CHAPTER 2

LITERATURE REVIEW

2.1 GENERAL

There are different definitions and approaches to social security which are subject to debate (Prabhu 2001). There is an argument that typically the evolution of social insurance is from social assistance first (including the ‘Poor Law’ in much of Europe) to social insurance later. Social security has been most widely defined by de Swaan in terms of ‘collective remedies against adversity and deficiency’ (de Swaan 1988). This is close to the Dreze and Sen distinction between protection (preventing decline in living standards or adversity) and promotion (enhancing general living standards or counteracting deficiency) (Dreze and Sen 1989). Kannan (2007) argues that both forms of approached are required for countries like India. There is an argument that promotion measures, such as food distribution, land distribution, employment guarantees, micro-credit provision, primary health and primary education should come first (Osmani 1988).

Emmett (2002) based on the empirical study conducted by Rand Corporation reports that cost sharing for the insured reduced the number of episodes of treatment of all kinds compared to free care. This can be attributed as a check in mechanism by health insurance provider and by health care provider though this would not have had any negative externalities.
Sen (1999) takes a very broad definition of social security and makes it equivalent to all policies that promote and protect living standards. Drèze and Sen (1991) as well as Burgess and Stern (1991) distinguish two aspects of social security, which they define as the use of social means to prevent deprivation (promote living standards) and vulnerability to deprivation (protect against falling living standards).

According to Wouter van Ginneken (2003) there are three principal ways to extend social security.

- Through efforts to extend statutory social insurance.
- Extend coverage through community-based schemes.
- The main advantage of community-based schemes are; they improve health expenditure efficiency or the relation between quality and cost of health services and extend social security is through the promotion of cost-effective tax financed social benefits.

In the seminal paper ‘Extending coverage in multi pillar pension systems: constraints and hypotheses, preliminary evidence and future research agenda’, Robert Holzmann et al (2000) validates the hypothesis; The strongest motivation to regularly contribute to a second – pillar retirement account is not income security in old age, but rather to gain access to health insurance and better health care.

Surveys of the informally employed, as per Holzmaan, showed a greater demand for formal health insurance above all other forms of insurance including retirement. The greater demand for health coverage is not surprising since the returns from a worker’s investment in health insurance are usually enjoyed over his/her lifetime, while those from formal social security and
pensions are only enjoyed in old age. All other things are equal, the tighter access to health coverage (or disability) is bundled together with the pensions system, the more attractive regular participation will be.

In the essay Family Health protection Plans for India, Prasanta et al (2003) discusses various parameters that influence the success of any insurance plan. Especially in the case of health insurance, parameters like large enough insurance pool and extremely low probability of a catastrophic loss to the insurance pool are vital elements in the scheme of events while premiums are decided. Prasanta argues that there shall be large enough insurance pool so that the insurer find the large enough pool to allow for predictive accuracy of adverse events and lose incidence. Each insured’s mathematically fair share of losses and expenses is based on the expected probability of loss for the risk class in which the exposure is placed. Subsidisation occurs if each insured does not pay the mathematically fair price for insurance. If significant subsidisation occurs, the result would be so unfair to insured so it would create either an incentive to switch insurers or forgo the insurance. In the case of health insurance, there are accidental and beyond the insured’s control events that results wear and tear uninsured (Dorfman 2001). When the losses produce no regret for the insured, claims can go up that would not do good for the insurer. Dorfman remarks that in the case of any insurable event, the detrimental factor for the sustenance of any insurance scheme can be found out from the kind of loss that would have been envisaged for that particular insurance coverage.

Prabhu (2001) cites a shift in the connotation of the term social security from the prevention of a sharp decline in income stressed in the ILO definition to the tackling of persistently low incomes in subsequent formulations. The distinction can also be seen in terms of the fact that the ILO definition seeks to prevent deprivation whereas Dreze and Sen’s definition is
aimed at protecting against vulnerability to deprivation (Rodgers 1995). The conceptual difference between the two definitions is maintained in the literature by naming the former set of measures ‘protective’ or ‘formal social security’ and the latter ‘promotional social security’. The promotional category is rather broad and comprises several measures aimed at improving endowments, exchange entitlements, real incomes and social consumption (Guhan 1994). A package containing both protective and promotional measures is often referred to as the wider concept of social security.

