receive very low wages. They generally lack unions or associations that could help them fight against many day-to-day injustices they face, and empower them with the bargaining power or collective strength to demand just policies and laws, including laws for social protection and social security.[1] People who belong to this sector are thus bereft of any type of formal social security.

The poor, for lack of resources to pay for health care, are far more likely to forego medical care, rather than become indebted or impoverished trying to pay for it. On average, the poorest quintile of Indians are 2.6 times more likely than the richest to postpone medical treatment when ill.[2] Aside from cases where people perceived that their illness was not serious, the main reason for not seeking care was cost. The burden of treatment was particularly found unduly large when they seek inpatient care.[3] On the whole, about six per cent of the household income is spent on curative care.[4] The burden of expenditure on health care is unduly heavy on households engaged in the informal sector. The 'out-of-pocket' private expenditure has grown at the rate of 12.5%, and for each 1% increase in per capita income it has increased by about 1.44%.[5] It is estimated that at least 24% of all hospitalized persons fall below the poverty line because they are hospitalized, and resultant out-of-pocket spending on hospital care might have raised the proportion of the population in poverty by two percentage points.[6]

Other concerns directly linked to the poor at large relate to the availability, affordability, accessibility and the use of subsidized public health facilities on the one hand and gender bias and low health insurance cover on the other.

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The high incidence of morbidity cuts household budget both ways: while spending a large amount of money and resources on medical care they are also unable to earn during the period of illness. Often they have to borrow at high interest rates to meet both medical expenditure and other household consumption needs, thus pushing their families into a zone of permanent poverty. There is also a societal loss of income in terms of output as well as an inability to enhance productivity due to ill-health. In the absence of effective regulation of private health services, health care costs are inevitably high, and it is people belonging to the lower income classes who suffer the most. In recent times, health care has become almost unaffordable and has given rise to serious equity issues. Hence it is imperative that we find alternative health financing mechanisms.

Health insurance emerges as one such alternative. But the public insurance companies so far have paid little attention to voluntary medical insurance because of low profitability and high risk together with lack of demand. From the consumer point of view, the insurance coverage is low because of lack of information about private health insurance plans as well as the mechanisms used by health insurance providers being unsuitable for low income consumers.

Who subscribes to health insurance? The information on health insurance (voluntary as well as mandatory schemes) as collected in NSS 60th round (2004) shows that about 1.2% of the population was enrolled with health insurance (0.4% for voluntary and 0.8% for mandatory) schemes and paid on average an annual premium of Rs 510 (Rs 962 for voluntary and 263 for mandatory schemes). The premium per subscriber household works out to Rs 1414 (Rs 877 for rural India and Rs 1626 for urban India). When compared with NSS 52nd round (1995-96) there is nearly a four-fold increase in the subscription rate in 2004 (Table 1).

TABLE 1

Health Insurance Uptake and Premium Payment (% of households), 1995-96 and 2004

Year	*Characteristics*	*Rural*	*Urban*	*Combined*
1995-96	Uptake level (%)	0.2	1.1	0.5
	Premium payment (Rs)	2195	2697	2540
2004	Uptake level (%)	0.7	4.8	1.9
	Premium payment (Rs)	877	1626	1414
	Premium as % of monthly per capita expenditure	35	11	18

	Poor	188	57	135
	Non-Poor	9	9	9
2004	Uptake level by characteristics			
	(a) Monthly per capita expenditure quintile			
	1 (Bottom)	0.37	0.94	0.53
	2	0.19	2.61	0.86
	3	0.31	3.61	1.23
	4	0.62	5.48	1.98
	5 (Top)	2.17	11.21	4.70
	(b) Poverty group			
	Poor	0.29	0.84	0.40
	Non-poor	0.99	5.92	2.57
	(c) Social group			
	Scheduled castes and tribes	0.51	3.97	1.13
	Other backward class	0.73	2.88	1.26
	Other	1.01	6.50	3.25
	(d) Religion			
	Hindu	0.74	5.01	1.89
	Muslim	0.32	1.15	0.61
	Other Minorities	1.39	9.67	4.00
	All	0.73	4.77	1.86

Source: Re-analysis of NSS 52nd and 60th rounds data on morbidity and health care.

