CHAPTER
FIVE

ECONOMIC POLICY

5.1. Introduction

As the focus of the present study is demand for health insurance, it would be worthwhile to discuss some strategies for future improvements relating to the access to health cares and services. In the previous chapter we have already seen the factors that are responsible for higher health care expenditure, out-of-pocket payment for health cares and services and the demand for health insurance by the several groups of households and their use of health cares and services. The existing situation in the district of Birbhum shows that the demand for health insurance is not sufficiently high. This indicates that lower rate of utilization of health cares and services exists in the district owing to heavy burden of health care expenditure, which necessitates huge amount of out-of-pocket payment for health cares and services by the households. This study suggests some alternative forms of health care strategies basically for the low-income people.
In order to discuss the policy issues relating to the health insurance in the district of Birbhum we should depend on the empirical facts found in chapter four. So it would be rational if we present in the beginning some of the basic findings of our empirical study on the demand for health insurance and this is presented in section 5.2. In section 5.3 the picture of the supply of health insurance provided by different insurance companies has been depicted. Based on these discussions we have presented in section 5.4 the issue of reforms in the health insurance sector in India. In order to promote the health care sector we have discussed and analyzed the Governmental policy for improving health in section 5.5. Section 5.6 discusses the policy guidelines and implications. In section 5.7 we discuss the alternative policy of health insurance for the low-income people, which is simply the community based health insurance programme and this is an emerging movement in the realm of the health insurance schemes. We have put an overview of the participation constraint in section 5.8. Section 5.9 discusses the observations of the study in brief and concludes.

5.2. Basic Findings

In chapter four, we have estimated probabilistic models of decision to visit health care centers or the rate of utilization of health cares and services and the decision to purchase health insurance in the district of Birbhum. Along with it the log linear model for the out-of-pocket payment for health cares and services is also estimated. Our basic findings of the empirical experiment based on the sample of households during the period 2002 – 2003 in the district of Birbhum may be summarized as follows.
(i) In the district of Birbhum during the year 2002 – 2003 the percentage of urban households who purchased the health insurance directly form the market exceeds that of the rural households. The difference between these two percentages is not significantly different. The difference in the level of income, the degree of awareness and information about the health insurance scheme and some misconception may be responsible for lower participation in the purchase of health insurance by the rural households.

(ii) In the rural areas the households from the group of service holders are much more forward in protecting themselves by health insurance compared to the households from the group of households dependent on agriculture for their livelihood. The income tax benefit is, no doubt, one very much important cause for such incident. Since the businessmen are capable enough to bear the cost-burden of treatment in any unforeseen situation, they don't show their much interest in the purchase of health insurance in the district of Birbhum. The casual labours are refrained from the purchase of health insurance due to their low financial capacity.

(iii) The income of the households protected by the health insurance scheme and unprotected in the rural area has been noted to be widely varying in the district of Birbhum. This is also true in the urban area of the district. But, this inequality is not reflected in the average expenditure on food and annual consumption amongst these households. When we look at the annual health care costs, the rural households in the district of Birbhum are seen to be spending much more than the urban households.
(iv) The male and female literacy are not significantly different in the district of Birbhum. Both male and female literacy rates are greater in the urban area than those in the rural areas. The rural-urban family size differential is not significantly noted. The average household size is around six plus.

(v) Due to the presence of more female agricultural labour in the rural area and the female casual labour in the urban areas, in both the rural and urban areas of the district female participation in work force is greater than the male participation. Hence the dependency ratio amongst the female population in the rural area and in the urban area is smaller than the dependency ratio amongst the male population in the district of Birbhum.

(vi) In the rural areas of the district of Birbhum the gap between percentage of males and females protected by health insurance appears as much wider than that in the urban area. The said gap is very big for the children in the district of Birbhum. The children in the rural area are almost left uncared and go without being protected by health insurance compared to the picture in the urban area.

(vii) As it was expected, the rate of morbidity of any type in the rural area has been found to be greater than that in the urban area in the district of Birbhum. The incidence of morbidity is highest amongst the persons not protected by health insurance. It is lowest amongst the male population protected by health insurance and highest amongst the female population.
even if they are protected by health insurance. The incidence of morbidity is highest amongst the females in the rural area and also in the urban area. When we consider the health status as self-perceived, we see that females reporting their health as good, are low in number than the males in both the rural and urban areas in the district of Birbhum.

