ABSTRACT

From literature reviews and secondary research, it has been found out that social security schemes are not proven to be successful in India. The covered population and accessibility to social security schemes are still at a very low level as the studies reveal. Social security is primarily a social insurance program providing social protection, or protection against socially recognized conditions, including poverty, health care, old age, disability, unemployment and others. Government of India has been trying to improvise social security schemes through various legislations and acts like; Employees' Provident Fund and Miscellaneous Provisions Act 1952, Employees State Insurance Act 1948, Maternity Benefit Act 1971, Workmen Compensation Act 1923, Payment of Gratuity Act 1971 etc. In the recent times, more thrust has been given to the social health care insurance schemes. From the literature review and secondary research, it has been noted that health care support in the form of an insurance scheme is very much pivotal to the success of any type of social security schemes. This study has concentrated on evaluating the success rate of various health insurance schemes introduced as a part of social security schemes and finding out the gaps and demands if any, from the primary and secondary sources of research.

As things stand, currently in India, private healthcare expenditure amounts to around 4.2 percent of the GDP, making India one of the highest ranking countries in terms of private expenditure on health. Out of this, health
insurance accounts for only 5-10% of expenditure, employers around 9% and personal expenditure amounts to an astounding 82%. This shows there is a huge gap in health care sector and the present study tries to correlate the health care expenditure and health care consumption with health insurance schemes administered as a part of the universal social security schemes.

This study focuses on urban poor population of Chennai and Cochin. With the rapid urbanisation and marginalisation of urban poor, the intended focus has been to find out the impact of social security schemes and how health care and consumption pattern influence the utility and in turn rate the success of existing health insurance schemes. In the course of the study, a survey was conducted in Chennai slums and the results were analysed. The study shows that health care is given priority under various social security schemes. The insured have perception about the health care provisions offered by both public and private entities that influences their decision making processes while they suffer from ailments. The choice for health care provisions is there but the choice for health insurance schemes under social security is limited. This finding has led to a focused study on Rashtriya Swasti Bhima Yojana (RSBY). Stake holder and cost benefit analyses have suggested the need for customising or designing the health insurance policies at the regional level instead of applying it universally. Surveys and interviews with the stake holders including the administered hospitals for RSBY scheme shows that the urban poor looks for support in primary health care system. This also demands for innovative health insurance policies at the regional
level taking the health care provisions into consideration. The study suggests policy reforms to bridge the gaps existing in the present system.

The World Bank prescribes four major tools for analysing the existing policy by in which reforms can be suggested. They are 1) stake holder analysis 2) political mapping 3) network analysis and 4) transaction cost analysis. In the context of this study stake holder analysis, network analysis and transaction cost analysis are used. Political mapping is not considered as it is beyond the scope of this study. The study has been carried out in three phases and the framework analysis of the results suggests the alternatives to improve the social security through health insurance schemes.

Findings suggest the creation of health circles like in telecom sector for the wider reach out and penetration for the health insurance sector in India. Periodic updating of the patients registry shall be prepared. Not fringing into the privacy of the patients’ case history, numbers reflecting the various types of ailments and diseases at the local, regional and national level shall be set up. This alone cannot be a Government’s responsibility but a better policy facilitating the level playing field for investors in health sector can mandate the collection of such data by both private and public institutions in the longer run. Like in the financial markets, rating and grading of various health infrastructures, quality of the skilled man power available with the health sector, treatment fees for different ailments in different health providers and so on can be complementary to the data base of the patients. This would help a transparent mechanism to evolve and a better business
opportunity for the investors. In the net effect, Government can monitor and regulate the sector in an efficient manner and the needy will get the provisions at a cheaper and available distance. A policy to ensure participation of private players can lead to a variety of health insurance products in the market that are available at an affordable price for different needs. Such a healthy competition amongst the health insurance providers within a circle may be able to check the quality of the health care provided. Adverse selection, moral hazard and cream skimming can be dealt diligently by the health insurance providers as a result of such a policy. Other suggestions include the creation of a government body specifically for health insurance regulations and practices. The State would be able to fund and incentivise the health insurance providers and health care providers on a priority basis leading to an overall improvement of health indicators for the country.