Insurance should be purchased when losses are large and uncertain but this would be a risk factor to be assessed in the health insurance sector. Borch (1990) address the issues of adverse selection and moral hazard in his seminal essay; Economics of Insurance. According to Borch, there are at least two elements which can make a risk uninsurable; adverse selection and moral hazard. The problem of adverse selection occurs if it is impossible or prohibitively expensive to examine each risk and set the correct premium. Its flip side is ‘Cream Skimming’, commonly observed in health insurance field where the insurer uses various non premium mechanisms to increase the proportion to low risk persons in the larger pool. Doherty (1984) defines moral hazard is present if the insurance policy might itself change the incentives and therefore the probabilities upon which the insurer is relied. Most of the times, the cause is the departure from the standards of conduct acceptable to the society, which in turn increases the likelihood of losses to the insurer.

Reddy (2003) discusses the remedies for adverse selection and moral hazard issues; for the adverse selection, she recommends; 1) no claim bonus in the case of any false information found out at later stages 2) risk rating based in homogeneity of classes, reliability, incentive values and social acceptability 3) mandatory insurance coverage for all thus reducing the risk
elements. To tackle moral hazard, the recommendations include; 1) co-payment by the insured and insurer 2) financial engineering under less than ideal condition by the insurer.

According to Patricia (2003), more than a third of the world population lives under extreme conditions of poverty and deprivation. These are typically people found in remote areas with difficult access to markets and institutions, not educated, with poor health, employed in jobs with little security and with inadequate access to productive assets. Such characteristics make the poor vulnerable to shocks caused by life cycle changes, economic reforms and other types of events such as illness or bad weather conditions. The vulnerability of the poor to socio-economic shocks can be reduced by policies that protect their livelihoods, increase their human capital and assist them in times of crises. However, despite the need for social security policies, it is not immediately clear that developing countries are able to implement programmes of social security. Patricia argues that adequate social security policies can be an important endogenous factor in the process of socio-political development and economic growth of developing economies.

The role of social security policies in developing countries must, consequently, be extended not only to that of a ‘safety-net’, but, more importantly, to ‘prevention’ against increases in deprivation and the ‘promotion’ of better chances of individual development (Guhan 1994). In this sense, social protection policies would not only address negative outcomes of development but would also promote more equal opportunities amongst all population groups, thereby reducing the likelihood of negative outcomes. The focus of social security policies in developing countries should thus be on the reduction and mitigation of structural forms of vulnerability and on the implementation of ways of coping with all types of risk (Norton et al 2001, Kabeer 2002) and be integrated within the overall development
strategy of the country rather than implemented as individual programmes (Kabeer 2002).

National Health Policy (NHP 2002) states the major challenges in the sector as;

1. Financial resources to support health mission.
2. Equity for the citizens to access and avail the health services.
3. Relatively slow pace of success in national health programmes.
5. Extension of public health services.
6. Role of local self governments and community organisations.
7. Norms for health care professionals.
8. Educational avenues for health care professionals.
9. Health research and investment in research and technology.
10. Role of private sector.

NHP clearly states the need for robust health statistics required to attain the goals at the national level. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need to establish, in a longer time-frame, baseline estimates for non-communicable diseases, like Cardio Vascular Diseases, Cancer, Diabetes; and accidental injuries, and communicable diseases, like Hepatitis. NHP-2002 envisages that, with access to such reliable data on the incidence of various diseases, the public health system would move closer to the objective of evidence-based policy-making.
Madhavarao (2006) narrates different social security approaches by scholars; Getubig for instance defines social security for the developing countries as “any kind of collective measure or activities designed to ensure that members of the society meet their basic needs. As well as being protected from contingencies to enable them to maintain a standard of living consistent with social norms” Dreze and Sen distinguish two aspects of social security, which they define as the use of social means to prevent deprivation and vulnerability to deprivation.