(viii) The private sector plays significant role in providing medical services to both rural and urban population. Contrary to the expectations of the common people, the government sector does not play very much significant role in all types of morbidity. In the case of acute morbidity, whereas the private sector dominates, in the case of hospitalizations the government sector provides medical cares and services to a moderate degree only. Actually, the persons protected by health insurance are free to depend on the private sector health cares and services much more than the persons not protected by health insurance. The persons not protected by health insurance are mainly dependent on the government sector for medical care and services. But the government sector failed to fulfill their expectations in the district of Birbhum. The penetration of private health care providers, contrasted with public health care providers, in the district of Birbhum (and perhaps everywhere) in the rural area is much less than that in the urban area.

(ix) The cost of treatment, composed of the medical costs, direct costs and the indirect medical costs, is greater in the rural area than that in the urban area. The cost of treatment varies directly with the time span stay in the health care centers for the cure of the patient. For all types of morbidity
the indirect cost component in the aggregate medical costs is higher than the
direct cost component in the rural area in the district of Birbhum. This is
because of the fact that most of the rural households had to lose their earning
during the period of treatment and that is why the indirect costs increased.
Further, the rural households often had to finance their cost of treatment
through borrowing money at some high rate of interest.

(x) The family size, regional differences, frequency of illness and
engagement in occupation like business do not significantly affect the
demand for health insurance. The important and significant factors that
affect the demand for health insurance are the level of annual income,
worker population ratio, literacy, awareness about health insurance scheme,
health consciousness, income and consumption, annual health care costs and
tax exemption etc. The socio-economic factors like caste and religion along
with the level of awareness and literacy are also no less important factors in
the determination of the demand for health insurance.

(xi) In the use of hospitalization services and then in the determination
of demand for health insurance we note that age, sex, education, and health
consciousness serve as the statistically significant individual characteristics
in the district of Birbhum. But the frequency of illness does not stand
significant. The worker population ratio, income, religion, caste, region and
annual expenditure on health care serve as most important control variables
related to the households characteristics. Our profile of correlation also
supports these points.
In order to assess the probability of decision to visit health care centers and the rate of utilization of health cares and services we have used a logit model. In Model A income has been used as the explanatory variable and in Model B income dummies have been used as the explanatory variables. The basic findings of our empirical exercise are as follows.

- In both the models the probability of decision to visit health care centers and rate of utilization of health cares and services increases for the persons protected by health insurance.
- The males are much less likely to visit hospital and use hospital care and services in contrast to females.
- For the persons below the age 25 years and between 25 –50 years the probability of visiting hospital and using hospital services and cares there declines. For the persons in the old age groups with age above 50 years the probability of visiting hospital and rate of utilization of health cares and services in the hospital increases.
- In the determination of the rate of utilization of health cares and services the regional differences do not stand as significant. The frequency of illness appears also as an insignificant factor in the determination of the rate of utilization of health cares and services and probability of visiting health care centers.
- Both literacy and health consciousness have strong and statistically significant impact on the probability of visiting hospital and using hospital services and cares in the district of Birbhum.
- The most important and significant variable in the determination of probability of decision to visit health care centers and rate of
utilization of health cares and services is definitely the income. The rate of utilization of health cares and services by the persons in the lower income group declines. But, the picture is opposite in the case of persons in the middle and higher income groups. It’s a fact that the probability of decision to visit health care centers and rate of utilization of health cares and services for persons in the higher income groups is greater than that of the persons in the middle income groups.

- We cannot draw any conclusive inference about the effects of the community characteristics on the probability of visiting health care centers and the rate of utilization of health cares and services. The rate of utilization of health cares and services by the Hindu people declines as contrasted to that by the Muslim people. For the general caste and the scheduled caste people the probability of using hospital cares and services increases; but that for the scheduled tribe and the OBC people declines significantly in the district of Birbhum during the sample period 2002 – 2003.

(xiii) We can sum up the impacts of various explanatory variables on the out-of-pocket payment for health cares and services as follows.

- For persons protected by health insurance the out-of-pocket payment for health cares and services, is found to be smaller than that for persons not protected by health insurance. The burden of health care costs for the insured persons is smaller than that of the non-insured persons.
• It is also found that in the district of Birbhum the males spend much more than the females for using health cares and services.

• For the persons in the old age group the out-of-pocket payment is greater than that for the persons in the young and middle age groups.

• As it was expected, the health care expenditure in the rural areas in the district of Birbhum is greater than that in the urban area.

• Literacy and health consciousness have a depressing impact on the health care expenditure.

• The elasticity of out-of-pocket payment for health cares and services with respect to the level of income is, as expected, positive.

• The people in the low-income group cannot afford to pay for health cares and services and their out-of-pocket payment declines with a slight insignificant rise of their income. The income elasticity of out-of-pocket payment for health cares and services for the people in middle and upper income category, is positive. The rate of increase in the out-of-pocket payment for health cares and services for the people in the upper income category is greater than that of the people in the middle-income category.

• The community characteristics like caste and religion have no significant impact on the health care expenditure.