However, over time the average amount of premium per subscribing households has gone down (reduction by 44% over 1995-96) and the reduction was the highest in rural areas. The underlying reasons are: the entry of private players, thus increasing the competition through higher number of

cheaper plans in the market; the government's Universal Health Insurance Scheme (UHIS) targeting the poor and low income households, and lower premium for the rural households for group insurance schemes under the self-help groups.

Despite all these efforts, the burden of insurance premium on poor households is not only disproportionately higher than their better-off counterparts, it is regressive with monthly per capita expenditure. This clearly raises the issue of affordability of insurance by the poor and low income households. As further revealed by NSS data, in 2004 there were less than two per cent of households (where at least one member of the household was enrolled) covered by health insurance. The uptake level rises with monthly per capita expenditure quintile, and the top quintile reported nine times higher level than the bottom quintile. The coverage level was higher in urban India (4.8%) than in rural India (0.7%).

Multivariate analysis of the determinants of a household taking up health insurance suggests that the odds of uptake increased with expenditure groups with the top 20% of households reporting 4.4 times greater likelihood of taking up insurance than the bottom 20% of households. The odds of having insurance also rose with household size. The likelihood (odds ratio) was higher for urban areas (2.2), among wage earners (1.5) and living in *pucca* houses (1.5) as well as among those having better toilet (1.6), drainage (1.8) safe drinking water (1.6) facilities and using gas, kerosene or electricity as cooking energy sources (1.7). The likelihood of taking up insurance was very low among Muslim households (0.6). Thus the analysis clearly suggests that the poor and vulnerable households are least likely to go for health insurance coverage despite claims put forward by the insurance companies to have designed specific schemes targeting the poor and low income people.

Given that only 1.2% of the population was enrolled with health insurance, and only 9% of the Indian workforce in the organized sector environment is covered by some form of health insurance or medical reimbursement benefits, indicates both the need as well as vast potential of the health insurance sector. The level of health insurance coverage is literally negligible for the unorganized sector. The social security schemes that are currently in place barely cover 5 to 6% of the estimated number of total informal workers.

Barring a small number of states (Kerala and Tamil Nadu) with some social security cover for workers in the unorganized sector, a majority do not offer any cover, especially for addressing such core concerns as health care and maternity. States like Maharashtra, Gujarat, West Bengal, Punjab and Haryana have a number of schemes for the aged poor and vulnerable population, but no social security schemes specifically meant for the unorganized sector workers.

A vast majority of the workers earn meagre wages, live and work in unhygienic conditions, do not have any statutory social security cover and face the problem of 'deficiency' or capability deprivation (of basic needs) as well as the problem of 'adversity' (arising out of such

contingencies as sickness and accidents). Given that government spending is inadequate (just around 1% of GDP compared to an average share of 2.8% globally in low-and middle-income countries), the beneficiaries of this meagre spending are not the poor, and with over 80% of total health financing which is private financing taking the form of out-of-pocket expenditure not spent efficiently, there is a serious need to explore other options including community financing.

It has been rightly argued by the NCEUS that the effectiveness of a national minimum social security programme for all workers in the economy is predicated on the success of extending social security cover to unorganized workers.[7] In view of the fact that the economy is growing at a high rate of more than 6 to 8% per annum, it is time to introduce a social security system with national coverage. In fact, the two earlier national commissions, viz., the National Commission on Rural Labour (1991) and the Second National Commission on Labour (2002) had emphasized the importance of social security.

