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Research Article

HEALTH INSURANCE: NEED OF THE HOUR IN INDIA

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ABSTRACT
Health insurance is the reduction or elimination of the uncertain risk of loss for the individual or household. The people who have the risk of a certain event contribute a small premium in a health insurance programme. This fund is used to treat patients who experience that particular event (e.g. hospitalization). Around 24% of all people hospitalized in India in a single year fall below the poverty line due to hospitalization. According to an analysis of financing on hospitalization shows that a large proportion of people either borrow money or sell assets to pay for hospitalization especially among below poverty line population. A health insurance programme should ideally promote in both ways i.e vertical and horizontal equity. This always promotes cross-subsidy between both equals and unequal. Major aims of health insurance are: to increase access to healthcare services and to protect families from high medical expenses at the time of illness. In India, there is need to take some steps and these shortcomings need to be addressed so that every poor or rich, urban or rural person should take advantage health insurance scheme.

Key Words: *Insurance, Employee, Social security, Policy, Scheme*

INTRODUCTION
Health insurance is a method to finance healthcare. The International Labor Organization defines health insurance as "the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member". In more simple way, people who have the risk of a certain event contribute a small amount (premium) towards a health insurance fund, in a health insurance programme. This fund is then used to treat patients who experience that particular event (e.g. hospitalization). The main advantage of a health insurance programme is that of prepayment. Individuals or families pay when they are healthy and are able to pay. However, when they are affected by illness, the insurance fund can be used to finance their healthcare needs. Thus there is no burden at the time of illness.

Only 4.05% of India's GDP spends on healthcare, which is one of the lowest healths spending globally (Trade Economics, 2013). What is worse is that most of this Rs 1,057 billion is spent by individual households, who pay for care at the point of use. While in most high and middle-income countries, the governments contribute a sizable portion of the health expenditure, in India, it is one of the lowest, less than a quarter of the total expenditure. In fact, as a percentage of GDP, it has declined from 1.3% in 1990 to 0.9% even today and the most common source of health expenditure in our country is the out-of-pocket payments. This means that individual households pay at the time of illness. It is accepted that this form of payment is very inefficient and inequitable. There is no risk pooling and the patient is not able to purchase care efficiently.

Data from the National Sample Survey Organization (NSSO), Ministry of Statistics and Government of India indicate that escalating healthcare costs is one of the reasons for indebtedness not only among the poor but also in the middle-income group. With 40% of the hospitalized having had to borrow money or

sell assets during the decade 1986–96, there was an increase in the absolute number of persons unable to seek healthcare due to financial reasons. Around 24% of all people hospitalized in India in a single year fall below the poverty line due to hospitalization. According to an analysis of financing on hospitalization shows that a large proportion of people either borrow money or sell assets to pay for hospitalization especially among below poverty line population. In the light of the fiscal crisis facing the government at both the Central and State level, the shrinking public health budgets, health insurance is emerging as an alternative mechanism for financing of healthcare. Currently, only 4% of the population is covered under health insurance. The central and state governments are exploring various mechanisms to protect the population with a health insurance mechanism, so that they pay a small amount when healthy and are protected from high medical costs at the time of illness (Devadasan, 2013).

India is very large and diverse population and one single solution will not meet the needs of all its population. That why the planners and policy makers need to categories the population in stratifies way and designs each scheme that is specific for each category. Thus for those in the formal sector, mandatory social health insurance, voluntary private health insurance or voluntary medical savings accounts are available options in India that need to be explored.

Health insurance functions, only when there are large numbers individuals enrolled. This is because the chances of adverse events are reduced when large numbers enrolled, and there is outflow from the insurance fund. To success the health insurance programme, the people must contribute and they knowing well that their contribution may not help them directly, but will help to others who require the support. Without this value, a health insurance programme is doomed to fail as people will insist on withdrawing at least their contributions from the fund. This will destroy the concept of health insurance and will result in failure of the programme.

One of the important values, rarely we talked about is one of equity. A health insurance programme should ideally promote in both ways i.e vertical and horizontal equity. This always promotes cross-subsidy between both equals and unequal. Major aims of health insurance are: to increase access to healthcare services and to protect families from high medical expenses at the time of illness. Any health insurance programme requires an insurer who can take the risk and organizes the health insurance programme. There should be a community that will pay the premium and enroll into the health insurance programme. Lastly, the patients need to avail of services from healthcare providers (doctors/private/government nursing home) when they fall ill.

The insurer should organize to pay the providers for the services rendered and there are three subsidiary elements i.e that of administering the programme, that of managing the risk, and finally of ensuring quality both in the healthcare as well as in the health insurance programme. It is essential that these nine elements are in place for a health insurance programme to be successful.

In India, Mainly the Three Types of Health Insurances

1. ***Social Health Insurance:*** This is compulsory health insurance, usually for the formal sector. Here the employees contribute through payroll deductions and the employers provide a grant. This is used to finance healthcare of the employees, their dependents and, the rest of the population.

