COMPARATIVE STUDY OF HEALTH INSURANCE SCHEMES
CHAPTER IV

COMPARATIVE STUDY OF HEALTH INSURANCE SCHEMES

Though the basic purpose of health insurance is cover health related risks, health insurance can exist in different forms. Many forms of health insurance are practiced in India and abroad. This chapter focuses on the details of various forms of health insurance schemes in India and select foreign countries to provide insight about various forms of health insurance coverages. Such insight can help to design new plans for health insurance.

This chapter is classified into two parts. The first part focuses on the various forms of health insurance that exist in India and the second part focuses on the health insurance schemes in select countries.

Section I: Overview of Health Insurance Schemes in India

The various health care programmes presently operating in India can be categorised as follows:

- State-run schemes for formal sector employees;
- Health Insurance Plan offered by Insurance companies
- Corporate sector health care programmes;
- Community and self-financing schemes, primarily for workers outside the formal sector; and
- Micro-credit linked health insurance schemes.

Membership of Various Schemes

The health insurance policyholder figures of various schemes are depicted below
Table 4.1
Health Insurance Coverage in India

<table>
<thead>
<tr>
<th>Schemes</th>
<th>Beneficiaries (in million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Employee State Insurance Scheme (ESIS)</td>
<td>25.3</td>
</tr>
<tr>
<td>Central Government Health Scheme (CGHS)</td>
<td>4.3</td>
</tr>
<tr>
<td>Railway Health Scheme</td>
<td>8</td>
</tr>
<tr>
<td>Defence Employees</td>
<td>6.6</td>
</tr>
<tr>
<td>Ex-servicemen</td>
<td>7.5</td>
</tr>
<tr>
<td>Mining and plantations (public sector)</td>
<td>4</td>
</tr>
<tr>
<td>Health insurance (Public sector non life companies)</td>
<td>10</td>
</tr>
<tr>
<td>Health insurance (Private sector non life companies)</td>
<td>0.8</td>
</tr>
<tr>
<td>Health segment of life insurance companies (public and private sector)</td>
<td>0.23</td>
</tr>
<tr>
<td>State sponsored schemes</td>
<td>&lt;0.5</td>
</tr>
<tr>
<td>Employer run facilities/ reimbursement schemes of private sector</td>
<td>6</td>
</tr>
<tr>
<td>Employer run facilities/ reimbursement schemes of public sector</td>
<td>&lt;8</td>
</tr>
<tr>
<td>Community health schemes</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>~85</td>
</tr>
</tbody>
</table>

State-run schemes for formal sector employees

There are two schemes, the Central Government Health Scheme (CGHS) and the Employees’ State Insurance Scheme (ESIS), sponsored by the central and state governments, respectively, which extend free medical care for both inpatient and outpatient services on co-payment basis to the organised workforce. ESIS also extends cash benefits towards loss of wages due to sickness as well as cash compensation towards permanent physical impairments.

Employees’ State Insurance Scheme

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

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excluded from the ESIS coverage. Any organisation offering benefits as good as or better than the ESIS is obviously excluded from the coverage.

The monthly wage limit for enrolment in the ESIS has been raised from Rs. 3500 to Rs. 6500 and now to Rs.7500. The contribution is paid in the form of a payroll tax of 4 per cent by the employer and 1.4 per cent by the employee. Medical benefits comprise cash payment for sickness, maternity, temporary or permanent disablement, and survivorship and funeral expenses. Expenditure for medical benefits constitutes 70 per cent of the total benefits paid under the ESIS. These medical benefits are provided primarily through hospitals and dispensaries. But there is mismatch between the requirements and infrastructure despite the fact that less than 10 per cent of the country's total workforce is engaged in the organised sector. Hospitals run by ESIC suffer from lots of pitfalls like poor infrastructure, corruption etc. Also there are instances where employers deprive workers through manipulations to avoid coverage of workers under ESIC Act.

Central Government Health Scheme

The scheme, introduced in 1954 as a contributory plan, was aimed at providing 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 nominal but progressive with salary scales (the contribution starts at an amount as low as Rs. 20 per month). Separate dispensaries are maintained for the 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 was 4.2 million in 1997. Besides providing medical services, the CGHS provides reimbursement for out-of-pocket expenditure for availing treatment in government hospitals and approved private facilities. The list of beneficiaries contains all current as well as ex-government employees, including Members of Parliament, Supreme and High Court judges, and Central Government bureaucrats. The CGHS is widely criticised for its quality and accessibility. Though the number of beneficiaries is increasing the actual use of facility is declining due to switching over to private facility. There are plans by the government to hand over CGHS to the hands of private. Though the scope of the CGHS is limited, inefficient functioning of CGHS reveals the lacunae on the part of policymakers and users to plan properly.

If CGHS and ESIS had been good and efficient enough, it could have served as miniature model for spreading health insurance across the country.

**Employer Managed Facilities and Reimbursable Schemes**

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 and the services are provided free of charge. Railways alone provide health care services through 110 hospitals and 665 dispensaries to nearly 8.6 million beneficiaries. An industrial sector that offers similar kinds of services is the mining sector. There are numerous reimbursement plans offered by the employers for private medical expenses. Many private sector companies, in addition to ESIS and other health insurance schemes, reimburse the expenses. There are normally two kinds of reimbursement.
Employers contribute towards a medical grant/fund, which is annually disbursed as medical allowances to their employees.

