A concept note on health insurance for workers in the informal sector

GUMBER, Anil <http://orcid.org/0000-0002-8621-6966>

A Concept Note
on
Health Insurance for Workers in the Informal Sector

Anil Gumber

Assisted by

Ms. Veena Kulkarni

Background Paper

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I. Background

A large number of workers engaged in the unorganised sector in both rural and urban areas are illiterate, poor, vulnerable, living and working in unhygienic conditions and susceptible to many infectious and chronic diseases. In fact, they are caught in the vicious circle of poverty, assetlessness, malnutrition, disease and low productivity. They don't have bargaining power to fight for all sorts of discrimination and victimisation so as to protect their rights to lead a minimal standard of living.

The persistent poverty and disease syndromes have pushed the families of informal sector in the process of decapitalisation and indebtedness to meet their day-to-day contingencies. Both the NCAER and NSS Studies on the use of health care services show that the poor and scheduled caste and tribe households are spending a higher proportion of their income on health care than the better off. The incidence of illness cuts their household budget both ways, i.e. not only they spend a large amount on medical care but also unable to earn during the period of illness. Very often they have to borrow at very high interest rate to meet both medical expenditure and other household consumption needs.

On the other hand, there are issues related to accessibility. A majority of poor households especially the rural ones are inhabited in backward, hilly and remote regions where neither government facilities nor the private practitioners are available. They have to depend heavily on poor quality services provided by local unqualified practitioners and faith healers. Further, wherever accessibility is not a problem the primary health centres are either not functioning or providing very inferior quality of services.

Overall about six per cent of the household income is spent on curative care which amounts to Rs. 250 per capita per annum. However, the burden of expenditure on health care is unduly heavy on households of informal sector indicating the potential for voluntary comprehensive health insurance schemes for such section of the society. It is estimated that, only a small percentage (less than 10) of the Indian population is covered by some form of health insurance (through CGHS, ESIS and Mediclaim), a majority of them belong to organised work force. Further, the low level of health insurance coverage is due to the fact that the national policy has been to provide free health services through the public sector. In reality, the public sector health agencies on the one hand charge for their services and on the other hand have poor outreach. Also, the public insurance companies so far have paid very little attention to voluntary medical insurance because of low profitability, high risk as well as lack of demand.

Thus, a majority of the rural and urban slum population is not covered by any type of health insurance, they either do not have any information about the available modicum health insurance schemes or the mechanism used by the providers of health insurance is not suitable to them. There is also a gender bias i.e. men avail of or get better health care than women due to various socio-cultural and economic reasons. Institutional arrangements are lacking in correcting these gender differentials. It is, therefore, proposed to undertake a study on the availability and needs of health insurance coverage and associated constraints in providing health insurance scheme to the workers of the informal sector.

1. Objectives

The objectives of the study are the followings.

1. To review the existing health insurance schemes available to the workers of the organised sector on contributory basis (such as CGHS and ESIS) with special reference to its coverage, mechanism, financial viability and legal framework.

2. To identify the limitations of existing voluntary health insurance schemes floated by the General Insurance Corporation (Mediclaim and Jan Arogya Bima Policy) regarding its (a) coverage, e.g. existing schemes cover only hospitalisation cases and do not cover pre-existing disease or maternity etc., and (b) delivery and claim settlement mechanism, e.g. reimbursement procedure is very cumbersome and time consuming. Unlike developed countries, it is not entirely based on the trilateral health insurance model where consumer gets the maximal satisfaction out of the plan.

3. To examine the legal framework in our country for providing health insurance, with special reference to the new liberalisation policy in our country for health insurance.

4. To review the existing formal and informal models developed by both national and international organisations who have succeeded in providing health insurance to poor with respect to coverage, mechanism, financial arrangements and legal framework and especially with possibility of its replicability, efficacy and sustainability.

5. To examine the health expenditure and assess the needs of health insurance coverage for workers including their families in the informal sector.

6. To develop a minimal health insurance package after examining in detail the existing schemes in a viable way for the informal sector and explore future player in providing health insurance to general public and to the poor in particular.

2. Scope of the Study

Before assessing the need of health insurance as a social security measure for the poor section of the society, it is aimed to undertake first the stock of existing health insurance schemes and explore the possibility of extending coverage to include population engaged in the informal sector. The focus would be on the delivery mechanism as to whether various procedures could be rationalised and simplified. Also, it would try to explore the monitoring system of the delivery mechanism.

The study would primarily focus on the accessibility and use of health care services, the level and composition of health spending and the need for health insurance for poor households pursuing varied occupations in both rural and urban areas of two states. It would also include the feasibility for health insurance to poor people in terms of their willingness and capacity to pay and the associated mechanism and legal framework in delivery of such type of services.

3. Data and Methodology

To undertake a comprehensive study on health insurance for people engaged in the informal sector, both primary and secondary data would be collected from several agencies. As far as the review of existing health insurance schemes is concerned, the published and unpublished secondary data would be collected from the offices of CGHS, ESIS and GIC. The study would also plan to collect information on a sample basis from those enrolled in the voluntary health insurance plan offered by the GIC.

To design, formulate and suggest a better health insurance package for the unorganised workers, it is decided first to reanalyse some of the data collected by the NCAER on household health spending pattern. Later on, a sample survey would be designed to elicit information from households to estimate the demand for health insurance and their willingness and capacity to pay for such schemes in two states. Here the states of Gujarat and Maharashtra, the two most urbanised and industrialised states of the country, would be selected for an in-depth study.

An alternative source of meeting health care needs is through community financing. Some efforts would also be made to examine user charges and operational mechanism introduced in a couple of community health insurance experiments managed by NGOs in Maharashtra and Gujarat. For this, the group discussions would be held with both providers and users of the services.

4. Plan of the Study

Issues on health seeking behaviour of households in regard to prevalence of morbidity, accessibility and use of health services for inpatient and outpatient care, reasons for choice of provider and expenditure on treatment are addressed in Section II. In Section III, experiences of various developing countries from Asia and Latin America whose health care systems are largely based on health insurance are reviewed and lessons for India are drawn. A comprehensive review of existing public sector and community based health insurance schemes already operational in India is presented in Section IV. The possibility of future players in health insurance sector is discussed in Section V. In Section VI, a feasibility of comprehensive health insurance scheme for informal sector is narrated and the modalities for implementation of scheme on a pilot basis are outlined (for which work is currently under progress).

II. Health Care Use and Spending Pattern

There are only two agencies namely the NSS and NCAER which have so far disseminated information on the basis of their household surveys. The recent data made available by the NSS pertains to 1986-87 and that by NCAER for 1993. The data have been analysed with respect to incidence of morbidity, disease rate, inpatient and outpatient care in public and private facilities, cost of treatment and burden of treatment in both rural and urban areas across population groups by state.

The following table presents annual morbidity rate (per thousand population) for major states during 1973 to 1993 as estimated by the NSS and NCAER. The data point to considerable inter-state differentials in the prevalence of morbidity. Incidentally, Kerala (considered to be in the advanced stage of demographic and health transition) has recorded the highest level of morbidity in all the surveys reviewed. The estimated level of morbidity in the population is less than two illnesses per person per year. Generally speaking, incidence of morbidity is higher in rural than in urban areas.

In terms of incidence of morbidity, as compared to males the rate was marginally higher for females, but the difference was larger in urban than in rural parts of India. Both the NSS and NCAER data reveal that the incidence of morbidity for women in the reproductive age group 15-44 is considerably higher than those for men. According to the NCAER survey, the rate was 89 and 136 per month per thousand population for women aged 15-24 and 25-34, respectively; the respective figures for men were 79 and 116. The NSS data suggest that both the incidence of illness and hospitalisation have shown increase with the Monthly Per Capita Expenditure (MPCE) Class. On the other hand, the NCAER data indicate that the decision to hospitalise is not significantly related with income. However, both the surveys conform to that the SCs and STs report lower levels of hospitalisation which is largely due to their inaccessibility to health care facilities on the one hand and lack of resources on the other

About 10 to 15 per cent of all those reporting sickness may not seek treatment at all; the proportion tends to be higher in rural than in urban areas. It is revealing that the probability of not seeking treatment is higher among females, elderly (aged 60 years and above), and the never married individuals. This probability is also higher among the SCs and STs, and those belonging to lower MPCE quintile. Accessibility, physical proximity and financial constraints are extremely important for taking decisions to seek treatment. Of those having received treatment, 93 per cent had received outpatient care and the remaining 7 per cent received inpatient care, without much inter-state variation.

Both the NSS and NCAER data confirm that the patients from rural as well as urban areas have overwhelmingly chosen public facilities (government hospitals, CHCs and PHCs) for inpatient care. The reliance on public hospitals for inpatient care was much greater in hilly and backward states, among the SCs and STs and those belonging to lower MPCE quintile. On the other hand, the private facilities are used largely for outpatient care, particularly in urban parts of India. Unlike public facilities which are centrally located, the private practitioners are found even in remote and backward areas. (For instance, 70 per cent of hospitals and 85 per cent of hospital beds in the public sector are located in urban areas.) The private practitioners are usually contacted first for day-to-day health care needs before availing of the distantly located public facility.