Dror (2001) in his paper ‘Re-insurance of health insurance for the informal sector’ finds that most Indians are willing to pay 1.35 per cent of income or more for health insurance and most people prefer a holistic benefit package at basic coverage over high coverage of only rare events. The needs of the poor, and their demand for health insurance, depend on local conditions. Dror talks about health insurance for the poor: myths and realities in India. His analysis is based on the largest comparative survey conducted in 2005. Based on the survey, he offers evidence to show why the commonly held opinions are in fact myths. According to Dror, the willingness to pay levels is much higher than what has been assumed as feasible. Consequently, the demand for pro poor and pro rural health insurance at realistic premiums exceeds the supply available at present (read as then here). Health insurers and policy makers that aim to grant to poor households effective financial protection against the cost of illness would wish to ensure that the benefit packages should include drugs, tests and consultations, in addition to hospitalisations. Intra household information sharing, resource-and-asset sharing and demographic balancing within can lower the prevalence of illness in households. Additionally, en bloc affiliation of households can lower the risk of adverse selection. Ignoring household features when calculating the premiums could result in premiums that are unjustified by the insured risk. To sum up the findings, Dror demonstrates that the poor can participate actively in the design of the health insurance packages, and they make judicious
choices. As a result, the role of communities have to be redefined as the insurance policies have to respond to the context specific needs, costs, and willingness to pay level.

Fraser (2007) analyses various social security schemes existing in the formal and informal sector as his analysis is reproduced here;

a) For the Formal Sector

A variety of schemes exist for protective social security. I will mention two established ones and one new one:

1. Provident Funds, instituted by an Act of 1952. In 2000 19 per cent of workers in India had provident fund membership. These are compulsory savings schemes providing a lump-sum payment, retirement pensions and death benefits. There are prescribed contributions from workers (12 per cent) and employers (13.61 per cent) and a defined interest rate (8.5 per cent) which its investments cannot make in full.

2. Employees’ State Insurance Scheme. This provides medical benefits (in particular) to formal sector workers in Employment State Insurance (ESI) hospitals.

3. The New Pension Scheme under the Pension Fund Regulatory and Development Authority, 2005. This is a funded pension, especially for new government employees. It can be used by other employees but it is doubtful that it will attract many.

b) For the Informal Sector

A social security mechanism which mainly assists unorganised workers in certain occupations is the provision of welfare funds. These are
financed by earmarked taxes, eg. the Beedi (cigarette) Workers Welfare Fund is financed by a tax on beedis. This gets round problems of getting the employers to contribute. They fund a range of benefits. This method has been pursued much further by the State Government of Kerala which has more than 30 funds for different categories of workers providing pensions, etc.

In recent times, there are initiatives at the national level, which include;

1. National Social Security Scheme for unorganised sector workers, 2004. This was a pilot project in 50 selected districts based on mobilising contributions from workers. National Commission for Enterprises in the Unorganized Sector (NCEUS) report that in 2004 it had an enrolment of only 3,500 workers and was virtually closed, with no contribution from employers.

2. The Universal Health Insurance Scheme, 2003. The potential demand for health insurance is very great, given that there is a lot of out-of-pocket spending for health care by all income groups. There were 10 million members in 2005-6, helped by a government subsidy, but then the government decided it should target poor households only, negating the ‘universal’ claim. A big problem is the poor state of the public health system where benefits might have to be spent.

3. A contributory life insurance scheme, JanaShree Bima Yojna (JSBY), started by the government and a public sector insurance company, had 6.3 million members in 2005-6. Enrolment is much of it through NGOs and micro-credit organisations, which is seen as a positive feature.
He discusses that the absence of employment benefits (protection against arbitrary dismissal and accidents at work) and social security benefits (health care benefits, pension) are crucial in the definition of unorganised employment. In 2004-05, 86 per cent of total workers were in the unorganised sector (395 million out of 458 million). Of the 395 million unorganised sector workers 253 million were in agriculture and 142 million outside agriculture. And 92 per cent of total workers are unorganised workers, counting in informal workers in the organised sector. That leaves only 35 million out of 458 million total workers as organised workers. Furthermore all the increase in employment between 1999-2000 and 2004-5 was informal.