Employees incurring medical expenses submit their claims to their employer for reimbursement and reimbursements are linked to individual contributions.

Health Insurance Plan offered by Insurance companies

Health Insurance policies, is not a total indemnity policy but covers upto certain extent towards hospital care and domiciliary hospitalisation benefits, which means specified outpatient treatment provided in place of inpatient treatment. Premiums, eligibility, and benefit

Coverage

GIC introduced first health insurance policy during 1980’s in the pre-liberalisation era for public. But during 1990’s, in the light of the cumbersome procedure to reimburse the hospitalisation expenses, certain changes were made in the Mediclaim policy and accordingly, the premia was revised from 1 September 1996. The salient revisions are as follows.

Sum insured was raised from Rs. 83,000 to Rs. 300,000.

Fixation of premium according to the category of hospital/ward was removed, and now it varies according to five age groups, viz. up to 45 years, 46–55 years, 56–65 years, 66–70 years and 71–75 years.

Rate of premium was reduced (and it became 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.
Extending coverage to children between the age of 3 months to 5 years provided one of the parents is concurrently enrolled.

Extending reimbursement of cost of health check-up once at the end of a block of every four underwriting years.

This plan also provides family discount and cumulative bonus. The GIC also floats a 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 GIC, in its efforts to expand coverage, introduced a new policy called Jan Arogya Bima Policy on 15 August 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. In a short span of about six months, about 400,000 individuals (till March 1997) opted for this plan as against 1.6 million under the previous scheme.

The GIC also offers medical benefits and compensation under personal accident policies for individuals and groups. If an injury results in total disablement of the insured and thereby prevents him/her from engaging in any activity or occupation, then 100 per cent of the sum insured is paid. In other cases like irrevocable loss of eyesight, hearing, and different parts of limbs, different percentages of the sum insured are being paid. Bhavishya 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 is reimbursed up to the amount of sum insured. The advantage of this plan is that it assures coverage of all types of conditions from the effective date of benefits.

In 2004, GIC launched Universal Health Insurance scheme at the rate of Re.1 premium per day, this scheme was mainly targeting Below Poverty Line segment. But this scheme also did not fly well. The Government is likely to provide a subsidy of about Rs. 30 crore during the October-March period of the current fiscal under the universal health insurance scheme, it is reported. The scheme, launched in 2003-04 has been modified. As per the scheme, there would be three slabs of subsidy for three different policies. The Government will provide Rs. 200 crore for a policy covering an individual, which has a yearly premium of Rs. 365. The premium for a policy covering five members of a family has been fixed at Rs. 548 and for a seven-member family, it is Rs. 730. The Government has decided to provide a subsidy of Rs. 300 and Rs. 400 respectively for the latter two policies.

**Other Public Sector Health Insurance Schemes**

Unit Trust of India (UTI), 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 years. Anyone in the 18–54 years age group can join the scheme by a one-time investment and his/her spouse can also become eligible for the medical insurance benefits. Now the scheme stands withdrawn.
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. Anyone 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 fixed at 65 years. The benefits can be claimed only once out of four specified diseases. It includes an immediate payment of 50 per cent of the sum assured, waiver of subsequent premiums; subsequently annual payment up to 10 per cent of sum assured till the policy matures or the insured dies, whichever is earlier; the payment of balance 50 per cent of the sum assured and vesting bonuses are on maturity or death, whichever is earlier. The bonus is 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 popular by selling 175,000 polices during 1995–96 with total sum assured of Rs 13.620 million.

Life Insurance companies started floating health insurance riders in the post-liberalisation era, critical illness rider offers health risk coverages, it can no way comparable to the benefits of core health insurance policies. For example, though the policyholder if diagnosed with any of these illnesses listed by the life insurer at any time during the policy term, he would get benefits under the rider, there is a clause that if policyholder is once diagnosed with any one of the illnesses, the rider would terminate. The list of diseases varies from company to company and there are conditions like the policyholder must survive for at least 30 days after the diagnosis. This period of 30 days varies from company to company. Health Insurance policies also have lots of restrictions when compared but the benefits are more. Hence basically, the policyholders should get cleared of all the doubts before taking policy.
Private Sector Health Insurance Schemes

In the lines of Mediclaim policy of GIC, private insurers like Royal Sundaram, Cholamandalam, Reliance General Insurance, IFFCO-TOKIO Marine Insurance, HDFC-Chubb, ICICI-Lombard, TATA AIG has launched policies with similar features and competitive premium rates.

Plans offered through Bancassurance Channels

With the emergence of Bancassurance Channel in India, many insurance companies have started wooing the customers of their banking channel partners by designing a slightly modified health insurance plan. Though exact performance statistics of those schemes are not yet available, these types of plans attract a negligible audience. But it can be promoted in a right manner by proper strategies.

Cancer Insurance Policy

Cancer is a dangerous disease, which requires lot of financial assistance during the time of suffering. Though many life insurance companies have come out with the concept of critical illness insurance riders which also includes cancer, the benefits offered by those riders is different from regular health insurance policies. But it also happens that regular health insurance policy may not be able to cover the cancer disease with specialised attention. Hence Cancer Patients Aids Association (CPAA) came out with policy which mingles the benefits of critical illness insurance rider and regular mediclaim policy even before the liberalisation period.