It is also observed that public facilities are used more often in the cases of severe and

catastrophic illnesses as well as for certain diseases such as tuberculosis, complications of pregnancy and childbirth, injury and STDs, which the private practitioners are reluctant to deal with. The most common diseases like malaria, typhoid, diarrhoea and dysentery, ARI, pneumonia, etc. are treated most by the private health care providers. Further, relatively poor are spending higher proportion of their income on health care than the better-off. The burden of treatment is unequally distributed across different population groups indicating the potential for voluntary comprehensive health insurance schemes.

According to the NCAER data, the average medical expenditure (expenses on fees, medicines, clinical and diagnostic tests, surgery, and hospital bed charges) per epsode in 1993 was Rs.850 and Rs.1065 for inpatient care in rural and urban areas, respectively; and the respective figures for outpatient care were Rs70 and Rs.97. There were large inter-state and rural-urban variations in the cost of treatment. As expected, the cost of treatment was higher in urban than in rural areas, in private than in public sector and for inpatient than for outpatient care. For both inpatient and outpatient care the private sector agencies, on an average, charged three to four times than the public sector agencies. Overall medical expenditure constituted 84 per cent of the total cost of treatment which also included indirect cost such as expenses on transport, special diet, rituals, gifts, tips and other miscellaneous expenses. In most states, the proportion of indirect cost (mainly transportation) was higher in rural than in urban areas thus reflecting poor distribution of health care facilities in rural areas particularly in hilly states.

An average Indian household spends Rs. 250 per capita per annum on the use of health services; the figure for urban households was about 40 per cent higher than their rural counterparts. The earlier estimates provided by the World Bank (1995:20) for 1990-91 was Rs. 240, which was based on the 1991 household survey of the NCAER using two weeks reference period for illness reporting. It appears that the an estimate of Rs.250 from the 1993 survey of NCAER is an underestimate because of 30 day reference period for morbidity reporting. Overall, 80.2 per cent of the total health expenditure by the households was for receiving the private health care facility. This is largely because the private health care expenditures, both for inpatient and outpatient care, are considerably higher in terms of out-of-pocket payments by the households. Even though it is also a fact that the public health care services are not free and people do incur considerable out-of-pocket expenditure to realise public health care. The NSS data, for instance, clearly highlights that more than two-fifths of inpatients and one-third of outpatients who availed of public facilities had to pay for the services. The public facilities nevertheless are relatively cheaper to realised compared to the private facilities.

There are large inter-state variations in both government and household spending on health care whether expressed in per capita terms or as percentage of state domestic product (SDP). The hilly states of Jammu and Kashmir, Himachal Pradesh, and the state of Kerala spends more than nine per cent of their SDP on health whereas the percentage was around three for relatively developed states of Punjab, Haryana and Maharashtra. It appears from selected health care indicators across major states that leaving aside the hilly states, government spending on health among the poorer states is low and, therefore, the out-of-pocket expenditure by households in these states are relatively higher. Also, high level of morbidity raises the share of households expenditure in the total health spending.

Table 2.1
Annual Morbidity Rate (Per Thousand Population) for Major States, Estimated by the NSS and NCAER During 1973 to 1993

Major States	NSS			NCAER	
	1973-74 Prevl	1973-74 Incid	1986-87	1990	1993
RURAL INDIA	605	348	805	2056	1248
Andhra Pradesh	847	560	1094	1955	1452
Assam	468	236	677	395	1020
Bihar	288	145	428	2321	1176
Gujarat	270	122	425	1344	900
Haryana	435	260	918	660	888
Himachal Pradesh	NE	NE	597	1726	1752
Jammu & Kashmir	472	308	781	3359	NE
Karnataka	399	231	622	1138	1392
Kerala	1935	1053	1925	3479	2196
Madhya Pradesh	555	280	515	2200	1320
Maharashtra	733	478	534	1832	792
Orissa	657	406	838	3115	2124
Punjab	737	523	1768	981	1548
Rajasthan	463	278	729	707	1308
Tamil Nadu	906	559	729	2674	936
Uttar Pradesh	359	222	910	2003	1284
West Bengal	755	330	1297	1755	960
URBAN INDIA	612	371	434	1760	1212
Andhra Pradesh	735	485	492	1687	1644
Assam	325	176	393	4236	780
Bihar	319	179	203	2498	1224
Gujarat	170	81	318	1441	1008
Haryana	453	245	605	836	1044
Himachal Pradesh	NE	NE	497	1653	2136
Jammu & Kashmir	351	248	317	3487	NE
Karnataka	359	200	393	1288	1116
Kerala	1157	977	1024	2677	2100
Madhya Pradesh	578	308	115	2129	1404
Maharashtra	853	537	129	1425	936
Orissa	657	470	342	2273	1956
Punjab	658	454	965	1292	1740
Rajasthan	335	203	228	834	1800
Tamil Nadu	851	566	370	1659	900
Uttar Pradesh	286	175	389	2029	948
West Bengal	919	489	599	1520	972

Note: The estimates for 1973-74 included the prevalence of chronic long-duration diseases; the figures for rural and urban India were 21 and 20 per thousand population, respectively. The estimates for 1986-87 included annual incidence of hospitalisation; the figures for rural and urban India were 26 and 57 per thousand population, respectively. NE - Not Estimated.

Source: India, National Sample Survey (1980), (1992); Visaria and Gumber (1994), (1997); Visaria, Gumber and Jacob (1996); Sundar (1992); Shariff (1995).

Table 2.2
Percentage Distribution of Patients by Type of Health Care Provider, 1986-87

State/Sector	Rural Areas			Urban Areas		
	Public		Private	Public		Private
	Free	On Payment		Free	On Payment	
Inpatient Care						
Gujarat	23.2	32.8	44.0	21.3	40.5	38.2
Maharashtra	31.2	14.6	54.2	27.2	22.2	50.6
Tamil Nadu	50.0	6.9	43.1	50.7	7.5	41.8
Uttar Pradesh	17.1	41.2	41.7	23.5	37.6	38.9
West Bengal	58.3	33.5	8.1	38.8	37.1	24.1
Kerala	33.1	10.5	56.4	36.8	19.4	43.7
Punjab	12.0	37.2	50.8	13.2	38.8	48.0
Andhra Pradesh	24.1	6.7	69.2	34.3	7.3	58.3
Madhya Pradesh	43.5	37.3	19.2	45.0	34.0	21.0
All	33.4	24.0	42.6	33.7	25.8	40.5
Outpatient Care						
Gujarat	18.5	16.6	64.9	10.1	9.5	80.4
Maharashtra	21.2	5.9	72.9	16.1	9.8	74.1
Tamil Nadu	33.3	5.3	61.3	29.7	5.8	64.5
Uttar Pradesh	5.5	4.9	89.6	9.3	7.8	82.9
West Bengal	14.1	5.6	80.3	15.2	10.2	74.6
Kerala	27.9	6.6	65.5	29.0	7.5	63.6
Punjab	5.7	7.3	87.1	7.2	4.1	88.7
Andhra Pradesh	18.5	1.6	79.9	18.6	4.1	77.3
Madhya Pradesh	15.0	17.7	67.2	20.6	12.1	67.3
All	15.0	6.3	78.8	17.0	7.5	75.5

Table 2.3
A. Morbidity Prevalence Rate (per month per thousand population) by Selected Characteristics, 1993

Characteristics	All	Male	Female	Rural	Urban
1. Age					
0-5	130	134	125	129	134
6-14	78	84	72	81	72
15-39	89	83	95	90	85
40-64	147	138	159	149	142
65+	211	218	203	200	237
2. Education					
Illiterate	124	123	125	123	132
Primary	97	99	94	95	101
Middle	94	93	97	94	95
Secondary	94	97	89	94	95
Hr. Secondary	98	98	99	106	89
Graduate & Above	87	84	95	88	86
3. Work Status					
Self Employed					
-Agriculture	106	108	82	106	94
-Non-Agriculture	98	95	166	95	102
Regular Employees	106	103	141	110	103
Casual Employees	112	108	139	113	109
Students	77	83	69	80	70
Household Chores	117	--	117	116	122
Others	131	136	124	130	137
4. Income Quintile					
1	120	121	120	121	118
2	104	98	110	101	115
3	113	116	110	113	112
4	102	99	105	103	100
5	92	88	96	91	93
Overall	**106**	**103**	**108**	**107**	**103**

B. Annual Per Capita Illness Days by Selected Characteristics, 1993

Characteristics	All	Male	Female	Rural	Urban
1. Age					
0-5	12	12	12	12	12
6-14	8	10	7	9	8
15-39	12	11	13	12	11
40-64	25	27	24	25	26
65+	44	45	43	41	54
2. Education					
Illiterate	16	16	17	16	17
Primary	14	15	12	14	15
Middle	14	14	14	13	14
Secondary	14	14	14	14	14
Hr. Secondary	14	14	13	15	13
Graduate & Above	14	14	15	14	14
3. Work Status					
Self Employed					
-Agriculture	16	17	9	16	15
-Non-Agriculture	17	16	27	16	18
Regular Employees	18	17	19	18	17
Casual Employees	18	18	22	19	18
Students	9	9	7	9	8
Household Chores	18	--	18	17	19
Others	15	17	12	15	17
4. Income Quintile					
1	17	18	16	17	19
2	15	14	15	14	16
3	15	16	14	15	15
4	14	14	14	14	14
5	14	13	14	14	14
Overall	**14.8**	**15.0**	**14.7**	**14.8**	**14.8**