Health insurance protects the poor against the catastrophic financial burden resulting from unexpected illness or injury, mobilizes funds for health services, increases the efficiency of mobilization of funds and provision of health services, and achieves certain equity objectives.[8] Insurance is based on the principle that what is highly unpredictable to an individual is predictable to a group of individuals. Various forms of health insurance can be broadly categorized (based on ownership of scheme) as follows: state-based systems, market-based systems, member organization (NGO or cooperative)-based systems, and private household based systems.[9]

In recent years, community based health insurance (CBHI), defined as member-managed-not- for-profit insurance for the informal sector and formed on the basis of a collective pooling of health risks, has assumed importance. It is accepted as an instrument of (*a*) improving access to health care among the poor; and (*b*) protecting the poor from indebtedness and impoverishment resulting from medical expenditure. The prepayment schemes represent the most effective way to protect people from the costs of health care, and calls for investigation into mechanisms to bring the poor into such schemes.[10]

Thus, one of the important challenges before India is how to provide health insurance to the people who cannot afford to pay premium, and convert private out-of-pocket spending into health insurance premium to benefit the unorganized sector. This would help in providing a measure of protective social security for all *the unorganized workers* in all parts of the country.

The various health care programmes presently operating in India are: (*i*) state-run schemes such as the Central Government Health Scheme (CGHS) introduced in 1954 and the Employees' State Insurance Scheme (ESIS) for formal sector employees (launched in 1948); (*ii*) public and private sector health insurance schemes; (*iii*) corporate sector health care programmes; (*iv*) community and self-financing schemes, primarily for workers in the unorganized sector; and (*v*) micro-credit linked health insurance schemes for the poor and low income people.

Various research studies have examined these schemes from the perspective of equity, coverage, quality and administrative inefficiency, and concluded that both CGHS and ESIS have not served their basic purpose. There is a heavy subsidization of services for one section of the workforce; only around 30% of the organized workforce is covered by the benefit though the government spends 12% of the total medical expenditure on ESIC. Reports of negligence and corruption are seen in terms of employers depriving workers their right of coverage by not informing the employees of their coverage, disallowing injury claims by changing eligibility, and manipulation of part-time employees' work schedules so as to make them non-eligible for ESIS coverage.

Despite an increase in the number of ESIS and CGHS beneficiaries, their actual use has declined due to switching over to private facility. The government also provides direct health services for employees of a large number of public enterprises, state-owned departments like railways, post and telegraphs and defence and police services. These departments have set up their own system of dispensaries, hospitals and personnel, with services provided free of charge.

There are numerous reimbursement plans offered by the employers for private medical expenses. The often used reimbursement schemes are: (*i*) employers contribute towards a medical grant/fund, which is disbursed annually as medical allowances to their employees; (*ii*) employees incurring medical expenses submit their claims to the employer for reimbursement, which are linked to individual contributions.

In India, the *Mediclaim* plan is the currently prevalent public insurance scheme. It has been in the market for over 25 years and is run by the General Insurance Corporation (GIC), a public-sector undertaking with its four subsidiary companies. Though a full range of insurance cover is offered by GIC, such as on property, liability, casualty, and business, health insurance is also a part. The GIC, in its efforts to expand coverage, introduced the *Jan Arogya Bima Policy* on 15 August 1996 to cater to the health care needs of people belonging to middle and lower income groups, and the *Bhavishya Arogya Policy* (old age medical insurance) to enable a person to plan for medical needs during old age out of savings during the current earning phase.

The response to the Mediclaim policy, unlike that for ESIS, is favourable. A major shortcoming of the programme, however, is that only hospitalization expenses are covered while routine outpatient care is not. Even the hospitalization coverage is subject to numerous exclusions, coverage limits, and restrictions on eligibility. Also, claim payments are higher than premiums, thus questioning its viability. It does not allow reimbursement of expenses against AIDS, venereal diseases, pregnancy, dental treatment, hearing aids, spectacles, and contact lenses. Similarly, the Unit Trust of India (UTI), a public-sector undertaking launched the Senior Citizens Unit Plan (SCUP) in April 1993 to provide coverage for hospitalization expenses up to Rs 500,000 for the investors after attaining the age of 58 years. The Life Insurance Corporation (LIC) introduced a special policy known as *Asha Deep II* in 1995 to cover insurance against four major ailments, namely cancer, paralytic stroke, renal failure and coronary artery diseases.