In 1994, CPAA introduced the Cancer Insurance Policy in collaboration with New India Assurance Company. The policy is available to healthy individuals who have not suffered from cancer in the past. An individual wishing to take this policy
must first undergo a mandatory free check up at one of the CPAA’s Cancer Detection Centres. During the check up, a Physician, a General Surgeon, a Gynaecologist and an E.N.T. Surgeon will screen them. Basic blood tests and a Pap smear test (for women) is performed. If the individual is found to be symptom less as per the screening procedure, they are then enrolled under the scheme of their choice from those listed below. The policy takes effect 30 days from the date of the medical check up. If a pre-cancerous condition is detected, the patient is kept as a follow up case, and enrolled in the scheme after treatment and recovery. In some cases additional tests may be necessary, charges for which are reimbursed for the first check-up. If cancer is detected during the check-up, the policy will not be issued and the premium charge is returned after deducting charges for any extra investigations conducted. The policy has many unique benefits. If the person is subsequently found to be suffering from cancer, reimbursement of expenses for treatment, hospitalisation, investigations related to cancer as specified in the policy document up to the insured amount is made each year against bills submitted until the patient is considered cured or succumbs to the disease. All treatment has to be taken in India and must be allopathic in nature.

The policy also covers a free annual check-up at CPAA facilities. Literature and information about the disease is available to the policyholder. Certificate for 50% tax exemption is provided. A cumulative bonus payable to the policy holder shall be increased by 5% on the sum assured for every year during which the policy has been in force prior to claim but this increase will not exceed 50% of the sum insured. Whenever a claim is submitted, CPAA interacts with the patient on one hand and New India Assurance Company on the other hand to ensure that it is settled quickly.

Since inception, 39 patients have made 147 claims. There is also a corporate policy, which is becoming increasingly popular among companies who make the cover available to their employees. Some 6500 members are participating in the scheme.
including employees from companies such as HDFC, Godrej, TIFR, SICOM, J.B. Boda and Tata Assets. December 2004, we have over 11,750 policyholders and 61 detected cases of whom 39 survive. Almost Rs. 80 lakh has been disbursed against 228 claims so far. There is also similar plan floated by Cancer society of India (CSI).

**Corporate Sector Health Care Programmes**

Major corporate houses, given the limitation of the state-owned and ESIS health care services, have developed their own systems for the benefit of their employees. There are broadly two approaches: the first one can be called as empanelment and second one is direct provision of services. Empanelment refers to the arrangement where the employer develops a panel of private hospitals/clinics and/or group Mediclaim coverage. In the context of the second approach, there are instances of emergency services and dispensaries. Some major corporates like the Hindujas and the Tatas have even developed hospitals as trusts or societies. These hospitals more often than not possess the latest state-of-the-art technology.

Apart from this, there are big corporate hospitals, like the Apollo Hospitals, which are characterised by high quality exhaustive hospital benefits but very little outpatient coverage. The delivery of health care services by such hospitals is obviously extremely expensive and some hospitals, to make the availability of its services more viable, have tied up with major insurance companies.

**Community-based and Self-financing Programmes**

Community and self-generated financing programmes are those usually run by non-governmental organisations (NGOs) or non-profit making organisations. These organisations rely on finances from various sources, including government, donor
agencies, and community and self-generated sources. Workers and families outside the formal sector. The sources of revenue for the programmes can be categorised as:

User fees defined as the payment made by the beneficiaries directly to the health care provider, such as fees for services or prices paid for drugs/immunisation. This mode of financing is not common.

Prepayment/insurance schemes, including payment by members for drugs either at subsidised rate or at cost price.

Commercial schemes for-profit actively run by organisations to finance health care.

Fund raising activities by organisations for financing health care services. In some cases the revenue raised in this manner constitutes more than 5 per cent of the total funds of the organisations.

System of making contributions in kind (such as rice, sorghum, community labour, etc.). This method is not very popular due to difficulty in management.

Other sources of community-based and self-financing include instances like Tribhovandas Foundation providing health care through village milk cooperatives and Amul Union (the milk cooperative organisation) contributing significantly towards health services through putting a cess on milk collection.