2. ***Private Health Insurance:*** A voluntary health insurance wherein people can enroll and purchase the insurance product of their liking, paying a risk-rated premium.

3. ***Community Health Insurance*****:** A voluntary but not-for-profit health insurance scheme and targeting the informal sector. These are usually small schemes and the community is very involved in its management.

The first health insurance Act was passed in 1912 and latest version of the Insurance Act was introduced in 1938. Till the year 1972, there has been very little changes were made in the insurance act and under the umbrella of the General Insurance Company (GIC), all nationalized insurance companies and the few hundred private insurance companies were brought under this. In the year 1999, private and foreign

entrepreneurs were allowed to enter the market with the passage of the Insurance Regulatory and Development Authority (IRDA) bill.

1. Social Health Insurance

There are two mandatory and contributory health insurance schemes in India – the Central Government Health Scheme **(**CGHS) for civil servants of India and the Employee's State Insurance Scheme (ESIS) for the low-paid industrial workers. Here the eligible people contribute through a payroll tax towards a specific health fund. This fund then finances specific benefits for them.

The Central Government Health Scheme (CGHS): This contributory health scheme was introduced in 1954, to provide comprehensive medical care to the central government employees and their families. The CGHS includes all categories of current as well as former central government employees, members of parliament, Supreme Court and High Court judges. Under this scheme, the staff contributes minimal amount Rs 50 to Rs 500 per month from their salaries on the basis of pay grade. The CGHS includes the benefit package for both outpatient care and hospitalization. The outpatient care is provided through its own dispensaries in 25 major cities.

One of the benefits of this scheme is that the employee can avail the facilities of the government and approved private hospitals for inpatient care and all inpatient care medical bill reimburses to the patient. The CGHS provides comprehensive health care to the CGHS Beneficiaries in India. Besides central government employees, the scheme also provides services to members and ex-members of parliament, judges of the Supreme Court and high court (sitting and retired), freedom fighters, central government pensioners, employees of semi-autonomous bodies/semi government organizations, accredited journalists, ex-governors and ex-vice-presidents of India

The medical facilities are provided through Wellness Centres (previously referred to as CGHS Dispensaries)/polyclinics under Allopathic, Ayurveda, Yoga, Unani, Sidha and Homeopathic systems of medicines. Currently 254 allopathic dispensaries, 19 polyclinics, 78 Ayush dispensary/ units, 3 Yoga Centres, 65 Laboratories, 17 Dental Units are running in India (Ministry of Health and Family Welfare 2013).

The Employee's State Insurance Scheme (ESIS) **(Employers Guide, 2001; Sharma, 2010):** Employee's State Insurance Scheme (ESIS) of India was launched in 1948 and it is an integrated social security scheme tailored to provide social protection to workers in the organized sector and their dependants in contingencies, such as, sickness, maternity or death and disablement due to an employment injury or occupational disease. Towards this objective the scheme of health insurance provides full medical facilities to insured persons and their dependants, as well as, cash benefits to compensate for any loss of wages or earning capacity in times of physical distress.

The Employee's State Insurance Corporation (ESIC) scheme headed by the Union Minister of Labour as Chairman and a Director General as the chief executive. Its members are representatives of central and state governments, employers, employees, medical professionals and Members of Parliament.

Contribution

The ESI Scheme is mainly financed by contributions raised from employees covered under the scheme and their employers, as a fixed percentage of wages.

As of now, the rates of contribution are:

Employee's Contribution: 1.75 percent of wages

Employer's Contribution: 4.75 percent of wages

Note:

a) Employee's earning upto Rs.70/- a day as wages is exempted from payment of their part of contribution.

b) The State Govt. bear one-eighth share of expenditure on Medical Benefit within the per capita ceiling of Rs.1200/- per annum and any additional expenditure beyond the ceiling.

1. ***Rashtriya Swasthya Bima Yojana (RSBY):*** The RSBY is a government-run health insurance scheme for the Indian poor started in October, 2007. It provides for cashless insurance for hospitalization in public as well private hospitals. The scheme started enrolling on April 1, 2008 and has been implemented in 25 states of India. A total of 23 million families have been enrolled as of February 2011. The RSBY is a project under the Ministry of Labour and Employment. The scheme is run on shared financial contribution by both central and state governments: 75% of the Rs. 600 (approx US$13) premium (per person per year) is borne by the central government and the rest by the state governments. There is profit motive for all parties involved. Private insurance companies provide the risk coverage, while private third-party administrators empanel hospitals and manage claims. Fixed rates have been prescribed for a long list of interventions (Rashtriya Swasthya Bima Yojana, 2008).