National Commission for Enterprises in the Unorganised Sector (NCEUS 2005) refers to ‘a high congruence between unorganised work and poverty’ – although their figures do not make the congruence all that strong. The total of workers and dependents with an income below $2 per person per day in purchasing power parity terms was, according to NCEUS for 2004-05, 836 million people, 77 per cent of the Indian population. The remaining 23 per cent 254 million people are the middle and high income group – the ones who have enjoyed most of the growth in India’s boom economy. Of unorganised workers 79 per cent are poor by the same definition, which leaves 21 per cent of unorganised workers as middle and high income – successful self-employed and workers in small businesses who still do not have social security.

The proliferating micro-credit organisations, (mainly) women’s self-help groups, are now seen as a major way to spread life and health insurance in the unorganised sector.

In the Government Health Expenditure in India: A Benchmark Study, Economic Research Foundation (2006) discusses the burden on citizens in healthcare domain. The burden is particularly high because, even
as households bear the brunt of aggregate health spending in the country, systems of affordable health insurance are non-existent or poorly developed. The employers (both public and private) account for relatively little in terms of spending on health, and in any case with more than 90 per cent of Indian workers having “informal” or unorganised status, there are few possibilities of ensuring that employers bear at least part of the costs of medical treatment. Therefore instances of accident or severe illness requiring hospitalisation have drastic effects upon the households of the affected persons, even among poor households.

This is equally true of urban and rural households but the effects may be particularly sharp among the rural population because of the relative paucity of any publicly provided treatment.

![Figure 2.1 Health spending as per cent of household consumption expenditure, 1993-94 to 2004-05](Source: NSSO Surveys of consumption expenditure, 50th, 55th and 61st Rounds)
Sujatha (2007) discussed five features that characterize the health insurance system in India:

1. By and large, the system offers traditional indemnity, under which the insured first pay the amount and then seek reimbursement. Under indemnity, all known diseases or health conditions are excluded and therefore such policies typically have a large number of exclusions.

This also means that those most in need of insurance, i.e. the sick, get excluded for any financial risk protection against the diseases they are suffering from.

2. It is a fee-for-service-based payment system. Such a system of payment is advantageous for the provider since he bears no risk for the prices he can charge for services rendered by him. Combined with the asymmetry in information, such a system usually entails increased costs.

3. Policies provide a ceiling of the assured sum. Such a system, and that too within a fee-for-service payment system, results in short changing the insured as he gets less value for money, as the provider and the insurer have no obligations to provide quality care and/or over provide/over charge services so long as the amounts are within the assured amount of the insurance policy.

4. The system is based on risk-rated premiums. This again puts the risk on the insured as the premium is fixed in accordance with the health status and age. Under such a system, women in the reproductive age group, the old, the poor and the ill get to pay higher amounts and are discriminated against.
5. The system is voluntary, making it difficult to form viable risk pools for keeping premiums low

According to Approaches to Social Security in India by Ministry of Labour and Employment (2008), the term social security is generally used in its broadest sense, it may consist of all types of measures preventive, promotional and protective as the case may be. The measures may be statutory, public or private. The term encompasses social insurance, social assistance, social protection, social safety net and other steps involved.

In the primer to How Private Health Coverage Works (2008), the leading health policy research organisation, Kaiser Foundation describes health coverage as a mechanism for people to 1) protect themselves from the potentially extreme financial care if they become severely ill and 2) ensure that they have access to health care when they need it. Private health coverage products pool the risk of high health care costs across a large number of people, permitting them to pay a premium based on the average cost of medical care for the group of people. This risk spreading function make the cost of health care reasonably affordable for most people. Health insurance policy is the contract between the health insuring organisation and the policy holder. In United States, health coverage providers use underwriting to maintain a predictable and stable level of risk within their risk pools and to set terms of coverage for people of different risks within a risk pool. Underwriting is the process of determining whether or not to accept an applicant for coverage and determining what the terms of coverage will be, including the premium.

Tanner (2008) analyses National health care systems around the world and arrives at the following conclusions;
1. Health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have long waiting lists for treatment.

2. Rising health care costs are not a unique phenomenon. Even in the countries spend less, both as percentage of GDP and per capita, costs are rising almost everywhere, leading to budget deficits, tax increases and benefit reductions.