The most pertinent point about these schemes is their rural orientation and ability to mobilise resources in a village community. However, most of these schemes have catered to a small section of population with limited health coverage restricted to elementary, preventive, and maternal and child health (MCH) care.
<table>
<thead>
<tr>
<th>Name, Location, year of initiation, nature of scheme and ownership/management</th>
<th>Target population, type of membership, size of enrolled population</th>
<th>Premium</th>
<th>Benefits</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCORD</strong>: Nilgiris, Tamilnadu Established 1991 NGO-intermediated (with GIC as insurer)</td>
<td>Adivasis 6 months-70 years of age. Voluntary individual 4446 out of 13000</td>
<td>Rs. 20 per person per year (scheme subsidises an additional Rs. 2.50)</td>
<td>All hospitalisations to a maximum of Rs. 1500. Covers care at one trust hospital (or others if referral required)</td>
<td>Only two admissions for delivery covered per woman</td>
</tr>
<tr>
<td><strong>KKVS</strong>: Madurai, Tamilnadu, Established 2000, NGO-owed</td>
<td>Women members of self help groups (SHG) and their families, age 12 months -55 years. Excludes those with a history of chronic disease. Voluntary family or individual 5710 out of a general population of 69278</td>
<td>Rs. 150 if the coverage is for a family including the SHG member and at least one other beneficiary and Rs. 100 if coverage is only for the member</td>
<td>Reimbursement of 75% of hospital expenses up to Rs. 10,000 per family per year. Except in an emergency, benefit only for treatment at kadamaikundu Hospital.</td>
<td>Must be an inpatient for at least 48 hours. NO coverage of pre-existing disease nor normal delivery</td>
</tr>
<tr>
<td><strong>Navsarjan Trust</strong>: Patan, Gujarat, Established 1999, discontinued 2000 NGO-Intermediated (with GIC trust)</td>
<td>Dalits (scheduled caste), 5-80 years of age, voluntary individual 574 individuals</td>
<td>Rs. 159 per individual (payment of which was partly subsidised by an external donor)</td>
<td>Hospitalisation to a maximum of Rs. 15000</td>
<td>Normal delivery, pre-existing disease, &gt;1 hospitalisation for newly developed chronic disease, HIV/AIDS and its complications, diseases resulting from drug/ alcohol use</td>
</tr>
<tr>
<td><strong>Seba</strong>: Calcutta, W.Bengal, established 1982, NGO-Intermediated (with GIC as insurer)</td>
<td>Information on characteristics of target population: na Voluntary Family &lt;3000 families (?1993 data)</td>
<td>Rs. 105 per member per annum</td>
<td>Hospitalisation expenses up to Rs. 8000</td>
<td>NA</td>
</tr>
<tr>
<td><strong>SEWA</strong>: Ahmedabad, Gujarat established 1992, NGO-intermediated (with GIC as insurer)</td>
<td>Self employed women and their spouses (ages 19-58 years) Voluntary individuals 92000 of 285000 in target population (2001-2002)</td>
<td>Individual coverage Rs. 20 per annum. Also membership can be paid by fixed deposit</td>
<td>Inpatient costs (private or public hospital) to Rs. 2000. Fixed deposit members receive one-time flat</td>
<td>Normal delivery, pre-existing disease, &gt;1 hospitalisation for newly</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>TF – old: Anand, Gujarat, established 1993-94, discontinued 1999, NGO-owned</th>
<th>Residents of one rural district Voluntary household 16%-20% if the target population of 800,000</th>
<th>Rs. 10 per household per year</th>
<th>Discounts on inpatient care (inversely proportionate to their wealth) as a single trust hospital in the district</th>
<th>People deemed sufficiently wealthy (as adjudged by doctor or social worker) were not provided with benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>TF – New: (Sardar Patel Insurance scheme) Anand, Gujarat established 2001, NGO-Owned</td>
<td>Members if a dairy co-operative depositing at least 300L/year Mandatory Household 113883 households (size of target population: na)</td>
<td>Nominal fee of Rs.1 per household per annum in addition to 3 paise per L of milk deposited (i.e., minimum Rs. 9)</td>
<td>Covers 100% of direct costs of hospitalisation at any of 8 trust hospitals but DOES NOT cover medicines</td>
<td>Costs of special (v. standard) hospital rooms. Heart surgery, cancer, HIV/AIDS, major orthopaedic surgeries, kidney transplants</td>
</tr>
<tr>
<td>WWF: Chennai, Tamil Nadu established 2001-2002, NGO-intermediated (with Royal Sundaram as insurer)</td>
<td>Women members of WWF and their families, voluntary Individual Data not available on enrolled population</td>
<td>Children Rs. 65 per year Adults: &lt;45years, Rs. 125 per yr, &gt; 45 yrs, Rs.175 per yr</td>
<td>Inpatient expenses up to Rs. 7000 per year (maximum Rs. 5000 per claim) Limits: Maternity care Rs. 3000 cataract Rs. 2000, bed charges Rs. 100 per day</td>
<td>NA</td>
</tr>
<tr>
<td>Mallur Milk Co-operative: Karnataka, established 1973, provider owned scheme</td>
<td>7000 in 3 villages</td>
<td>Previously, mandatory enrolment of all members of Mallur Milk Co-operative (? 1997 data). Now, premiums paid from endowment fund, for all community members</td>
<td>Preventive and curative care (entirely free of charge?)</td>
<td>NA</td>
</tr>
<tr>
<td>RAHA: Jashpur, chattisgarh, established 1974, NGO owned</td>
<td>Information characteristics of target population: na Voluntary individual 75000 enrollees (1993 data)</td>
<td>Can be paid in rice</td>
<td>Free outpatient care and after aping an initial entrance fee, members receive free hospital care</td>
<td>NA</td>
</tr>
<tr>
<td>Scheme</td>
<td>Eligibility</td>
<td>Fees</td>
<td>Benefits</td>
<td>Other Details</td>
</tr>
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</tr>
<tr>
<td><strong>Sewagram:</strong> sorghum health scheme wardha, Maharashtra established 1978, provider-owned scheme</td>
<td>For the residents of 40 villages, for a village to be included, at least 75% of the households should be enrolled. Voluntary Household 40 villages (data on population: na)</td>
<td>Rs. 48 per landless household up to 5 people (or can be paid by 15kg of jowar). Additional fees for land-owning households</td>
<td>50% coverage of OPD visits and planned hospitalisations (including normal deliveries), 100% coverage for emergencies and unplanned hospitalisations. Hospitalisations must be at a single teaching hospital</td>
<td>None mentioned</td>
</tr>
<tr>
<td><strong>SHH:</strong> Calcutta, W.Bengal, Established 1955, provider-owned scheme</td>
<td>University students only Voluntary Institutional or individual 1,020,000 students covered in 1993-94</td>
<td>Rs. 4 per annum, collected through the schools (1998 data)</td>
<td>Free doctor consultations, drugs and hospital stays at nominal rates</td>
<td>NA</td>
</tr>
<tr>
<td><strong>VHS Medical Aid plan:</strong> Chennai, Tamilnadu, established 1963, Provider-owned scheme</td>
<td>Anyone may join Voluntary individual 124,715 members (March 1995); but 74% enrolled for free due to their low income</td>
<td>Membership fee graded according to monthly income</td>
<td>Free annual check-up; curative and diagnostic services for outpatient and inpatient services at discounted rates</td>
<td>NA</td>
</tr>
</tbody>
</table>