C. Annual Per Capita Expenditure on Health Care by Selected Characteristics, 1993

Characteristics	All	Male	Female	Rural	Urban
1. Age					
0-5	114	123	103	98	168
6-14	74	91	53	66	97
15-39	154	156	151	143	180
40-64	436	523	324	415	490
65+	539	569	508	395	917
2. Education					
Illiterate	181	209	161	172	229
Primary	180	208	146	170	210
Middle	211	226	189	208	217
Secondary	262	299	192	208	346
Hr. Secondary	202	204	195	178	229
Graduate & Above	314	285	409	251	356
3. Work Status					
Self Employed					
-Agriculture	291	295	243	292	238
-Non-Agriculture	260	251	431	193	325
Regular Employees	374	348	646	322	414
Casual Employees	222	226	198	204	285
Students	92	109	65	80	120
Household Chores	205	--	205	182	269
Others	200	262	97	173	291
4. Income Quintile					
1	165	219	105	166	158
2	136	150	120	127	176
3	225	270	171	230	209
4	202	208	194	187	233
5	276	294	255	230	331
Overall	**199**	**226**	**169**	**181**	**250**

Table 2.4
Average Annual Health Expenditure by Households in Rural and Urban Areas, 1993

Characteristic	Health Expenditure (Rs.)			Health Exp. as % of Income		
	All	Rural	Urban	All	Rural	Urban
Income Quintile						
1	772	782	699	12.3	12.6	10.4
2	696	664	826	5.6	5.4	6.6
3	1210	1286	1005	6.9	7.3	5.7
4	1084	1037	1176	4.4	4.3	4.7
5	1657	1506	1806	3.1	2.9	3.3
All	1052	973	1254	4.8	5.2	4.2
Household Type						
Self-Employed						
Agr.	780	784	1259	4.1	4.1	4.1
Non-Agr.	1397	1569	1211	5.2	7.4	3.7
Regular Employed	1488	1505	1474	4.4	4.9	4.1
Casual Labour	769	739	872	6.1	6.2	5.7
Others	1336	1360	1288	9.9	12.9	6.6

Table 2.5
Reasons for Choice of Health Care Providers

Reason	Inpatient Care		Outpatient Care	
	Overall	Share of Public	Overall	Share of Public
1. Free/Cheap	32.6	95.6	29.1	85.9
2. Easy Access	5.3	25.1	25.4	18.0
3. No Alternate Facility	15.2	43.9	11.1	24.2
4. Cannot Afford Other Facility	6.5	86.5	2.9	67.5
5. Suitable Timing	2.6	19.5	4.6	12.5
6. Good Reputation	33.5	39.4	24.2	12.5
7. DK Any Other Facility	2.9	40.4	0.7	20.5
8. Others	1.3	66.1	1.9	20.6
All	**100.0**	**60.4**	**100.0**	**39.6**

Source: NCAER Survey, 1993.

Table 2.6
Level of Satisfaction from Treatment

	Inpatient Care		Outpatient Care	
	Overall	Share of Public	Overall	Share of Public
1. Fully satisfied	57.1	57.4	71.6	37.5
2. Somewhat satisfied	26.3	54.7	19.5	43.0
3. Not satisfied	8.6	86.0	4.3	53.3
4. Cannot say	8.1	73.1	4.7	44.1
All	**100.0**	**60.4**	**100.0**	**39.6**

Source: NCAER Survey, 1993.

Table 2.7
Source of Finance for Meeting Cost of Treatment
Inpatient Care

Source of Finance	Overall	If Private Care	If Poor
1. Self Financed	84.6	81.5	80.9
2. Health Insurance/Reimbursement	1.4	0.7	1.5
3. Assets Liquidation	0.4	1.0	0.2
4. Loans from Friends & Relatives	8.0	12.6	11.4
5. Loans from Money Lender	2.6	3.9	3.0
6. Others	3.0	4.0	3.0
All	**100.0**	**100.0**	**100.0**

Source: NCAER Survey, 1993.

Table 2.8
Selected Health Care Indicators for Major States in India, 1993

State Tanked by Col. 6	Per Capita Annual Health Exp.			Share of Household Health Exp. (2 as % of 3)	Household Health Exp. As % of Household Income	Total Health Exp. As % of NSDP/NNP	Annual Morbidity Rate/1000 Population	% Use of Public Facility
	Govt.	Household	Total					
	1	2	3	4	5	6	7	8
Jammu&Kashmir*	238	325	563	57.7	-	10.7	2130	NE
Kerala	111	482	593	81.3	11.9	9.5	2171	37.6
HimachalPradesh	209	370	579	63.9	6.7	8.9	1785	56.4
Bihar	51	223	274	81.4	6.1	7.5	1182	37.2
Orissa	74	276	350	78.9	8.2	7.4	2102	70.1
AndhraPradesh	66	421	487	86.4	7.8	7.4	1504	36.0
Karnataka	93	360	453	79.5	8.8	6.5	1306	55.9
Rajasthan	83	196	279	70.3	4.2	5.4	1421	62.8
UttarPradesh	55	175	230	76.1	4.5	4.9	1217	30.5
Gujarat	78	259	337	76.9	4.7	4.4	938	35.0
MadhyaPradesh	63	168	231	72.7	6.9	4.3	1340	36.3
TamilNadu	100	202	302	66.9	6.5	4.2	924	45.0
WestBengal	73	154	227	67.8	3.4	3.8	841	24.4
Haryana	83	267	350	76.3	4.1	3.4	927	39.6
Punjab	110	282	392	71.9	6.2	3.2	1606	40.6
Maharashtra	85	259	344	75.3	5.4	3.2	848	40.5
Assam	66	96	162	59.3	2.4	2.8	994	64.0
All-India	**84**	**250**	**334**	**74.9**	**6.0**	**5.5**	**1253**	**41.3**

Note: Estimates for Jammu & Kashmir are based on the previous NCAER survey of 1990.

III. Features of Health Care Financing Programmes in Developing Countries

China

China's performance compares favourably with that of industrial countries and is much better than its counterparts in Asia. The outcomes are even more commendable when the per capita GNP figures are taken into account (see Table 3.1). The gap in per capita GNP between India and China is much lower than that in the output measures. This divergence leads to the question of health expenditure and health sector financing. Table 3.2 indicates the total health expenditure, government and private expenditure along with the insurance as a percentage of GNP. China has low government spending as compared to India but is also the one which substantially spends on insurance. As was emphasised by the World Bank's first study of the health sector in China, preventive and promotive care has been the hallmark of China's government health policy. The small portion of spending channelled through state budgets has emphasised controlling communicable diseases.

India's position in this regard is not at all encouraging. India despite a high level of spending - both government and private is unable to achieve good results.

China's health financing and expenditure can be characterised as that of high total expenditure, low government expenditure and relatively heavy dependence on insurance financing. Given the level of per capita GNP, it is quite evident that policy decisions can affect the performance in the health sector and the financing strategies. Important public decisions are not so much direct spending decisions as they are indirect allocation decisions (such as reimbursement policies) that affect the sector through behavioural reactions of providers and hospital administrators.

Insurance constitutes an important element of the financing strategies of China and this a little surprising since insurance as a tool of financing health care largely exists in the rich industrialised countries (see Table 3.3). China's experience shows that insurance can provide half of the health sector's revenues even at extremely low levels of per capita income. Insurance is widespread even in rural areas. Rural and private sector insurance are in fact the fastest growing areas of insurance coverage in China according to an internal World Bank report.

In China, workers can enjoy the necessary medical services for illness, injury and child birth in accordance with the state provisions. This is the basic right of the workers stipulated by the Constitution and the laws.

There are two kinds of coverage:

(a) Labour insurance medical coverage is usually implemented for state owned enterprise workers and the retired persons.
(b) Free medical service caters to workers and retired persons of government agencies, political groups and parties, non-profit institutions.

In fact, by the late 1970s, insurance covered virtually the entire urban population and 85 per cent of the rural population. This positive character of the Chinese health sector being operative in the rural parts has been possible because following the development of the rural economy, many places are experimenting with different forms of health insurance system according to local economic conditions and public opinion. Some of these various methods are:

a) raising of insurance funds and scale and range of insurance funds.
b) co-operative medical care.
c) clinics financed by peasants.
d) high risk medical insurance.
e) contract on preventive health care.
f) single insurance for preventive health care.
g) dental care insurance for primary and middle school students.
h) subsidies for medical care.

Despite more than 30 years of the medical coverage scheme, there are yet certain problems which need to be solved. The main problems are:

1) The medical cost borne by the state without payment from individual workers leads to inefficient control. Because workers know little about medical costs, the medical consumption may not be always rational. In addition the examination and reimbursement functions are not strictly carried out.
2) The mechanism is not adequate for increasing medical funding according to need.
3) Management institutions are not perfect and there is little pooling of risk. At present labour insurance medical coverage is managed by labour departments and trade union organisation while the free medical services is run by health and financial departments without an integration between the two systems.
4) Since the economic situations vary across the provinces, ideally speaking different systems of health insurance are required for each of them.
5) Health insurance should be supported and co-ordinated by local governments to function smoothly.
6) An administrative organisation made up of skilled workers should manage health insurance work.
7) Health insurance being new to the system should be given propaganda.