With the opening of the insurance sector to private and foreign players, several companies have entered the market since 2000. These are: Birla-Sunlife, Kotak Mahindra-Old Mutual, HDFC-Standard Life, Reliance, ICICI-Prudential, Max India, New York Life and Tata-AIG. Competition has improved quality in terms of quick settlement of claims and low premiums. However, like the GIC Mediclaim plan, their products are essentially catering to urban markets and meant for people in the middle and higher income groups.

An interesting aspect of all these policies is that the premium qualifies for income tax benefits. However, all these schemes provide partial medical benefits by limiting hospitalization coverage to mainly communicable diseases and selected non-communicable diseases.

Major corporate houses have developed their own health care services or tied up with private hospitals for the benefit of their workforce, given the limitation of state-owned and ESIS health care services. The growth of high-tech health care service has, however, been rapid and unchecked, and needs government review.[11]

Community and self-generated financing programmes are usually run by non-governmental organizations (NGOs) or non-profit making organizations. These organizations rely on finances from various sources, including government, donor agencies, and community and self-generated sources. Many innovative methods of financing health care services have also been used, like progressive premium scales, community-based pre-payment/insurance schemes, and income-generating schemes. The target population for provision of health care services by such organizations is primarily workers and families in the unorganized sector.[12]

Several NGOs and governments worldwide have started micro-credit schemes for vulnerable groups to break the vicious circle of poverty, malnutrition, disease, low productivity, and low income. Micro-credit is now considered not only an effective tool for poverty reduction but also an instrument for empowering the poor, particularly women. This operation generates income to the poor by extending them small credit for self-employment and other economic activities. However, it was soon realized that loan repayments by these groups was much below expected levels. The experience suggested that ill-health and expenditure on treatment and associated consumption needs were the prime reasons for defaulting on repayments. To plug the erosion of income of borrowers for health care needs, some NGOs (such as Grameen Bank in Bangladesh which won the 2006 Nobel peace prize and the Self-Employed Women's Association in India) have introduced health insurance schemes for their members.

In India, SEWA – the Ahmedabad based trade union of 250,000 women workers in the unorganized sector, works towards the goals of full employment and self-reliance at the household level. Since 1992, health insurance has been a part of SEWA's primary health care programme including occupational health services. Thus, insured members – rural and urban – have access to preventive and curative health care with health education. SEWA's comprehensive

health insurance scheme addresses the very basic women's need and thus includes hospitalization care, occupational health coverage, maternity benefits, life and assets insurance coverage of women member and life coverage for their spouses. The average premium collected per woman for life insurance cover was Rs 50 and that for health insurance Rs 118 in 2001-02. Most of the insurers opt for fixed deposit depending upon the type of coverage with SEWA Bank and the interest accrual goes towards annual payment of premium. It is the large membership and assets of the SEWA Bank that has made possible the provision of the insurance coverage at low premium.

The Community Based Universal Health Insurance Scheme (CBUHIS) in India took firm roots only in 2003-04. This scheme with an element of financial contribution from the government, focuses on a family as a unit and comes in three forms: (*i*) One rupee 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 up to seven members. Individuals between the age of 3 months and 65 years can join the scheme. In all these options, the government provides a subsidy of Rs 100 which remains fixed and is given only to BPL families, whether it is an individual who buys insurance or a family of five or seven. The scheme is designed to cover not a poor individual/family, but persons who are members of groups such as cooperative societies, *bidi* workers and handloom weavers. Claims are to be settled either by intermediary called third party administrators (TPAs) or by the insurance companies themselves.