Micro Credit Linked Health Insurance Schemes

Several NGOs and governments worldwide have started micro-credit schemes for vulnerable groups to break the vicious circle of poverty, malnutrition, disease, low productivity, and low income. Micro-credit is now considered not only an effective tool for poverty reduction but also used as an instrument for empowerment of the poor, particularly the women. This operation generates income to the poor by extending them small credits for self-employment and other economic activities. However, it was soon realised that loan repayments by these groups were much below the expected level. The experience suggested that ill health and expenditure on treatment and associated consumption needs were the prime reasons for defaulting on repayments. To plug the erosion of income of borrowers on health care needs, many community based health insurance schemes operate in India. IRDA has come out with plans for micro-insurance schemes and regulations, it has recently launched the concept paper for the same and the discussions are happening around it. Hence very soon some changes in the micro-insurance arena are expected.

Despite the presence of various schemes, the enrolment numbers are not large enough to portray India as health insurance interested nation. Since India is a country with majority of informal population, the NGO & Micro Insurance channels can serve as better option for reaching the informal masses in the country. But from the excerpts of the expert interview\(^3\), it was noted that such schemes get impartial treatment from insurance companies. Insurance companies tend to serve more for high-end customers and not low-end customers from informal sector. Moreover, NGOs and Micro Insurance organisation feels that they are the better people to judge the risk of the segment as they are in closer touch with the people, hence they expect the control

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\(^3\) Interview with Jim Roth, Co-ordinator for Micro Insurance Schemes, ILO office, Bangalore on 12.12.2004
over the premium collections and cash management. But insurance companies deny the privilege stating that there are chances for misuse of the funds. Some NGO's like SEWA came out of the insurance net due to the above factors and even it ran successfully making good surplus for 2 years, but following the Gujarat earthquake, SEWA funds drained out very fast and hence after that, it again joined hands with insurance company for managing the risk operations. One important factor noticed is that NGOs and Micro Insurance organisation lacks professional experience to handle risk management in health insurance and hence there requires proper training by IRDA to promote the professional interests of the organisation which in turn can help the health insurance in reaching the masses. As a research note, it was found that many NGOs hesitated even to respond to the researcher when it was tried to reach them to get their opinion about the insurance coverages.

Though various schemes are available in India, none of the schemes are very effective due to the fact that ‘had any of the schemes been effective it would have served as ideal model for spread of health insurance’. Hence, new models are required for India for promoting health insurance by overcoming the demerits.

Section II: Health Insurance Schemes Abroad

In the first part of the chapter, various health insurance schemes existing in India was detailed. At this juncture, it may be worthwhile to summarise the experience with health insurance of select foreign countries to understand their health insurance system. The specific experiences of China, Thailand, Sri Lanka, LATAM countries, USA, UK, Australia, Singapore, Germany is discussed below.
China

China stands out as an example where insurance has been successful in covering a large part of the population both in rural and urban areas. The Chinese expenditure is characterised by high total expenditure, low government expenditure and heavy dependence on insurance financing. There are two kinds of coverage, which are in practice in China, labour insurance medical coverage for state-owned enterprise workers and retired persons, and free medical service, which caters to workers, and retired persons of government agencies and parties and non-profit institutions. A noteworthy feature of China's health care system is the coverage of rural population through various kinds of schemes, which have been designed in accordance with the local economic conditions and public opinion. China’s system of health care certainly scores better vis-à-vis some of its Asian counterparts like India and Indonesia. India, which is similar to china in terms of population growth, has lots of learnings from china.

Thailand

Thailand has four different kinds of health care financing programmes: voluntary health schemes, mandatory schemes, social welfare schemes, and fringe benefit schemes presents the coverage of these programmes with their important features. The target population of each of these schemes varies in terms of their place of residence (rural/urban) and employment status (formal sector/informal sector). The coverage of population in the informal sector, especially in rural areas is, however, far from a desirable level. In fact, 41 per cent of the population, which is not covered by health insurance scheme largely, consists of subsistence farmers, self-employed, rural workers and urban dwellers engaged in informal sector activity such as street vending
and small-scale commercial undertakings. From this, it can be inferred that India unlike Thailand is having largely similar type of policies for the whole country. Hence India should plan for designing schemes particular for various segments and sectors.