3. In countries weighed heavily toward government control, people are most likely to face waiting lists, rationing, restrictions on physicians’ choice and other obstacles to care.

4. Countries with more effective national health care systems are successful to the degree that they incorporate market mechanisms such as competition, cost sharing, market prices, and consumer choice, and eschew centralised government control.

According to The Unorganised Workers’ Social Security Act, 2008, the workers in unorganised sector will be covered by social security schemes that:

The Central Government shall formulate and notify, from time to time, suitable welfare schemes for unorganised workers on matters relating to

a. life and disability cover;

b. health and maternity benefits;

c. old age protection; and

d. any other benefits that may be decided by the Central Government

It also mentions that upon registration, every worker will be entitled to a floor level scheme to be funded by the Union Government directly or through cess or through contribution or through any other means.
The floor level schemes shall include

1. Without worker contribution – covering life, health and permanent disability, insurance and maternity benefits, and

2. With worker contribution – old age benefit, including pensions.

In the Report to the People on Health by Government of India (2010) progress made in the health sector is examined and identifies the constraints in providing universal access and provides options and future strategies. In terms of life expectancy, child survival and maternal mortality, India’s performance has improved steadily. Life expectancy is now 63.5 years, infant mortality rate is now 53 per 1000 live births, maternal mortality ratio is down to 254 per lakh live births and total fertility rate has declined to 2.6. However there are wide divergences in the achievements across states. There are also inequities based on rural urban divides, gender imbalances and caste patterns. The current policy shift is towards addressing inequities, though a special focus on inaccessible and difficult areas and poor performing districts. This requires also improving the Health Management Information System, an expansion of NGO participation, a greater engagement with the private sector to harness their resources for public health goals, and a greater emphasis on the role of the public sector in the social protection for the poor.

2.2 BURDEN OF DISEASE-INDIA

India has 16 per cent of total world population and 21 per cent of global disease burden. Major reasons for mortality in India in 2004 were non communicable diseases (50.4 per cent), communicable diseases including nutrituous and prenatal problems (39.0 per cent) and other causes (10.8 per cent). India ranks first in the world in diabetes prevalence followed only by China. In India, more than half of the total deaths are attributed to non
communicable diseases including diabetes which in turn is posing a serious threat to country’s health systems; that are already fighting with unfinished agenda of infectious diseases. India had the” highest loss in potentially productive years of life lost” in 2004, according to a Canada based think tank (Taylor 2010). In the same year, deaths due to non communicable diseases were twice that of from infectious diseases. Similarly, out of pocket expenditure for non communicable disease management in India was around 1.9 billion U.S dollars, which was 3.3 per cent of country’s GDP for that year. (Taylor 2010) Urbanization, westernization, and socio-economic development contribute substantially to the rise of such disease. Major risk factors for incidence of NCD include smoking, alcohol abuse, a sedentary lifestyle, and unhealthy dietary habits. It is important to note that 40-50 per cent of non-communicable diseases resulting in early death are preventable.

Communicable diseases is still persistent with even more resistant varieties of vectors causing malaria, TB, HIV in addition to rising chronic conditions. Nearly 40 per cent of the Indian population of all ages has Mycobacterium tuberculosis infection and at any given time 85 lakh people with TB resides in India. (WHO 2005) Death and disease registries are not up to standards and around 6.4 million deaths per year, only less than .4 million is registered which will ultimately skew different related disease burden statistics.

2.3 HEALTH CARE SECTOR IN INDIA

2.3.1 Health Care Delivery System

Health care delivery system in India consists of private, public and mixed ownership institutions. The government sector or the public sector includes medical colleges, district hospitals, primary health centers, community health centers and tertiary care hospitals. While the Central
Government is limited to certain programs like family welfare and disease control, the state governments are responsible for primary and secondary medical care. They are also in some extend responsible for specialty care in the state. All these institutions work on a no or minimal fee basis and are intended for people who cannot afford to pay for their health care needs. But in reality even the most poor in India prefer private care rather than government facilities in spite of huge out of pocket expenses in private hospitals. According to a UK based study on health care spending in India, it was found that there is not much difference in spending in private health care sector between poor and non poor people in the country. Around 69 per cent of poor people’s health care expenditure is on private health care facilities compared to 75 per cent of non poor. (Berg and Ramachandra, 2010)

Reasons for not relying on public hospitals include huge disparities in the standard of care, lack of proper infra structure, outdated equipments and unclean environments. Most government institutions are way below quality expectations of a normal hospital in India and this, when combined with corruption make government hospitals and health centres score very low in customer satisfaction. But one cannot deny the fact that they are a great help for the absolute poor in the country though not very high tech in nature.