The following reform measures are being carried out to make the system more efficient:

- making regulations on standards of medication covered by health insurance and on the limitations of reimbursement;
- educating medical staff to improve their morals and style of work so as to carry out the principles of medical care in accordance with the patient's illness and right use of medications;
- setting standards of charges based on the technical levels and equipment of different medical institutions;
- strengthening management and supervision of some related links in medical coverage;
- making a strict distinction between a medicine package for domestic use and that for export;
- carrying out a policy of putting prevention first, developing prevention and health work and greatly encouraging workers' health and reduce diseases.

Thailand

Thailand like many of its counterparts in the developing world faces the challenge of determining how to finance and manage health care services.

There are four main types of health care financing schemes in Thailand:

(1) voluntary health schemes,
(2) mandatory schemes,
(3) social welfare schemes, and
(4) fringe benefit schemes.

The following table shows a schematic presentation of these various programmes with their highlighting features.

Table 3.1
Coverage of Health Schemes in Thailand

Scheme	Target Population	Population Covered in 1992	Per cent	Source of Finance	Subsidy per head 1992
Voluntary Health Insurance					
Health Card	Mainly rural	1.3 million	2.3	Card holder and government (MOPH)	63 baht
Private insurance	Mainly urban	0.9 million	1.6	Insurer	-
Mandatory Schemes					
Worker's compensation	Former sector employees	2.5 million	4.4	Employers and government (MOLW)	--
Social Security	Formal sector employees	2.5 million (1992) 4.5 million (1995)	4.4 7.56	Employers, employees, and government (MOLW)	541 baht
Welfare					
Low income support	Low income Mainly rural	11.7 million	20.7	Government (MOI)	214 baht
Support for the elderly	Population	3.5 million over 60	6.2	Government (MOPH)	72 baht
School children	Primary school children	5.1 million	9.0	Government (MOE)	--
Government fringe benefits					
Government reimbursement	Government/Officials/ emp and families	5.6 million	9.9	Government (various agencies)	916 baht
State enterprise benefits	State enterprise employees and families	0.8 million	1.4	Government (various agencies)	815 baht
Insured population		33.2 million	58.7		
Uninsured population		23.3 million	41.3		

Notes: Other welfare recipients include veterans, monks and those deemed truly needy.
MOPH = Ministry of Health, MOI = Ministry of Interior, MOLW = Ministry of Labour and Welfare, MOE = Ministry of Education.
Source: Khoman (1998).

These various schemes result in 59 per cent of the population being protected by some health care coverage and 41 per cent not being covered by any one of them. This group largely consists of subsistence farmers, the self-employed, rural workers and urban dwellers engaged in

informal sector activity such as street vending and small scale commercial undertakings. Some of these programmes namely low-income support, health card programme and social security fund may require some elaboration.

Essential features of Low income support programme

(1) The goal of this government policy is to reduce the prevailing inequity in access to health services. Free medical care is provided at government hospitals to low income groups and has become the main health scheme for rural population.

(2) coverage initially (1975) was limited to those with monthly incomes of less than 1000 baht and presently it is for the families with monthly incomes less than 2800 baht and individuals with an income of below 200 baht.

(3) initially no identification was required but now cards are issued for the eligible citizens and these cards entitle the holders to free medical care at all government health facilities; cards are valid for three years and do not require cost sharing on the part of the eligible population.

Shortcomings and failures of the scheme:

(1) There are problems in identifying the eligible population; with a very high proportion engaged in agriculture, assessing and imputing incomes is difficult. Therefore there are anomalies like for instance, twenty per cent of the card holders are not poor. By 1988/89, the card covered just 28 per cent of the low income group as defined by the income cut-off level and 45 percent of the poor as defined by the poverty line. In 1990, the coverage improved as a result of the expanded efforts to reach the targeted groups and increased screening of card recipients. Nevertheless the coverage as per a study conducted in 1993 remains low with up to 20 percent of those below subsistence left out.

(2) About one-fifth of the card holders are not poor.

(3) Defining a household is a problem especially where family members work in cities and remit earnings.

Features of Health Card Scheme:

(1) The scheme was started in 1983 with a primary objective of improving health among rural population with an emphasis on primary care including health education , environmental health, maternal and child health; to familiarise rural population with concepts of preventive behaviour, insurance, risk pooling and fund management. In 1990 the health card scheme was modified and renamed New Health Card Approach which emphasised the concept of risk sharing.

(2) Three cards existed - a family card, maternal and child card and individual card each priced differently and with different benefits, in 1991 different types of cards were discontinued with only family cards offered.
(3) The health card fund was designed as a village level fund in order to foster grassroots participation and management skills. The allocation of funds was as follows: 15% to health care, 30% to community hospital, 30% to regional and provincial hospital, 10% to the provider institutions, 15% as operating expenses.

(4) Administrative changes were also implemented with the health card fund managed by a

committee at the district level in co-ordination with village level bodies.

(5) Two-fifths of the card price allocated to providers of medical care while the remaining 20 percent was retained for marketing and sale incentives.

(6) The coverage of health card has been proposed to expand to include those who lack insurance coverage.

Shortcomings and failures of the scheme are:

(1) confusion about the number of cards and their terms and conditions of use.

(2) losses incurred due to the inability of hospitals to recover costs from health card fund contribution.

(3) problems with strict referral which tends to disregard geographical proximity.

(4) there has been a decline in the population coverage from 1988 to 1992 which was mainly due to lack of policy direction during this period.

Essential Features of Social Security Programme:

(1) Health insurance is considered part of the overall package of benefits covering illness unrelated to work, death, child benefits, old age security, etc.

(2) Employers and the companies with 10 or more are required to contribute 1.5% of employers' wages to social security with an equal 1.5% provided by the government. Since the contribution is based on income and not the expected risk or incidence of illness, risks are pooled and benefits are skewed in favour of high risk individuals.

(3) Expansion of the scheme on a voluntary basis to include the self employed such as farmers, own account workers, and other uninsured groups.

(4) The system of providing medical care to the insured is as follows: The insured persons are required to register themselves at a hospital called the main contractor. The main contractor receives capitation fee from the social security fund (SSF) depending upon the number registered (700 baht per registered person). Main contractor is able to sub contract to supra and sub contractors which provide higher and lower levels of care respectively.

There is also encouragement for formation of provider intervals networks i.e. main contractor to increase efficiency in health care delivery, improve accessibility of services and pool risks.

Shortcomings and failures of the scheme:

(1) If self-employed are allowed to participate , then it is not very clear as to deal with their contribution.

(2) Problems with the functioning of the system:

(i) confusion with respect to insured persons receiving care where they are not registered.
(ii) inconvenience of workers receiving care at a hospital they were not able to select

and limited number of participated hospitals to choose from. As an aside, since 1992, insured persons were granted to choose their own hospital.

(iii) workers were ignorant of their rights and were not aware of their contributions they made to SSF because of automatic deductions from their wages.

(iv) providers were not prepared to manage the system in terms of health care delivery.

(v) considerable confusion in the system with great variation between networks with respect to network coverage of the three levels of care, ability to manage funds, payment mechanism to encourage cost containment, quality and standard of medical care.

(vi) evidence of abuse - medical providers recruited by some networks are located in so far away provinces that insured persons have few opportunities to use the services

Remarks : general and specific

(1) Thailand has various health schemes some of which overlap i.e. some population groups get protection of multiple programmes while some population groups are left unprotected.

(2) There is little co-ordination between schemes and different schemes contain varying elements of subsidy and could cause the allocation of resources to worsen between rural and urban areas.

(3) Although some schemes are specifically designed for rural population, there are many groups in the informal sector which are excluded from existing schemes.

(4) There are some lessons which can be drawn from Thailand's experience particularly in the context of financing health schemes for India's rural and informal sector. Given the problems of assessing incomes in the informal sector, a system based on community financing such as health card programme seems workable.

(5) However, for something as above to be feasible, it is required that there should be enough social capital accumulated through co-operation and co-ordination of families, associations, clubs, etc. Also for risk pooling i.e. insurance, there is a need for large number of people which is only possible with government initiative and subsidy as in the case of health card programme.

Indonesia

The health expenditure pattern in Indonesia is characterised by low government, high private and negligible insurance spending when compared to the Asian countries. The overall spending on health is also low enough considering the per capita GNP of the subject country i.e. nations like India spend a higher share of GNP on health than Indonesia despite being poorer than the latter. In one of the World Bank studies, (1993) it is shown that actual per capita and per capita government health expenditure falls short of that predicted. This low government spending is not compensated by private contribution. Not only the expenditure, but the performance of Indonesia has not been good especially when considered with respect to not so rich countries like Sri Lanka. A national health system (SKN) was developed in 1982 which established the constitutional basis for all health activities, government, community as well as privately sponsored. The SKN affirms health as basic right of every Indonesian citizen and establishes the government as a guarantor of the right.

The Government has developed a basic network of health facilities, delivering health facilities to the general population. There are:

(1) regional hospitals
(2)provincial hospitals
(3)*Puskesmas* in that order.