**Srilanka**

Srilanka's health care expenditure is characterised by high government, low private, and low insurance expenditures. But similar system cannot be expected from large country like India due to various factors like financial subsidies, varying morbidity patterns across regions etc.

**Latin American Countries**

The pattern of health care expenditure in Latin American countries varies according to the size of the country (both in terms of population and geographical size) and the income level. Taking a larger perspective, there are mainly two types of managed competition, which are emerging in this region, where government is the sponsor and where private employers are playing the role of sponsor. The former type is followed in countries like Chile, Uruguay, and Colombia. In Chile, for instance, 73 per cent of the population is covered by public health care whereas the remaining 27 per cent are enrolled into the ISPRAE, a private insurance plan. Colombia too has a system of mixed public funding and managed competition, which has not only increased the coverage but also made the system more equitable. In fact, Colombia's health care system has been hailed as one of the most successful ones in the region. Brazil has three distinct systems being availed of by three different income classes - public system primarily by informal sector and low-income workers, private supplementary medicine by formal sector and middle-income workers, and direct ou-
of-pocket payments by high-income workers. The lessons that can be learnt for India is that "India can try to adopt similar models of public private partnerships".

United States of America

In the United States of America in excess of $350 billion is spent on health care annually. Healthcare is provided by private hospitals, funded either by individuals, by employers, or by insurance. There are two state medical schemes – Medicare, which caters for the elderly and retired and Medicaid, which caters for the unemployed and the low-paid, the costs for these are shared by the State and Federal governments, although the patient will have to bear a certain percentage according to their means. Medical insurance in the United States has developed into two distinct classes, self funded and fully insured.

Self-funded medical insurance emerged from Employee Retirement Income Security Act (ERISA) was passed by the federal government in 1974, which allows employers to take on the risk of their employee benefits and still receive tax credits for payments made to those employee benefit programmes. The employer could protect his fund against single large claims by purchasing per person excess of loss (known as "specific" cover) and also against an unusually large aggregation of small claims by "purchasing aggregate" cover.

Fully insured medical insurance, for example, under conventional group health insurance, the insurance company assumes all the costs and risks of the group health plan in exchange for payment of a fixed monthly amount per employee. Blue cross and Blue Shield plans are medical expense plans that cover hospital expenses, physicians and surgeons, ancillary charges, and other medical expenses. Blue cross plans cover hospital expenses and other related expenses. The plans provide service
benefits rather than cash benefits to the insured. Blue shield plans cover physicians' and surgeon's fees and related medical expenses.

Managed Care is a generic name for medical expense plans that provide covered services to the members in a cost effective manner. There are several types of managed care plans in US. The most important are Health Maintenance Organisations (HMOs), Preferred provider organisation (PPOs), Exclusive provider organisations (EPOs), Point of service (POS) plans

A HMO is an organised system of health care that provides comprehensive services to its members for a fixed, prepaid fee. HMOs have a number of basic characteristics, first, the HMO has the responsibility for organising and delivering comprehensive health services to its members, second, an HMO provides broad, comprehensive health services to the members, third, selection of a physician is usually limited to physicians who are affiliated with the HMO, fourth, HMO members pay a fixed prepaid fee usually paid monthly for the medical services provided. In addition there is a heavy emphasis on controlling costs

A PPO is a plan that contracts with health care providers to provide medical services to the members at reduced fees. PPOs should not be confined with HMOs. There are two important differences, first, PPO providers typically do not provide medical care on a prepaid basis, but are paid on a fee-for-services basis as their services are used. However, as stated earlier, the fees charged are below the provider's regular fee. Second, unlike an HMO, patients are not required to use a preferred provider but have freedom of choice every time they need care. However, the patients have a financial incentive to use a preferred provider because the deductible and co-payment charges are reduced
An EPO is a plan that does not cover medical care received outside a network of preferred providers.

A POS plan offers a full range of health services through a combination of HMO and PPO features. If patients see providers who are in network they pay little or nothing out-of-pocket, which is similar to an HMO. However, if the patients receive care from providers outside the network, the care is covered, but the patients must pay substantially higher deductibles and co-payments.

USA also passed HIPAA (Health Insurance Portability and Accountability Act) which requires the portability of the health insurance information of the patients even if they move across various employment, hospitals etc. USA imposed strict regulations for compliance by hospitals and health care companies towards HIPAA. At this juncture, it has to be noted that India also needs to impose regulations like this in the future. It may not be possible right now due to unregulated scenario of health care sector. India has been working on a ‘Health Unite Framework’ in similar lines of HIPAA. The main formation of Health Unite framework is due to the recognition of the need for a standard system across the country that meets the needs of the diverse groups that record, use, transfer and disseminate health information, legal policies that govern the healthcare structure, and education system to help reinforce the strengths and values of the changing face of Indian healthcare system. This framework is under discussion and review.