The private sector hospitals have more perceived quality than public hospitals by the general population, which to a greater extend is true. Most hospitals are equipped with skilled staff, modern technology and imported machineries. Reduction of import duties and loosening of regulations helped in proliferation of quality private hospitals in the country in the last two decades. Now, India has such private hospitals that have all the facilities and quality of care comparable to any state of the art hospitals in the developed countries. Even though everything is available here in the country, majority of its citizens cannot access such high quality services due to
unthinkably high healthcare costs. This is especially true for the marginalized and unprivileged in the society. Again, private health sector also has varying degree of quality of care as it operates in an unregulated market.

Most people in India go to government hospitals not out of choice, but out of compulsion due to poverty and huge health care costs in the private sector. Non compliance to medical advice due to unbearable costs is another reason for increased morbidity and mortality since health insurance is not common at all. People have to pay the bills from their own pockets. Affordable and accessible healthcare programs are to be developed immediately to tackle this burgeoning problem in India.

2.4 HEALTH CARE ACCESS IN INDIA

Health care access is found to be significantly reduced for poor quintile of population in India. Unequal geographic distribution of health care facilities, socioeconomic conditions and existing gender norms all play an important role in significantly reduced access to health care especially by poor rural population. A person from the poorest quintile of the population is six times less likely to access health care facilities than a person from the richest quintile in India. Also skilled birth attendance at the time of delivery is six time more for women in rich quintile that the poor quintile of population. Geographic location of health care facilities and reduced transportation services affect access to care. This scenario is exacerbated by reduction in governmental health spending and high cost for health care services in private sector. The inequality in health care services between public and private sector and economic constrains are found to affect health of the poor sector of population which constitutes majority of India. Corruption in governmental health facilities, out of pocket expenditures and lack of insurance also affects utilization and access of care by needy people (Milind 2004).
2.5 HEALTHCARE FINANCING

In India, healthcare is financed through general tax revenue, community financing, out of pocket payments and social and private health insurance schemes. Twenty four percent of all hospitalized persons are pushed below poverty line in India due to huge healthcare bills in a single year (World Bank 2002). In 2004, around 6.2 per cent of household fell below poverty line as a result of huge health care costs. Among this, 1.3 per cent as a result of inpatient care and the rest 4.9 per cent due to outpatient care. Out of pocket payments, still the major health care financing system in India is responsible for such financial strain and bankruptcy that is especially affecting the lower and middle class population.

2.6 HISTORY OF HEALTH INSURANCE IN INDIA

Insurance industry in India has a history dating back to 18th century when Oriental Life Insurance Company was first started in 1818 in Kolkata. After that many insurance companies were founded. In 1912, the Life Insurance Companies Act and the Provident Fund Act were passed as a measure to regulate the insurance industry in India. Health insurance was introduced in India in this year. In 1972, the Parliament passed the General Insurance Business (Nationalization) Act which brought 107 insurers under one umbrella of General Insurance Cooperation with four subsidiary companies namely National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd and the United India Insurance Company Ltd. The General Insurance commenced its business on January 1st 1973. Again, the enactment of the Insurance Regulatory Development Act in 1999 facilitated the entry of private and foreign health insurance players into the Indian market.
2.7 HEALTH INSURANCE MARKET IN INDIA