The health delivery system has developed a full set of tariffs for every level of government health facility and every type of service, poor are protected by the low fees of outpatient and inpatient care in the lowest class of service. In addition the local village chief or other authorised official can issue an affidavit of indigence that formally excuses all fees for all the recipients.

There are three social security health plans prevailing:

(a) ASKES plan which is a compulsory health insurance system covering civil servants, active and retired and defence personnel and their dependants. Contributions are set at 2 per cent of monthly income, which entitles members to free use of government health centres.

(b) DUKM plan which is an extension of the ASKES plan to the other population groups. This consists of a pre-paid managed health care systems including the delivery of comprehensive health care and captivated financing.
(c) PKTK plan offers comprehensive health care to participating firms' employees and their dependants, which includes curative as well as preventive and primitive care. Health care is delivered through government health facilities or appointed private facilities. Contribution is 7 per cent of the monthly pay roll.

At the local level there are two implementation units : BPKD and BPPK. PKD, formed by ASTEK is responsible for membership, administration and collection of contributions and BPPK, formed by Regional Health Office arranges the delivery of care and payment to the providers of care.

Collected funds are divided as follows: 2 per cent to PKTK joint committee, 8 per cent to BPKD (ASTEK) for administration, 10 per cent for the reserve fund, 10 per cent for BPPK (Health Department) for administration and 70 per cent for BPPK (Health Department) for providing health services.

Sri Lanka

Sri Lanka is one the very few countries Asia whose performance in the health arena has been hailed by the rest of the world. Its output indicators like infant mortality and life expectancy at birth indicate a much higher level of development in the health sector than what one expects at the subject country's GNP level.

The health expenditure pattern of Sri Lanka is characterised by high government, low private and low insurance expenditure. A World Bank study reveals that the per capita government health expenditure slightly exceeds the predicted value whereas the per capita health expenditure falls short of the predicted figures.

Sri Lanka has established a National Health Development Network (NHDN) as a co-ordinating body for the various ministries and agencies responsible for health care, with National Health Council serving as the policy making body. In addition to the national health services, there are also individual employers who operate limited medical schemes for their employees.

There is very little health insurance in Sri Lanka though there is a well established social security system. There are a couple of government companies like NIC and ICSL which however have very little coverage. The government's thrust in Sri Lanka is more on the reorganisation of the health care delivery system and strengthening pimary care rather than on formulating policies to obtain regular contribution for availing health care services. There is however a view that the cost of providing health insurance benefits will reduce enormously as the coverage widens. Hence there is a scope for introducing health insurance at reduced costs.

Latin America and the Caribbean

The role of private sector in health care delivery is increasingly being recognised in Latin America and Caribbean. Such programmes called managed care programmes integrate financial responsibility by using techniques such as per capita prepayments to providers which put providers at risk for the cost of services provided. There is a contention that managed care programmes lead to considerable cost savings but that depends on the regulatory framework, often known as managed competition within which the former is functioning. Managed competition can be the government regulatory framework or that provided by the large group of health insurance provider. Hence there are a variety of forms of managed care and managed competition, and these concepts are highly relevant for the countries of Latin America and the Caribbean.

Latin America and Caribbean is a heterogeneous region with respect to income levels, health care spending, health care financing and delivery. The share of GDP spent on health varied from 2.7 per cent in Guatemala to over 8 per cent in Costa Rica, Argentina and Uruguay, with overall regional average of 6.3 per cent.

Although each country has a health markets and health insurance arrangements, four broad systems can be discerned. These are :

(a) private out-of-pocket spending;
(b) private health insurance markets financed by prepaid contributions;
(c) social insurance markets financed by mandated employer and employee to contributions; and
(d) public services financed by general tax revenue.

So, managed care appears in both private insurance and social insurance systems. These four systems serve different but overlapping groups. The groups covered by each of these are:

(1) poor tend to use the services of public hospitals and clinics supplemented by out-of-pocket expenditures on private practitioners and drugs.
(2) formal sector workers are largely covered by social insurance systems although out-of-pocket and private insurance expenditure is also incurred.
(3) rich tend to buy more of private insurance but are also covered by social insurance.

The common elements among these various different systems are those of universal access, quality and efficiency. Important variations across the countries remain.

The general shortcomings of the health care system, whichever kind it is, are cited as - populations are covered by overlapping and uncoordinated systems, poor having the worst access, decline in the quality of public health care services. These deficiencies, it is argued can

be managed through competition. The specific methods used to develop managed care in Latin America and Caribbean will depend on country's size and level of development as well the country's modalities of health care systems. In this regard, the region's countries are of three types:

(a) where public sector has played a dominant role in funding and provision of health care;
(b) countries where there are better developed markets for private finance and provision as well more experience with integrated delivery systems;
(c) countries where the population groups are highly segmented within the health care system and poor are excluded.

In countries belonging to category (a), the government needs to reorient its role as a regulator to provide greater autonomy to the health care providers and also greater choice to the consumers and also ensure efficient modes of resource allocation. In category (b), it will be possible to experiment with more competitive systems using the financial resources under social insurance schemes. As regards countries belonging to category (c), competition may be promoted within a publicly financed system to expand coverage.

Given these varieties in the provision of health care facilities, there are a number of managed care models developed in the different countries of this region and the new aspect of this is the growth in private insurance. Taking a larger perspective, there are two different models of managed competition which have emerged: (a) government is a sponsor e.g. countries like Colombia, Uruguay, and (b) private employers are playing the role of sponsor without public finance or regulation.

Chile

There are two main systems existing in Chile, public health care and ISAPRE.

Public health care covers 73 per cent of the population. All formal sector employees need to contribute 7 per cent of their salaries to national health system. There is no employer contribution. This contribution by the workers leads to the formation of National Health Fund. The unemployed and those workers with not so high salary contributions are covered by National Health Fund whose quality of services is not high.

ISAPREs programme covers 27 per cent of the population. This is a private insurance plan which workers whose salaries reach a certain level can purchase an ISAPRE. ISAPREs are therefore expensive but the quality of services is much better than what is provided with the National Health Fund.

There have been reforms introduced in the public health care and ISAPRE. The government has introduced provider payment reforms (payment by diagnosis). Public hospitals have been given more autonomy and are increasingly selling services to ISAPREs.

Despite these reforms, shortcomings remain like while the ISPRAEs compete to provide health care to one segment of the population but the minimum conditions for managed condition have not been achieved since most ISPRAEs enrol healthy, young and high income workers. Also the conditions put by them discourage patients who are ageing and/or suffering from illnesses which require expensive care to enrol with them.

Chilean system thus suffers majority from equity in the provision of services. There are two distinct systems each differing from the other in terms of type and quality of services provided.

The public system is poorly funded and also does not receive subsidies from ISAPREs. A regulatory office was recently set up to regulate the behaviour of ISAPREs and to maintain a minimum number of providers in the system. But this office is without legal authority to ensure that. Thus there is a lack of managed competition which is required to improve service quality and improve costs. Direct subsidies could be given to low income groups to enhance the demand side of the system.

Uruguay

Till 1995, 6 per cent of the population is not covered by any health plan although in theory, the entire population is covered by one or other programmes. During 1970s and 1980s the health system underwent a series of reforms. Formal sector employees can now choose among health plans, which are provided by private Collective Institutions of Medical Assistance (IAMCs). The IAMCs now cover about 65% of the population. The mode of financing is collective in the sense that part contribution was by the Bank of Social Provision finances (i.e. by the employer) and part by the workers and the amount of the latter's contribution is also fixed by the government. Employee and employer contributions to the IAMCs only cover services provided to employees and thus employees tend to select the IAMCs which provide the best terms for family coverage and therefore in that sense have choice. The degree of (consumer) choice however depends on the location – there are certainly more IAMCs to choose from in urban than in rural areas. That section of the population, which cannot buy the IAMCs, is covered by the public sector. The public sector too uses the system of co-payments to recover the costs and has many forms of it to recover the costs. Similar to Chile's ISAPREs, the public sectors here covers people usually the elderly who have been forced to leave IAMCs because of increases in health risk. The number of people being served by the public sector is on the rise and as a result public spending has increased with deterioration in the quality of services.

The shortcomings of this system are that there are elements of competition but without a regulatory framework. There are many market failures since there are certain sections of the population who are covered by many programmes, the lack of measures to control adverse selection by individuals and risk selection by insurers.

Columbia

Until the early 1990s, health care systems were highly segmented characterised by heavy out-of-pocket spending. The neediest were left out without coverage. Then there were three parallel health care systems. A social insurance system run by the Social Security Institute provided health services to formal sector workers and complementary agencies supplied health services to their families and government employees. The (existing) public health care system covered only 21 per cent of the population. Alongside there was a private health care system. This segmented system cost a great deal and the poorest 20 per cent of them paid about 18 per cent of their income on health. In 1991, constitutional reforms created the framework social for decentralising social services and developing a social security system grounded in the principles of universality, solidarity, efficiency and private sector

involvement. In 1993 the actual changes began in the system with the introduction of a health insurance system with an element of competition but with solidarity. A **Solidarity Fund** was created and the participants contributed 11 per cent of their earnings to enrol their families. The Fund assigns to each organisation chosen by the family a capitation payment that is risk adjusted by sex, age and geographic location. The average capitation payment is $120 per person annual. In addition to the basic contribution there is also co-payment system to encourage rational use of services. Public funds do not finance the Solidarity Fund, there are gradually being turned to directly fund health insurance for the poorest 30 per cent of the Colombians. There has been the growth of numerous Health Promotion Organisations (EPSs) which provide the insurer functions. Without privatising the EPSs, a lot of competition is being allowed among them. Families can choose the EPSs they wish to and are guaranteed high quality health services. The government budget outlays bolstered by contributions like solidarity payment of 1 per cent are strictly focussed towards the poorest 30 per cent of the population. Colombia's new health system combines both the elements of co-ordination of service delivery as well consumer choice. On the supply side are the EPSs which assume the risk of ensuring a universal package of services and on the demand side is the consumers' ability to choose their EPSs.