United Kingdom

In the United Kingdom over 40 billion pounds is spent on healthcare annually of which 97% is publicly funded and 3% is privately funded. Health care in the UK is
provided publicly by the National Health Service (NHS). The scheme provides free health care service to all residents in a network of NHS clinics and hospitals countrywide. It provides for primary, secondary and post-operative care. People must contribute towards dental and optical care according to their means. The government sets the annual NHS budget from tax revenues.

Private medical insurance in the UK evolved from dissatisfaction in the state health system due to long waiting lists for operations and over-crowding inwards. About 11 percent of the population purchase private medical insurance. The NHS does encourage its hospital trusts to have private patients units (PPU's) within their hospitals to attract private patients, who either fund themselves, or who have private medical insurance. It is the intention of the government that PPU’s are encouraged to care for more patients and so generate more revenue for the hospital trusts and reduce the burden on the state budget. As an alternative to the state system, insurance companies sold a product that, after a consultation with a General Practitioner (GP), allowed the patient to bypass the state system and enter a private hospital. Budget Indemnity Healthcare: Due to the increasing cost of full indemnity policies, insurance companies launched “budget” products. These did not offer inferior levels of cover, just that there was a waiting period before they became operative. If an operation was available on the NHS within a certain (typically six weeks) period, then the operation would be carried out within the state system. If however, the operation could not be performed within this period, then the insurance policy would pay for the operation to be carried out at a private hospital. Another alternative to budget healthcare is a daily hospital cash plan, which provides a cash benefit for each day a patient is in hospital to eliminate loss of earnings due to hospitalisation. Another method of reducing cost of private medical insurance is to restrict the hospitals that the insured can use in non-
emergency situations. India has long way to go for creation of such services. But a thing to note is that due to the long wait queue for NHS benefits, India seems to be a favorable destination for medical tourism business from UK. Even recently it was noted that Apollo group is planning to acquire some hospitals in UK and also it has aggressive plans for promoting medical tourism business.

Germany

Germany does not have national health services like the UK. There are a number of health insurance companies who provide health care for their members. Most of these are government controlled, although some are private companies. Employees with a permanent contract of employment are obliged to take out health insurance with a government controlled health insurer of their choice. The government-controlled insurers are not however, compelled to take on these risks. If the employee fails to contract with an insurer prior to the commencement of employment, their employer must register the employee with the Allgemeine Orts Kranten Kasse (AOK). AOK is the largest government controlled health insurer in Germany, and in effect is the insurer of last resort. AOK, therefore, has the worst negative risk selection of all healthcare providers in Germany. In the state controlled insurance system an insured person pays a premium, which is a percentage of his gross monthly salary. This percentage figure is the same for all insureds regardless of his salary or the type of risk. The employer must also pay the same percentage, so that the contributions are split 50:50 between employer and employee. Unemployed persons receive state funded unemployment compensation, which includes contribution to government health insurer. Since the private health premiums tend to be higher than the government premiums, if a private policy holder is made unemployed then he would be required to drop out of the private system back into the
state system. Another difference between the state system and the private system is that within the state system the insured pays a premium for his entire family and therefore cover is also provided for the spouse and the children. The private sector covers only the person who pays the premium, any cover for further family members requires an additional premium. This gives an idea for creating a health insurance corporation by government, which can mandatorily insure majority of the population for a small coverage. But given the performance of institutions like ESIC and CGHS, more cautious measures needs to be taken to learn from the mistakes made in the past.

Ireland

The numbers buying private health insurance in Ireland have continued to grow, despite a broadening in entitlement to public care, to the point where more than two-fifths of the population now has private cover due to concern about waiting times for public hospital care. This is similar to UK experience.

Australia

Under the present system, roughly 60 percent of the population rely on the public hospital system for acute care and 40 percent are privately insured for such care- the latter tending to use private hospitals primarily, but relying on major public facilities in complex or catastrophic situations. Everyone is covered for routine medical care, generally with a co-payment or gap to pay for each medical service. The public medicare system thus provides quality healthcare to all. It is funded from general taxes, mainly commonwealth, plus an earmarked levy on income. There is significant taxpayer support also for private health insurance primarily though a recently introduced government rebate on premiums. Private health insurance is
regulated in Australia to be community rated rather than risk-rated, although now on a lifetime basis, that is premium rise with age of entry and insurers may decline to cover pre-existing health conditions, but explicit discrimination is otherwise not allowed. A consequence of these arrangements is that costs of long-term care, an important component of existing future health costs, are spread across both the insured population and (predominantly) taxpayers. This provides idea for India that improving infrastructure for health care can lead to more public utility of services. By forming a larger tax base for health care specific, health insurance spread can be enhanced at this juncture in India.

Singapore

Singapore is just one of a number of countries which has “provident fund” arrangements providing for a range of welfare needs, but Singapore’s CPF is among the most comprehensive, funded by 20 percent contributions from each of the employer and the employee (although the employer component is to be reduced). Retirement income provision is actually not, as some outside comments seem to imagine, the major destinations of savings accumulated through the CPF. The largest need met though it by far is housing. Singaporeans in fact have a much higher level of home ownership (around 90 percent) than do we or, say, Canadians or Americans (all around 70 percent). Nevertheless retirement income provision is one of the CPF’s major purposes. CPF contains three elements to provide security against health costs.