Health care financing plays a major role in improving access to quality health care and improving health care delivery systems both in developed and developing countries. But even today, the penetration of health insurance market in India is very limited covering about 10 per cent of the total population. But data indicates than the health insurance industry is growing much faster than the average industry growth. According to IRDA Annual Report, 2007-2008, the premium collected from health insurance has been increased from Rs 4,894 crore to Rs 6,088 crore in 2008-09. (Chawla 2010) The industry is recognizing the growth potential and is concentrating on more of getting volume than depth to increase profitability. The schemes currently available in India can be categorized into the following:

1. **Voluntary health insurance schemes or private-for-profit schemes**

   Major Players in Public sector: General Insurance cooperation; 4 subsidiaries- National Insurance cooperation, New India assurance company, United Insurance , Life Insurance Corporation (LIC)

   Private sector: Bajaj Allianz, ICICI Lombard, Royal Sundaram, Cholamandalam General Insurance, TATA AIG (IRDA website)

2. **Employer-based schemes**

   These schemes are offered through employer managed facilities. Both private and public employers offer employer based schemes. Railways, defence and security forces, plantations, mining sector are covered by this type of policies. But coverage is minimal, only about 30 to 40 million people.
3. **Insurance offered by NGOs / community based health insurance**

   Community based health insurance schemes are mainly targeting the poor population in bypassing unexpected health care costs. Such schemes aim to protect poor from indebtedness by prepayment of a small premium rather than borrowing money. These schemes mainly operate through Non Governmental Organizations.

4. **Mandatory health insurance schemes or government run schemes (ESIS, CGHS)**

   Most of the above mentioned schemes and health insurance policies cater to middle and above middle class population in India and there are not many takers for absolute poor in the country. Either their employers do not give health insurance or simply cannot afford monthly insurance premiums. Even if some community or faith based institutions offer health insurance for poor people in the country, they are not enough to cover the entire BPL population in the country.

   Though government has implementing different insurance schemes catering to different sectors of population such as agricultural workers and marginalized women, it is not considered very successful so far. In order to provide quality medical access to the most vulnerable absolute poor population in the society, various schemes have been launched by both State and Federal governments. One such scheme is the UHIS from Central Government in 2003.

5. **Universal health Insurance Scheme**

   Central Government launched the Universal health Insurance Scheme in 2003 with the intention of covering low income population in the
country. The term ‘universal’ is misleading as it only meant low income people in India. Though it was intended for all low income individuals initially, the scheme ultimately was made available only to people who were identified as people below poverty line (BPL) as per the Planning Commission recommendations. The insurance is provided by four public companies and the benefits package offered include Rs 30,000 per year per family or 15,000 per individual per year. It also includes accident benefits and loss of wages benefit on daily basis. High subsidies in insurance premium were offered by Government of India. The scheme was operated through third party administrators or TPAs, which are independent agencies to coordinate between the various hospitals, customers and insurance agencies. (Nandraj et al 2006). The premium for joining the universal health insurance scheme is listed in Tables 2.1 and 2.2.

Table 2.1 Premium rates for universal health insurance scheme

<table>
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<th>Target population: BPL families in India</th>
<th>Total premium for joining the scheme</th>
<th>Payable by insured</th>
<th>From Government subsidy</th>
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<tr>
<td>For an individual</td>
<td>Rs 365</td>
<td>Rs 165</td>
<td>Rs 200</td>
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<tr>
<td>For a family of 5</td>
<td>Rs 548</td>
<td>Rs 248</td>
<td>Rs 300</td>
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<tr>
<td>For a family of 7</td>
<td>Rs 730</td>
<td>Rs 330</td>
<td>Rs 400</td>
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Source: (Nandraj et al 2006)