Though Colombia's system of mixed public funding and managed competition has substantially expanded the coverage and made the system made more equitable, yet there are many technical, institutional and political problems. However, what needs to be mentioned is that Colombia's success has been far greater than the rest of the countries in the region and it is required that the country consolidates its' gains to continue the performance in the future.

Brazil

There are three health care systems existing in Brazil:

(a) public system
(b) private system of supplementary medicine, and
(c) out-of-pocket system

Public system called as the Unified Health System was established in 1988. The federal government transfers the resources for expenditure to the local governments, which are in, turn responsible for the direct provision of services and also for contracting out services to private establishments. Low income citizens account for 78 per cent of the public system's users. The other 22 per cent of users constitute those who are covered by private insurance as well. The services of public system are rationed and quality of services is obviously not up to the mark.

The private system has four types of organisations: medical group organisations, health insurance institutions that do not provide services directly, medical co-operatives that use prepayment system and medical services provided by companies.

The out-of-pocket system entails household payments for services provided through medical networks and private hospitals. The number of people covered under this system is residual since the resources from public and private systems are the main sources of financing for hospitals, health services and doctors.

In a nutshell, the three kinds of health care services are as follows:

Group Covered	Public System	Private Supplementary Medicine	Direct out-of-pocket payments
Informal sector workers/low income	Primary care and hospitalisation	None	Complement Unified Health System
Formal Sector Workers/Middle Income	High technology & sophisticated procedures	Primary care, high technology & sophisticated procedures	Not used much
High income	High technology & sophisticated procedures	Primary care, high technology & sophisticated procedures	Used heavily

The overall system has a number of weaknesses and a few innovative experiments are under way to improve the situation. A Health Plan of Action was introduced but it has weaknesses like there are lack of incentives to provide preventive health care to plan members.

Argentina

Most formal sector workers and their dependants are required to participate in an *Obra Social* (Statutory sickness fund) linked to their place of employment. There is also a large market for private insurance. About 200 private plans cover more than 2 million people.

The health delivery system is mixed. About half of the hospital beds are in private institutions. Over the past few years *Obras Socials* have moved away from free-for-service provider payments towards captivated payments. The system is still facing financial difficulties and except for while collar workers until very recently the workers have not been able to choose their *Obra Social* – it is dictated by their employment. The government is now establishing a regulatory framework that supports a competitive environment for the *Obras Socials* based on the risk profiles of those who enrol. Designing and implementing these and many similar reforms would be difficult in the absence of required data.

These countries of Latin America and Caribbean show considerable diversity among themselves. The trends in these countries depending upon the level of development is as follows:

	Higher Income Countries	Lower Income Countries
Small homogenous countries	Managed care in public systems	Competition for primary care with public funds for the poor
Large heterogeneous countries	Managed competition with a mix of public and private funds and institutions	Structured pluralism with a stronger element of public finance.

A country's ability to introduce managed competition depends on its characteristics and institutional features. The basic determinants being country's size, level of development and the way its health system.

IV. A Review of Existing Health Care Schemes in India

The various existing health care programmes can be categorised as follows:

(a) state run schemes for formal sector employees
(b) public enterprises' health insurance programmes
(c) corporate sector health care programmes
(d) community and self financing schemes primarily for workers outside the formal sector

1. Health Insurance Schemes for Organised & Government Sector Employees

There are two other schemes, CGHS and ESIS sponsored by the central and state government, respectively, which extend free medical care for both inpatient and outpatient services on co-payment basis to the organised workforce. The ESIS also extend cash benefits towards loss of wages due to sickness as well as cash compensation towards permanent physical impairments.

Employees' State Insurance Scheme (ESIS)

The Employee State Insurance Corporation (ESIC) runs the ESIS which provides both cash and medical benefits. The scheme (launched in 1948) is essentially a compulsory social security benefit to workers in the industrial sector. The original legislation required it to cover only factories using power and employing 10 or more employees and was later extended to cover factories not using power and employing 20 or more persons. Persons working in mines and plantations are specifically excluded from the ESIS coverage. The coverage is for people earning less than 3000 as their basic. Any organisation which is offering benefits as good or better than ESIS are obviously excluded from the coverage.

The monthly wage limit for enrolment in ESIS is Rs. 3500 which has been raised recently to Rs. 6500. The employer's contribution is in form of a payroll tax of 4% paid by the employer and 1.4% paid by the employee. Medical benefits comprised cash payment for sickness, maternity, temporary or permanent disablement, survivorship and funeral expenses. Expenditure for medical benefits constitutes 70 percent of the total benefits paid under ESIS. These medical benefits are provided primarily through the facilities provided by hospitals for the ESIS enrolees. As on March 31, 1994, there were 29 million beneficiaries spread over 617 ESI centres across states. Under ESIC, there were 120 hospitals, 42 annexes and 1427 dispensaries with over 23348 beds facility. The total state government expenditure on ESIS was about Rs. 3300 million and the expenditure per insured person worked out to be little under Rs. 400.

There has been a steady rise in the share of total government medical expenditure on ESIC as also an increase in the number of beneficiaries. However, the latter has not been commensurate with the increase the number of workers in the organised sector. In fact over a period from 1955-56 to 1984-85, there has been a decline in the percentage of the the total organised sector employees covered by ESIS from 38.24 to 29.29. This implies that the ESIS could not keep pace with the rapid growth of the organised sector.

The Scheme however has not been as successful in terms of coverage as well as quality of services. The issue of coverage is related to that of equity. The states with a higher share of the total expenditure on ESIS are also the ones with a higher share of organised workforce. Such states are also invariably better placed in terms of other development indicators. Barring few

exceptions it can therefore be stated that the expenditure share for the ESIS is in relation to the size of the organised sector as well as the level of industrialisation and development of the states. Also only around 30% of the workforce is covered by the benefit though the government spends 12% of the total medical expenditure on ESIC. The larger question is of course that only 10% of the country's total workforce engaged in the organised sector. This kind of subsidisation of services for one section of the workforce nearly amounts to creating a two tier health system. Touching the other aspect of quality of services, the ESIS hospitals are really perceived to be poor. There have been studies showing that the hospital equipment is in a state of disorder and there is a shortage of medicines and drugs. The available drugs and medicines are more often found to be of substandard quality. Over and above there also have been reports of negligence and corruption in the system. Instances of employers depriving workers their right of coverage by not informing employee of their coverage, disallowing injury claims by changing eligibility, and manipulation of part- time employee work schedules so as to make them non-eligible for ESIS coverage.

Central Government Health Scheme (CGHS)

The CGHS was introduced in 1954 as contributory health scheme so as to provide comprehensive medical care to the central government employees (both in service and retired) and their families to replace the cumbersome and expensive system of reimbursement. The contribution by the employees is however nominal (a maximum of Rs. 50 per month). Separate dispensaries are maintained for exclusive use of central government workers. There are also central government run hospitals where the CGHS beneficiaries are treated. Over the years, the coverage has grown spatially and also in terms of beneficiaries. By covering all systems of medicines, it delivers services through 320 dispensaries in 17 major cities of most of states. In addition there are 108 polyclinics, laboratories and dental units. The total number of beneficiaries were 4.4 million in 1996. Besides providing medical services, the CGHS provides reimbursement for out-of-pocket expenditure in availing of treatment at government hospitals and approved private facilities. The list of beneficiaries include all the current as well as ex-government employees including members of parliament, Supreme and High Court judges, central bureaucracy.

The CGHS is widely criticised for its quality and accessibility. Since the (CGHS) services are confined for those who are in regular government jobs, it implies that the section of the population better off than the majority is enjoying the benefits. Apart from this, for those availing the services the waiting times are long, out-of-pocket costs of treatment are high (Rs. 1507 in 1994), supplies of medicine, equipment and staff are inadequate and conditions are often unhygienic.

However, various research studies show that both CGHS and ESIS are not serving the very basic purpose. The quality of services is poor. Long waiting period, non-availability of drugs, inadequacy of staff and non-functioning of equipments are the most common problems encountered by the insurers. Though the number of beneficiaries is increasing, the actual use of facility is declining due to switching over to private facility.

Employer Managed Facilities and Reimbursement of Out-of-Pocket Expenditure

The government also provides direct health services for employees of a large number of state owned departments like Railways and Defence and Police services. These departments have set up their own system of dispensaries, hospitals and personnel. An industrial sector which offers similar kinds of services is the mining one. Employers in schools and universities too

have their network of hospitals and dispensaries.