2. Private Health Insurance (PHI)

The objective of private health insurance is to improve access to affordable, quality healthcare through policies that cover a major portion of their healthcare spending. PHI aims at spreading the reach of health insurance in the country and enhancing the market share of health insurance in health financing by developing specific insurance schemes for the formal sector. The PHIs are of following types:

a) ***Mediclaim:*** The Mediclaim policy is consorted with health insurance in India under the umbrella of the GIC. This policy is voluntary health insurance scheme offered by the public sector launched in 1986 and since 1999 this scheme was introduced in the private health insurance companies. The standard Mediclaim policy covers only hospital care and domiciliary hospitalization benefits. This scheme includes 3 months to 80 years of age and who can afford the risk-rated premium is eligible to join the scheme. The premium depends on the age, risk and the benefit package opted for. The minimum premium is Rs 201 for < 25 years old for a maximum benefit of Rs 15,000. Group membership allows for discounts in the premium. The subscribers are usually the middle and upper class, especially as there is a tax benefit in subscribing to Mediclaim (Rashtriya Swasthya Bima Yojana, 2008).

b) ***Universal Health Insurance Scheme (UHIS):*** The Government of India launched the Universal Health Insurance Scheme (UHIS) in 2003 and it's a voluntary health insurance scheme for the poor. The scheme provides for reimbursement of medical expenses upto Rs.30,000/- towards hospitalization floated amongst the entire family, death cover due to an accident @ Rs.25,000/- to the earning head of the family and compensation due to loss of earning of the earning member @ Rs.50/- per day upto maximum of 15 days. The UHIS has been redesigned targeting only the BPL families. The premium subsidy has been enhanced from Rs.100 to Rs.200 for an individual, Rs.300 for a family of five and Rs.400 for a family of seven, without any reduction in benefits. Third Party Administrator means who, for the time being, is licensed by the Insurance Regulatory and Development Authority, and is engaged, for a fee or remuneration, by whatever name called as may be specified in the agreement with the company, for the provision of health services (National Insurance Company Limited, 2013).

c) ***Medical Savings Accounts (MSAs):*** MSAs are not a new concept in international health financing models. India has had its own MSA-type model in health insurance, which has been marketed by Bhavishya Arogya a public sector insurers (Universal Health Insurance Scheme, 2003). In MSAs, an individual or family account is opened in which insurance contributions are deposited, and whenever an individual or family deceases he/she can use this fund for health. In these accounts, funds do not lapse even when the funds have not been utilized by the beneficiary rather it can accumulate and be used later. MSAs act as a demand-side approach to reduce healthcare consumption. MSAs can cut costs, increase competition and reduce unnecessary public spending. MSAs can also encourage people who have not been covered earlier to join the health insurance pool (Insurance Institute of India, 2000).

3. Community Health Insurance (CHI)

CHI is a non-profit insurance scheme and it's aimed at the informal sector. This scheme was formed on the basis of a collective pooling of health risks. The main strengths of the CHIs are that they have been able to reach out to the weaker sections of society and have been able to provide some form of health

security. This insurance includes mutual health organizations, local health insurances and micro health insurances. There are 3 models of CHIs in the country. The oldest type is the 'direct' model, where a hospital has initiated a health insurance product. The hospital is both the provider of care as well as the insurer. The second type is the 'mutual' model, where the NGO organizes and implements the insurance scheme and purchases care from various providers. And thirdly is the 'linked' model, where the NGO collects premium from the community and purchases insurance from a formal insurance company and healthcare from providers. The membership to these CHIs varies from 1000+ to more than 2 million. Most of these schemes operate in rural areas and cover people from the informal sector. Enrolment is usually facilitated by membership organizations, e.g. micro finance groups, cooperatives, trade unions. The premium ranges from Rs 20 to Rs 60 per individual per year. Only three schemes had premiums larger than Rs 100. In most of the schemes, the unit of enrolment is the individual and membership is voluntary (Shortt, 2002).

There are various risks involved in the health insurance programme:

- ***Improper selection:*** In a health insurance programme, normally both the healthy and sick would enroll. However, any health insurance programme is poorly structured then there is a chance that the sick will enroll in larger numbers as compared to the healthy. Thus the programme becomes unviable as the outflow exceeds the inflow.
- ***Risk selection*****:** This occurs only when insurance companies wrongly select low-risk individuals and reject the high-risk individuals.
- ***Moral hazard:*** This takes place when the fact of being insured changes the behaviour of the patient or the provider. In India, it is found that the hospitals tend to charges the higher bills for an insured patient. This is called supply side moral hazard. In the demand side moral hazard, the patient tends to demand more care, or indulges in risky behaviour, because he is insured.
- ***Lack of funds:*** Some of the health insurance companies closed because the government does not provide subsidies for health insurance.

India has the broad spectrum of social, private and community health insurance but the entry in each of these is very less. The reasons are various like low awareness among people, low quality healthcare, poor designs, unsatisfactory products and inefficient administration of the scheme. There is need to take some steps and these shortcomings need to be addressed so that every poor or rich, urban or rural person should take advantage health insurance scheme.

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