In terms of benefits, this scheme principally offers a package of insurance cover for a limited reimbursement of expenses for hospital services to an individual/family, subject to specific sub-limits relating to expenses on room/bed; specialist/nursing etc. This scheme provides medical expenses up to Rs 30,000 per family subject to a sub-cap of Rs 15,000 for a single illness, compensates for the loss of livelihood at the rate of Rs 50 per day up to a maximum of 15 days if an earning member falls sick, and promises disability cover of Rs 25,000 to the nominee in case of an accidental death of the earning head of the family. The policy covers the expenditure incurred during hospitalization in listed health service centres.

This scheme though well-intentioned may not serve its end: it does not seem to be based on a rigorous actuarial analysis; the prescribed premium is unrealistically low; the government subsidy towards the premium is a nominal amount, and that too against the subscribers' contribution, only for BPL families; the core requirement is that government subsidize the entire insured pool equally, and that too at a much higher subsidy rate – i.e., a rate realistically linked to the actual costs of the scheme.[13] One can make the scheme more palatable by phasing it gently over a longer time span, but underestimating the unit cost of the insurance package would be self-defeating. Under-financed packages are bound to be a failure and would even rule out the possibility of a phased implementation in the future.

After realizing that the subscription of this scheme by BPL families was low, the government in July 2004 raised the subsidy component to Rs 200 for an individual, Rs 300 for a family of five and Rs 400 for a family of seven. Thus the revised premium BPL families worked out to be Rs 165, Rs 248 and Rs 330, respectively.

The coverage under the health insurance scheme, *inter alia*, excludes all pre-existing diseases, as also some common medical conditions even when contracted after enrolment under the scheme. The 'exclusion' provisions would imply that at the time of entry, the applicant would have to be fit to be eligible. The exclusion of all pre-existing diseases would effectively defeat the principal purpose of the scheme. Instead, for pre-existing diseases, a reasonable monetary cap can be placed on the reimbursement that may require prolonged (even lifelong) treatment to avoid misuse.

This scheme though theoretically designed to keep transaction costs low, may actually turn out to be administratively inefficient with the presence to TPAs.

The scheme only covers the risk of hospitalization, probably for reasons of convenient management. But as has been demonstrated in a number of cost studies of the primary health care services provided by NGOs over their small-span project population that the inclusion of primary sector health care component in the UHIS would immensely increase its viability, while simultaneously providing much more useful health care services to the subscribers.[14]

The scheme cannot be termed community based as it lacks a 'community character'. A universal standard package of costs and benefits takes away the needed flexibility in designing a scheme appropriate to local conditions. As argued,[15] it is designed on an impractical assumption that the poor would significantly contribute to their health security and the participation of private insurance companies would be significant. Even the public insurance companies may not come forward because (*a*) the claims liability is open-ended but the government subsidy is capped; and (*b*) public insurers showed total disinterest in a similar scheme 'Janraksha' announced in the Union Budget 2002-03.

This scheme is heavily biased in favour of the demand-side. Given a weak supply side of health care, health insurance is meaningless. The reach of the service centres will have to be increased several fold in order to serve the remote areas of the country, where the quantum of unmet health needs is the highest. The insurance authorities operating the scheme will have to quickly draw up and notify the guidelines for empanelment of non-state-funded delivery centres. Introduction of health insurance policies and any improvement must also be accompanied by the revival of health care facilities at all levels, increase in public health spending, reintegrating the public health system with the broad social security system meant for the poor which would also include safe drinking water, sanitation and family planning services.