Table 2.2 Scheme performance and enrolment rates

<table>
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<tr>
<td>Number of families covered</td>
<td>65,718</td>
<td>45,118</td>
</tr>
<tr>
<td>Number of individuals covered</td>
<td>1, 82,641</td>
<td>1, 49,442</td>
</tr>
<tr>
<td>Claims ratio</td>
<td>---</td>
<td>12 per cent</td>
</tr>
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Source: WHO India 2006
In spite of low premium rates and coverage benefits, the scheme was faced with low enrolment rates and had a very low claim ratio in the end of the year 2006, which was only 12 per cent. Only 9252 families enrolled in the first year. In order to raise the enrolment in the scheme, the government increased the subsidy share and reduced premium rates to Rs.165 for an individual, 248 for a family of 5 and 330 for a family of 7. This move from the government’s part increased enrolment to a great extent but still there are limitations noted in coverage and execution. The government failed to exploit the insurance market by allowing only the public ones to supply insurance schemes. Also there was no flexibility in schemes offered and the insurance companies were not allowed to fit schemes to beneficiary’s needs. This seriously affected the enrolment rates for the scheme. Another problem faced by the scheme was the lack of proper infrastructure and weak health system delivery. Insured people were unable to access quality care due to the lack of proper health infrastructure nearby. (Ahuja, 2006) This scheme also lacked a nodal agency which the Central or Sate Government can use to tap large number of beneficiaries.

The Government of India, after realizing that the UHIS is not as successful as desired, launched Rashtriya Swasthya Bima Yojna (RSBY) in 2008. After incorporating various lessons from similar schemes from the past and recommendations from various stake holders, professional think tanks and International organizations, policy makers came up with an exciting new scheme loaded with technology which targeted the absolute poor in the country.

Sujatha (2007) cites the following reasons for poor penetration of health insurance.
1. Lack of regulations and control on provider behaviour

The unregulated environment and a near total absence of any form of control over providers regarding quality, cost or data-sharing, makes it difficult for proper underwriting and actuarial premium setting. This puts the entire risk on the insurer as there could be the problems of moral hazard and induced demand. Most insurance companies are therefore wary about selling health insurance as they do not have the data, the expertise and the power to regulate the providers. Weak monitoring systems for checking fraud or manipulation by clients and providers, add to the problem.

2. Unaffordable premiums and high claim ratio

Increased use of services and high claim ratios only result in higher premiums. The insurance agencies in the face of poor information also tend to overestimate the risk and fix high premiums. Besides, the administrative costs are also high—over 30 per cent, i.e. 15 per cent commission to agent; 5.5 per cent administrative fee to TPA; own administrative cost 20 per cent, etc. Patients also experience problems in getting their reimbursements including long delays to partial reimbursements.

3. Reluctance of the health insurance companies to promote their products and lack of innovation

Apart from high claim ratios, the non-exclusivity of health insurance as a product is another reason. In India, an insurance company cannot sell non-life as well as life insurance products. Since insurance against fire or natural disaster or theft is far more profitable, insurance companies tend to compete by adding low incentive such as premium health insurance products to important clients, cross-subsidizing the resultant losses. With a view to get the non-life accounts, insurance companies tend to provide health
insurance cover at unviable premiums. Thus, there is total lack of any effort to promote health insurance through campaigns regarding the benefits of health insurance and lack of innovation to make the policies suitable to the needs of the people.

4. **Too many exclusions and administrative procedures**

Apart from delays in settlement of claims, non-transparent procedures make it difficult for the insured to know about their entitlements, because of which the insurer is able to, on one stratagem or the other, reduce the claim amount, thus de-motivating the insured and deepening mistrust. The benefit package also needs to be modified to suit the needs of the insured. Exclusions go against the logic of covering health risks, though there can be a system where the existing conditions can be excluded for a time period—one or two years but not forever. Besides, the system entails equity implications.

5. **Inadequate supply of services**

There is an acute shortage of supply of services in rural areas. Not only is there non-availability of hospitals for simple surgeries, but several parts of the country have barely one or two hospitals with specialist services. Many centres have no cardiologists or orthopaedicians for several non-communicable diseases that are expensive to treat and can be catastrophic. If we take the number of beds as a proxy for availability of institutional care, the variance is high with Kerala having 26 beds per 1000 population compared with 2.5 in Madhya Pradesh.

6. **Co-variate risks**

High prevalence levels of risks that could affect a majority of the people at the same time could make the enterprise unviable as there would be
no gains in forming large pools. The result could be higher premiums. In India this is an important factor due to the large load of communicable diseases. A study of claims (Bhat 2002) found that 22 per cent of total claims were for communicable diseases.

The proliferating micro-credit organisations, (mainly) women’s self-help groups, are now seen as a major way to spread life and health insurance in the unorganised sector.