Medisave: 6% of salary rising to 7% at age 35 and 8% at age 45 is paid into a medisave account until the balance reached S$16,000, after which the excess can be transferred into the ordinary account providing for housing, retirement, etc. These
funds possibly together with some out-of-pocket contribution, may be used to pay for hospital and attending doctor expenses.

Medishield: This provides the risk pool or insurance element, covering Singaporeans against extraordinary hospital costs. It is funded by a system of premiums which is essentially age-phased lifetime community rating in its character. There are some exclusion from the scheme (e.g., normal pregnancies) and a lifetime individual coverage limit of S$70,000. In practice, only about 20 to 25% of hospital costs are funded by it, the bulk coming from Medisave accounts.

Medifund: This is the government safety net to support those without enough resources in their Medisave accounts or in other personal savings to meet their health expenses. It is particularly important for lower income people and for elderly people whose resources have dwindled. Singapore also allows out of pocket medical expenses in a wider category than the hospital related costs primarily covered by these three elements to be deducted from tax, up to a maximum of 2 percent of salary. The government also subsidises the health system to a substantial degree from its budget. Singapore does not encourage its citizens to take out third party health insurance that could remove too much of their exposure to out of pocket costs. The government does not wish to see healthcare as “Free”. In this regard, it might be noted that when they do require hospital care, Singaporeans do have choices- as between private room or large wards and the like-which carry different costs, to be met from their medisave balances or out of pocket.

In India, as already the provident fund schemes are popular. It has to be thought of floating schemes in combination of Provident fund schemes which has feature of health insurance components attached to it.
Comparison Model

In summary, from the study of health insurance systems existing in various countries, it can be inferred that a generic model exists throughout all nations. It can be depicted as below:

Direct out of pocket system is a system wherein the patient pays for his medical expenses on his own. This system is present in all societies, particularly, where the awareness about insurance is not developed sufficiently or where due to paucity of funds the government has not been able to provide much by way of universal health care. However, for expensive medications the poor would be deprived of the medical care under this system.
Compulsory public insurance can be implemented by following either the general tax revenue model or the social insurance model. General tax revenue model is prevalent in nations like Australia, Canada, Russia, Sweden and UK. Here irrespective of one's employment status or any other eligibility criterion, universal coverage is provided by government through providers who may be employees of the state or on contract with the state. General tax revenue is used to finance the expenses. There are two modes of implementing this model i.e., the integrated model and the contractual model. These have been elaborated subsequently.

Social Insurance model is a model wherein the employees and employers are mandated to pay payroll tax to the insurers who negotiate with the physician group to provide the medical care to the insured. The poor, unemployed or the retired are either insured through social insurance funds or there exists hospitals run by state in addition to those privately managed. Nations like Germany, Japan, France, Brazil etc., follow this model. Again this may be subdivided into three models i.e., integrated model as in Italy and Spain, contractual model as in Germany and France and the indemnification model.

In Integrated model, the hospitals are owned by the state and physicians are employees of the government. Hospitals get funds out of the health care budget and patients do not have to share the expenses. The advantages are, low administrative cost due to unification of administrator and provider, no transaction cost between third party payers (i.e., insurers) and providers relating to verification of payments for service etc. The main disadvantages are that there is little economic incentive to providers to enhance service quality, no incentives for providers to reduce unit costs, and long waiting time for the patients and apathy of providers.
In contractual model, prevalent in Canada, this model is similar to the integrated model except that the state enters into a contract with the service providers either on a fee of service basis or on capitated basis. In a fee of service contract, the physician providing more service gets higher compensation. In order to reduce supplier-induced demand, cost sharing with the patient by way of deductibles may be introduced. Under the capitated payments, fixed payments are made to the providers to care for the patients regardless of the intensity or extent of the service needed by the patients. The advantages of this model is that economic incentive for the physician to deliver only necessary service, reasonable quality of care is assured as poor service may aggravate illness leading to higher cost to provide.

Patient indemnification model reimburses the patient for services they have already paid the provider for. This is prevalent in Belgium and France and suffers from the disadvantage of high processing cost and possibility of higher supplier induced demand.

Voluntary private insurance model wherein the health services are financed through voluntary private insurance either by the employer, employees or individuals. USA and Switzerland are the two nations following this model.

Integrated approach in voluntary private insurance unifies the insurer and provider function within the private sector as in the HMO. HMOs' offer comprehensive medical service to members on prepaid basis. It is a type managed care organisation where the financing (insurer) and delivery (provider) of health care are combined in the same entity. The advantages of this model are that administrative costs are saved, economic incentives are provided to providers to deliver minimum
service, quality is enhanced due to competition among HMO's for the customer group.

Contractual model in voluntary private insurance is prevalent in USA and Spain, the HMO acting as the insurer negotiates contracts with private independent physicians to provide care to HMO subscribers. PPOs are another example where groups of providers contract with the employers, insurers and other organisations to provide medical service at a discount.

Indemnification model in voluntary private insurance provides for reimbursement of payment to patients. In order to reduce costs in this model, the patient cost sharing is usually resorted to as in the USA, UK, and Netherlands.

Based on ownership of scheme various models of health insurance can be broadly categorised as state based systems, market based systems, member organisation based systems and private household systems.