The present government as a part of its Common Minimum Programme (CMP) is committed to enhance the welfare and well-being of all those engaged in the unorganized sector by expanding their social security, health insurance and other such scheme. It constituted the NCEUS, which has suggested that a contributory system of social security, known as national minimum social security, be initiated for workers in the informal economy.[16]

The constituent elements of National Minimum Social Security Benefits for any worker registered with the National Social Security Scheme for unorganized workers, on payment of the prescribed contribution, shall include: (*i*) health benefits in the form of health insurance for self, spouse and children below the age of 18 years, sickness allowance, and maternity benefits for women workers or spouses of men workers; (*ii*) life insurance of Rs 15,000 per beneficiary covering natural and accidental death; (*iii*) old age security in the form of old age pension of Rs 200 per month for BPL workers above the age of 60 years, and provident fund-cum-unemployment insurance benefit to all other workers. These three elements should be implemented with the backing of a national legislation. To this end, the commission has sought opinions of all the stakeholders and has re-formulated its draft bill as The Unorganized Workers' Social Security (Draft) Bill, 2006.

The bill will cover all workers in informal employment, contributing family workers and farmers other than small and marginal, having incomes of less than Rs 6500 per month which would make roughly 90% of the informal workers. The total number in line for the social security measures in the year 2005-06 was estimated at 300 million, to be covered in a phased manner over a period of five years. The registered workers, employers and the government will pay one rupee each per day per worker as contribution to the proposed National Social Security Scheme. This works out to Rs 365 each, per annum, per worker contributed by the three parties, amounting to a total of Rs 1,095 per worker. This defined would be split into three premiums consisting of Rs 380 for sickness and maternity cover, Rs 150 for life insurance and Rs 565 for old age security.

Health and maternity insurance cover with an annual premium of Rs 380 per worker would ensure a typical family of five members: (*a*) hospitalization cover up to Rs 15,000; (*b*) maternity benefit of a maximum of Rs 1000 per delivery; (*c*) personal accident cover in the event of the death of the earning head of the family (Rs 25,000); and (*d*) sickness cover for the registered worker during hospitalization (Rs 50 per day for a period of 15 days). The national and state boards may negotiate with insurance agencies to ensure the above mentioned minimum health and maternity benefits. The registered worker will be eligible for benefits as prescribed in the health insurance policy of the agencies with whom the state boards have entered into an agreement.

The registered workers shall avail of the services prescribed from the public health care system and designated non-government health care institutions as decided by the state boards. For this purpose, a social security identity card would be issued to the worker/family to be used to avail of the prescribed facilities on the basis of either a cashless system or the reimbursement of expenses.

The commission believes that a cashless system is the more appropriate one for the informal workers. The Department of Posts (DoP) would be involved given its considerable experience in marketing and servicing Postal Life Insurance schemes at costs that are lower than those incurred by insurance agencies.

The commission envisages an amount of Rs 530 per worker per year for the provisioning of health and life cover for all workers, though the contribution on behalf of the BPL workers is paid by the central and state governments. At the proposed rate of contribution of Rs 1,095 per worker per year, the total amount ranges from Rs 6570 crore in 2006-07 to Rs 32,850 crore in 2010-11, on the assumption that phasing (registration) of 30 crore workers will be at the rate of 20% per year.

Workers' contribution under the proposal (the BPL workers do not contribute any amount, while the APL workers contribute at the rate of Rs 365 per head per year) amounts to a total of Rs 1686 crore in 2006-07 and increases to Rs 8432 crore in 2010-11. Employers' contribution assuming just 17% of the workers as identified is estimated at Rs 1,862 crore. The government covers all BPL workers who are assumed to total 83% of the total number of workers, towards life and health insurance.