There are numerous reimbursement plans offered by the employers for private medical expenses. Many private sector companies in addition to the ESIS and other health insurance schemes like ESIS reimburse the expenses. There are normally two ways of reimbursement:

(1) employees allocate a share of their earnings medical expenses which is annually disbursed towards the medical allowances of their employees.
(2) employees incurring medical expenses submit their claims to their employer for reimbursement and reimbursements are linked to individual contributions.

2. Mediclaim Health Insurance Schemes

The public insurance scheme which is currently prevalent in India are the Mediclaim programme. The scheme is run by General Insurance Corporation, a government of India public enterprise. There are four subsidiary companies of GIC namely National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company. All these four companies' operate nationally and are controlled by GIC. Though a full range of insurance cover is offered by the GIC like on property, liability, casualty and business, health insurance is also a part. Since the merger of the various private insurance companies into one apex body, there has been a uniformity of the provision of medical benefits. The Mediclaim policy as it it is called covers hospital care and domicilary hospitalisation benefits which means specified outpatient treatment provided in place of inpatient treatment. Premiums, eligibility and benefit coverage for all the subsidiaries are as prescribed by the GIC.

In the light of cumbersome procedure to reimburse the hospitalisation expenses, certain changes have been made in the mediclaim insurance policy and accordingly premium has been revised from September 1, 1996. Followings are the salient revisions.

(a) Sum insured has been raised from Rs. 83,000 to Rs. 300,000.
(b) Fixation of premium according to the category of hospital/ward has been removed, and now it vary according to five age groups viz. up to 45, 46-55, 56-65, 66-70 and 71-75.
(c) Rate of premium has been reduced - now it is almost half of the previous rate in the higher categories of sum insured. The premium varies between a low of Rs. 175 (up to 45 years age group) and Rs. 330 (71-75 years age group) for Rs. 15,000 coverage to a high of between Rs. 2825 and Rs. 5770 for Rs. 300,000 coverage.
(d) Extending coverage to children between age of 3 months to 5 years provided one of the parents is concurrently enrolled.
(e) Now it extends reimbursement of cost of health check-up once at the end of block of every four underwriting years.
(f) This plan also provides family discount and cumulative bonus.

However, changes have not been made in regard to pre-existing diseases and exclusions of certain conditions during the first year of coverage. Also, the mediclaim policy does no allow reimbursement of expenses against AIDS, venereal diseases, pregnancy, dental treatment, hearing aids, spectacles and contact lenses. The only good aspect of the plan is that the premium has been reduced considerably thereby raising its affordability.

The General Insurance Corporation (GIC) also initiates group medical policy along the same lines as the individual or family mediclaim policy. Due to risk pooling the premium gets

reduced in the group mediclaim policy.

The response to the Mediclaim policy unlike that for ESIS is quite favourable. There has been a tremendous increase in the enrolment for the Mediclaim. There has been a 174% increase in the beneficiaries of Mediclaim over a period between 1986 and 1995. A major shortcoming of the programme is however that only hospitalisation expenses and expenses in place of hospitalisation are covered while routine out-patient care is not covered. The hospitalisation coverage is also subject to numerous exclusions, coverage limits and restrictions on eligibility etc. Also claim payments are higher than premiums, thus questioning its viability.

The GIC in its efforts to overcome the weaknesses has introduced a new policy called Jan Arogya Bima Policy in late 1996 to cater the health care needs of people belonging to middle and lower income groups. The annual premium ranges between Rs. 70 and Rs. 140 by age and it is just Rs. 50 for dependent children against a coverage limit of Rs. 5000 in a year. It is expected that this plan would certainly be affordable to large section of India's population. Over and above, it covers maternity expenses which are not admissible in the mediclaim policy. In a short span of about six months, about 400,000 individuals (as on March 1997) have opted for this plan as against 1.6 million under the mediclaim.

The GIC also offers medical benefits and compensation under personal accidents policies for individuals and groups. If an injury results in total disablement of the insured and thereby prevents from engaging in any activity or occupation then 100 per cent of the sum insured will be paid. In other cases the irrevocable loss of eye-sight, hearing and different parts of limbs leads to different percentages of the sum insured being paid.

Bhavishaya Arogya Policy (old age medical insurance), also introduced by GIC in 1991, was designed to enable a person to plan for medical needs during old age out of savings during his/her current earning phase, as an old age security. Under this scheme medical expenses to be incurred over the balance life span after a predetermined age of retirement will be reimbursed up to the amount of sum insured. The advantage of this plan is that it assure coverage of all types of conditions from the effective date of benefits.

3. Other Public Sector Managed Health Insurance Schemes

Similarly, the Unit Trust of India (a public sector undertaking) launched the Senior Citizens Unit Plan (SCUP) in April 1993 to provide coverage for hospitalisation expenses up to Rs. 500,000 for the investors after attaining the age of 58. Anyone in the 18-54 age group can join the scheme by one-time investment and his/her spouse can also become eligible for the medical insurance benefits.

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. Any one between 18 and 50 years can opt for an insurance coverage between Rs. 50,000 and Rs. 300,000. This is basically an endowment policy with three terms 15, 20 and 25 years with maximum age at maturity is fixed at 65 years. The benefits can be claimed only once out of four specified diseases. It include an immediate payment of 50 percent of the sum assured, waiver of subsequent premiums falling due; subsequently annual payment up to 10 per cent of sum assured till the policy matures or death, whichever is earlier; the payment of balance 50 per cent of the sum assured and vesting bonuses on maturity or death, whichever is earlier. The bonus will be paid on full sum assured even though half of the sum assured has already been paid. Though it is not primarily a medical insurance policy, it

became very popular by selling 175,000 polices during 1995-96 with total sum assured of Rs. 13620 million.

An interesting aspect of all these policies is that premiums qualify for income tax benefits. However, all these schemes covers a partial medical benefits by limiting to hospitalisation coverage for mainly communicable diseases and selected non-communicable diseases. Not a single policy has allowed reimbursement of expenses for outpatient care. Nevertheless, the health insurance market is growing faster than the general insurance (in terms of premia collected by GIC, the latter is growing annually at 14 per cent while the former at 26 per cent during the last five years). These facts clearly highlight that there is a lot of potential to tap health insurance market. As both the public health delivery and health insurance package are far below the quality, the increasing role of private facilities especially corporate hospitals would be warranted.

Statement 1: Salient Features of Important Health Insurance Schemes in India

Type of Health Insurance Scheme and Commencement Year	Coverage Age/Sum Insured	Estimated Enrolment ('000)	Remarks
1. General Insurance Corporation			
Mediclaim, 1973 (Individual/Family/Group)	Individual aged 5-75/Family-3 months to 75 yr., Rs. 15000-300000	1600	Only hospitalisation coverage with exclusion of pre-existing conditions & dental coverage.
Jan Arogya, 1996 (Individual/Family)	Age group up to 70 yr., Rs. 5000	400	Same as above but includes maternity benefits.
Bhavishya Arogya, 1991 (Old age security, Individuals/ Spouses)	Individual/spouse aged 18-55 for post retirement benefits up to Rs. 500000	100	Hospitalisation coverage after the age of retirement.
2. Life Insurance Corporation Asha Deep II, 1995	Individual aged 18-50, Rs .50000-300000	175	Endowment policy with coverage of four ailments - cancer, paralytic strokes, renal failure and coronary artery diseases.
3. Unit Trust of India Senior Citizens Unit Plan	Individual/spouse aged 18-54 for post retirement benefits up to Rs. 500000	100	Medical benefits with one time investment after the age of retirement.
4. Central Government Health Scheme Medical and Health Care Services	Any central government employees (current or retired) and families, all types of medical services	4361	Though provide coverage for both inpatient and outpatient care, the quality and delivery of services are poor.
5. Employees' State Insurance Scheme	Any employee and his/her family	28883	Poor quality and delivery of services; delay in enrolment and

Medical and Health Care Services along with Cash Benefits	in an organised sector with monthly wages under Rs. 6500, both cash and medical benefits		disbursement of cash benefits; non-coverage of temporary workers and their families.

4. Corporate Sector Health Care Programmes

The corporate sector too provides health care services. These services are offered by a network of providers owned by the large business houses. Typically the business houses own large urban based hospitals or diagnostic centres which possess the latest 'state-of-art' medical technology. There has been a rapid expansion of corporate sector health provision which has been possible because of the indirect and direct support from the government.

A negative consequence of this rapid expansion is the further skewing of the health sector resources in the urban areas. There is also an emphasis in these hospitals on expensive medical equipment and therefore leads to escalation in the costs of delivering medical care. The growth of this kind of high-tech health care service has been very rapid and unchecked. The government needs to review and initiate measures to regulate it.

5. Community and Self-financing Programmes

Community and self-generated financing programmes are those which are usually run by Non Government Organisations(NGOs) or non-profit making organisations and rely on finances from various sources including government, donor agencies and community and self generated sources. Also many innovative methods of financing health care services were used like progressive for scales, community based pre-payment/insurance schemes and income generating schemes. The target population for provision of health care services by such organisations is primarily workers outside the formal sector. The sources of revenue for the programmes can be categorised as:

(1) user fees are defined as payments made by the beneficiaries directly for the health care providers such as fees for services or prices paid for drugs/immunisation. This mode of financing is not so common.