It may be argued that the commission has launched a well-worked out but an overambitious scheme, particularly given centre and state government finances and a new Central Pay Commission already constituted to discuss the revision in salary-structures for government employees. The commission has relied on hard assumptions like the use of 2006-07 prices, 8% rate of growth per annum for the next five years, direct taxes growth at the rate of 25% per annum and the indirect taxes at 13% per annum assuming inflation rate at the average rate of around 5%. Given these assumptions, the first year's contribution by the central government will be Rs 6,674 crore including administrative expenses, which will increase to Rs 20,582 crore in the fifth year including administrative expenses of Rs 1448 crore. As a percentage of GDP, the additional financial requirements work out to 0.17% in the first year and 0.39% in the fifth year. Over the corresponding period for the entire additional expenditure burden of centre and states to be financed through central taxes, the tax-GDP ratio of the centre is estimated to increase from 11.50% to 14.60% of GDP at market prices.

To summarize the discussion so far, the public insurance companies as well as the government have not devised strategies to market low premium based health insurance schemes specifically targeted for the poor. Social marketing models need to be employed rigorously if the products have to reach the remotest area. Social marketing is a methodology inspired by commercial marketing that has proven effective in changing behaviours, preferences and tastes of people and simultaneously increasing access to needed health products. Social marketers in fact combine product, price, place (distribution), and promotion to maximize use by specific population groups.

The role of local institutions can be creative. It has been observed that in many states panchayat raj institutions (PRIs) are successfully monitoring and implementing various health programmes.[17] Also in Kerala, Tamil Nadu, and Rajasthan many other inter-sectoral functions are being efficiently handled by the PRIs, some of which has a direct impact on the primary health component. The state may delegate powers to PRIs to plan, manage and run various welfare schemes including community health insurance schemes. To begin with each state government must plan and try to run community based health insurance schemes with the help of PRIs in at least one pilot district and then scaling up to other districts to maximize welfare benefits.

There is a serious need for health insurance coverage to include poor households in general and those working in the informal sector in particular. Even among the fully insured households under ESIS, the burden is particularly heavy among rural ones. Innovative measures for improvement in ESIS and Mediclaim programmes are no doubt necessary, but they have to be substantially enlarged.

There is a strong inclination towards subscription to health insurance by the households in general and specifically by workers in the informal sector. But the workers want schemes which are easily affordable and accessible, locally managed, cover all types of illnesses, include services like hospitalization and maternity, require low premium, involve simplified procedures including filing claims, and offer timely attention. Incidentally, they are willing to pay according to their ability, and further want that such schemes be managed at the local level and/or through NGOs.[18]

Over the years, health insurance has emerged as an important financing tool in meeting the health care needs of the poor both in rural and urban areas. The government must take the lead, though neither market-mediated nor government-provided insurance is an ideal way of reaching the poor. Community based health insurance is more suitable as the unregulated development of private health insurance in the country has both high risks and benefits for the poor in accessing health care. Appropriate regulatory changes can minimize risks and turn potential benefits into concrete gains for the poor, but the regulatory decision-making system does not exist even for the private health insurance market, both in the supply of health services and in the demand for health insurance.

CBHI, which is the more appropriate insurance arrangement for the poor, could take different forms and each of them 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, different forms need to be explored. There is a need for a strong regulatory system as the degree of liberalization in the insurance market is increasing. The proposed scheme being a group insurance scheme is not meant to cover the entire BPL population; it also excludes outpatient care. As experience accumulates, the scheme can be fine-tuned and expanded to cover the entire low-income population. However, increased public health spending and reforming of public health facilities is a must for the success of these community based health initiatives.

We still need to learn from the different insurance practices undertaken by different agencies in different parts of the country while giving a lead role to the state. The role of government is

essential as health insurance is a complex issue, suffers from serious market failure problems and requires to be integrated with the existing government-sponsored welfare programmes. NGOs like SEWA can be involved in undertaking pilot studies by varying the key parameters related to different products and services, cost of each package, subscribers' size, requirements and their contributions, scatteredness of the groups, proportionate share of state and private funding sources, and management practices.

Despite the appreciable efforts being made by government, the corporate sector and NGOs, developing, operationalising and marketing of a unique and easily affordable health insurance package for the low-income people remains a challenge.

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