(2) prepayment/insurance schemes include payment by members for drugs either at subsidised rate or at cost price.

(3) commercial schemes are activities run by organisations on a profit basis to finance health care.

(4) fund raising- many organisations indulge in fund raising activities for financing health care services. In some cases the revenue raised in this manner constitutes 5% of the total funds of the organisations.

(5) contributions in kind - payment for services in cash or kind like in rice, sorghum, community labour. This method is however not very popular considering that the management of this becomes difficult.

(6) other sources of community financing and self financing- there are instances like the Tribhovandas Foundation providing health care through village milk co-operatives or milk co-operatives and organisations like Amul Union contributing significantly towards health services.

SEWA Health Insurance Scheme

SEWA has been providing health insurance to its members over the past five years as part of the integrated insurance scheme. The scheme is operational in the city of Ahemdabad, Gujarat. SEWA's members typify workers who are poor women and are engaged in occupations which form a part of the unorganised sector.

Health insurance is an integral part of the insurance programme of SEWA. The main motivations behind the initiation of a health insurance scheme for women are that women tend to place a low priority to their health care needs and therefore the health seeking behaviour is nearly absent. The poor women's health is most vulnerable both because of their unhygienic health conditions as well as because of the burden of bearing children. And poor health for such workers costs them loss of working days and the corresponding incomes.

The coverage of the SEWA'S health insurance programme are: (a) maternity coverage, (b) access to health care covering a wide range of diseases, and (c) insurance for occupational health related illnesses insurance coverage for diseases specific to women.

The contents of the health insurance programmes are as given below:

(a) occupational health coverage.
(b) coverage for women specific diseases.
(c) maternity benefit.
(d) coverage for a broad range of diseases not covered by the present Indian health insurance companies premium of Rs. 30 payable yearly or a one time fixed deposit of Rs. 500.
(e) attempts to simplify administrative procedures.
(f) part of the package containing life, asset and dismemberment insurance.
(g) allowance for life insurance coverage for members' husband or other members of household (in case of widowhood and separation).

Incidentally the maternity coverage is unique to the SEWA's health insurance scheme as none of the national level insurance companies recognise the maternity period.

SEWA's health insurance scheme functions in co-ordination with the insurance companies like LIC and United India Insurance company (UI). SEWA has integrated the schemes of LIC, UI and SEWA into a package given by SEWA. A schematic presentation of these various schemes is given as below:

Provider	**Description of Coverage**	**Coverage Amount (Rs.)**	**Premium (Rs.)**
United India Insurance Company	Accidental death of the woman member Loss of assets	10,000	3.50
	Accidental death of a member's husband	10,000	3.50
	Loss during riots/fire/flood/ theft/etc. Loss of work equipment Loss to the housing unit	2,000 (Maximum) 3,000 (Maximum)	8.00

SEWA	Mediclaim Health Insurance (Coverage for gynaecology ailments) (Coverage for Occupational Health related diseases)	1,000	30.00 (10) (5)
Life Insurance Corporation of India	Natural Death Accidental Death	6,000 25,000	15.00

The present total premium for the entire package is therefore Rs. 60 and the members pay Rs. 65 with Rs. 5 as service charge.

The claimants are the health-benefits seekers and since the availability of the insurance, the beneficiaries willingly pay the premium. The rural-urban distribution of these claimants is however skewed in favour of the urban members since though SEWA membership is rural, the majority of the claimants are urban. Recently schemes of Rs. 500 and Rs. 700 fixed deposit have been announced to mobilise resources for delivering the health care services. These fixed deposits are invested much in the same way as it is done for the premiums collected and other funds.

SEWA's membership has grown from 40,000 in 1992 i.e. when the insurance was introduced to 1,63,000 by the end of 1996. It is the large membership and assets of the SEWA bank that has made possible the provision of the insurance coverage at low premiums.

V. Entry of Private Sector in Health Insurance Market

Health insurance has come to the forefront following the announcement by the Union Finance Minister in his recent budget to open up the sector to private players. Unlike other south-east Asian countries, only organised sector employees, forming about less than ten per cent of the total workforce, are covered under some form of health insurance under ESIS and CGHS. A substantial segment of self-employed persons belonging to middle and higher income groups as well as professional and white collar workers, relying on private hospitals and facilities, would form potential consumers/buyers of a minimum package of health insurance either from existing public sector agencies (e.g. GIC and its subsidiaries) or from upcoming private sector agencies. Also, the enhancement of deduction limit for expenditure on health insurance (for income tax benefits) from Rs.6000 to Rs.10000 would generate additional demand for voluntary health insurance schemes.

With the announcement of breaking the decades old monopoly of GIC by opening out health insurance sector has exploded a whole Pandora of questions. Why the new players would be interested in health insurance when about two-fifths of Indian population is poor and another one-fifth barely meets their day-to-day requirements? What is the relative advantage when the health market is so much segmented with respect to demand, delivery and quality of services (for instance, 83 per cent of population - over 700 million - lives in 575,000 villages and 3400 towns)? Who would be taking risk when merely between 6 and 9 per cent of total illnesses intended to require hospitalisation and of which 60 per cent are being treated by public hospitals? Whether the new players would extend coverage for outpatient treatment? And what characteristics they would be possessing to enter first in a fast growing health market?

Let us first estimate the size of health care market especially the potential health insurance market. India spends over six per cent of national product on health care and nearly four-fifths of spending is private out-of-pocket. According to the recent estimate of NCAER, the per capita annual household expenditure on curative care in 1993 was Rs.250 which amounting to Rs. 223 billion. Of this, Rs. 179 billion were spent in using the private hospitals and facilities. Although six per cent of illnesses treated in private facilities required inpatient care, nearly half of this expenditure (Rs. 80 billion) was towards hospitalisation care. This is a conservative estimate because it does not include expenditure towards the use of private facility for childbirth, MTP, etc. as well as those illnesses which remained untreated (nearly 10 per cent). Therefore, to begin with, there is over Rs.80 billion market (or Rs.90 per capita) for hospitalisation insurance coverage alone without the likely switching over of demand from public to private facilities.

It has been clearly observed from the NSS data that a majority of patients who were undertaking treatment from private doctors switched over to public hospitals for inpatient care. This shift was entirely due to cost consideration as the cost of inpatient care in private hospitals was two to three times that of the public hospitals. A large section of poor and middle income population continue to prefer public hospitals for inpatient care. Once health insurance package would be available at affordable prices, there would be a shift in demand due to change in tastes and preferences of consumers towards private hospitals, which are perceived to be better care takers and quality service providers. In a way the consumer would be relieved from all sorts of hassles in getting modicum services offered by public hospitals. In this regard, at least one could expect net switching of one-fifth of patients to private hospitals and thereby raising the total private health care market for hospitalisation services very close to Rs. 100 billion.

Now the question arises who would like to capitalise on health care market? Basically there are three categories of private companies who can seek future endeavour and investment in this

sector: (a) those who are already manufacturing and delivering health care products; (b) those which are delivering medical services through high-tech hospital(s) such as Appolo, Batra, Hinduja, Escorts, etc.; and (c) those who have acquired name in production of consumer durable such as Tata group, Kotak Mahindra, DCM-Shriram, Godrej, etc. and/or have become successful managerial and financial companies such as ICICI, HDFC, First Leasing, Anagram, etc. The former two categories of companies have already dealing with the health sector market and has better distribution net-works whereas the last category of companies have acquired knowledge about behaviour and perceptions of consumers especially of the middle and higher income groups. These consumers would be most willing to opt for a better health insurance package primarily covering all types of expenses towards major illnesses/diseases including pregnancy.

Statement 2 supports our argument that even before opening out the health insurance sector for "select Indian players", a large scale investments by private corporate sector has already begun in establishing hospital facilities. (For instance, just 11 hospital projects located in metropolitan cities accounted for a total investment of Rs. 5.7 billion in 1995.) Over and above, several American and British insurance companies want to tie up with Indian players to offer and market superior health services, technology, products and distribution mechanism. They are definitely planning to enter in a big way by wider acceptability, low premia, higher returns and greater flexibility by converting so called unclaimed health insurance into household insurance. However, it is yet to be seen how the Insurance Regulatory Authority (set up in 1996) would laid down the policy guidelines to manage and regulate the insurance sector.

Statement 2: Major Private Hospital Projects Under Implementation, 1995

Type of company/project/location	**Products/capacity**	**Cost (Rs. Mn)**
Duncan Goenka Hospital, West Bengal	270 beds hospital	760
Sterling Hospital, Gujarat	Hospital	330
Keshlata Cancer Hospital, Uttar Pradesh	Medical & health	98
Cure Spects Laser, Gujarat	Eye care	72
Laser Eye Care, Gujarat	Medical & health	70
Pramila Kidney Hospitals, UP & AP	80 beds hospital	30
Agio Countertrade, West Bengal	Medical & health	1000
East India Hotels, Delhi	225 beds hospital	800
Nippon Denro Ispat, West Bengal	250 beds hospital	150
Gyanshri Pratishthan, Maharashtra	1000 beds hospital	2000
Medi Projects, West Bengal	250 beds hospital	350
Total for 11 Projects		5660

Source: Centre for Monitoring Indian Economy (CMIE), Bombay, February 1996.