(xiv) The demand for health insurance have been considered for all households in the sample (pooled) in the district of Birbhum. We have separately considered the demand for health insurance for households in the organized sectors, households involved in works of cultivations, households working as casual labour and households involved in business. With this end
in view, the logit and probit model has been used to assess the probability of
decision to purchase health insurance. The major findings for these different
categories of households are described as follows.

- Sex discrimination in favour of males and adversely against females
  in respect of demand for health insurance has been found empirically
  insignificant in the district of Birbhum.
- The probability of decision to purchase health insurance increases
  with increase in age. For persons in the middle and old age groups the
  probability of purchasing health insurance is seen to increase
  compared to that of the persons in the young age group.
- Literacy increases the probability of demand for health insurance. But,
  the impact of female literacy on the probability of decision to
  purchase health insurance is stronger than male literacy.
- In the determination of the probability of demand for health insurance
  family size does not appear statistically significant. But in the case of
  households involved in business the exception of this result occurs.
- The probability of demand for health insurance is affected directly
  (inversely) by the worker population ratio (dependency ratio).
- The regional differences does not appear statistically significant in
  affecting the probability of demand for health insurance in the district
- Literacy, health consciousness and awareness of the households
  regarding the health insurance schemes, are found empirically
  significant to affect the probability of decision to purchase health
  insurance favourably.
• The illness ratio and annual health care costs did not significantly affect the probability of demand for health insurance.

• Income, as it is very much expected, appears to be the most important and significant determinant of the probability of the demand for health insurance.

• Premium benefit ratio, which as good as the price of the insurance scheme, in all cases serves to have a depressing effect on the probability of demand for health insurance.

• The community characteristics do not have similar effects on the probability of decision to purchase health insurance. For scheduled tribe and OBC people in most cases the probability of demand for health insurance does not significantly change. But, for general caste population the probability of decision to purchase health insurance is seen to increase significantly. This is of course, not true for the households working as casual labour and businessmen.

• All characteristics – individual, household and community characteristics affect directly the probability of demand for health insurance for the service holders at faster rate than that of cultivators, businessman and casual labour.

5.3. Health Insurance Schemes in India

The extent of financial burden of health care services has created the needs for protection. The protection may come through a number of ways either through public provision, conventional insurance, and public subsidies or through community based financing. In India there is a mix of such
alternative devices in the sphere of health insurance schemes. The reason for this is that any arrangement that enables the households to avoid, delay or reduce full payments is a form of insurance. The earlier literature on the Indian insurance system often ignored this full array of arguments and confined itself to the formal system of insurance by companies like General Insurance Corporation (GIC). We see that the basically formal insurance for health cares and services exists and the richer section of the society enjoys it. But, in some parts of India, there are some community based health insurance schemes, which provide health insurance benefits to the low income and vulnerable rural people either through reimbursement or through supplying health cares and services and medicaments etc. Further some formal insurance schemes also provide health care facilities to its members and employees. Some schemes reimburse the health care expenses incurred by the insured households. We shall discuss different schemes separately.

5.3.1. Central Government Health Scheme (CGHS)

The Central Government Health Scheme was introduced in the year 1954 as a contributory health scheme to provide comprehensive medical care to the central Government employees and their family members. The said scheme is basically designed to substitute the cumbersome and expense system of reimbursement (Annual Report, 1993 – 94, Ministry of Health and Family Welfare). Separate dispensaries or health care centers are maintained for the exclusive use of the central Government employees covered by this scheme. The coverage of the scheme is growing substantially with provision for the non-allopathic system of medicine as well as for allopathic system of
medicine. The CGHS reimburses the households for a part of their out-of-pocket payment for treatments at the Government hospitals and some other facilities are also provided in this scheme. The list of beneficiaries includes all categories of current as well as former Government employees, members of parliament and so on. Since, the large central bureaucracy in India definitely belongs to the middle income and high-income categories, they are likely to make above-average use of the health cares and services provided through the CGHS. Thus, this scheme does not cover the poorest of the poor and the people of low-income category of the country who are not central Government employees. However, the CGHS has been widely classified and criticized due to low quality of health cares and services and accessibility.

5.3.2. Employees State Insurance Scheme (ESIS)

In 1948, the Employees State Insurance Scheme was launched. The scheme managed by the Employees State Insurance Corporation (ESIC), provides both the cash and the medical benefits to its members. Thus the ESIS is fully a Government enterprise. It was conceived as a compulsory social security benefits for the workers in the formal sectors. The original legislation that created this scheme allowed it to cover only the factories, which have been using power and employing ten or more workers. However, since 1989 the scheme has been expanded and it now includes all such factories, which are 'not using power' and employing twenty or more persons. Mines and plantations are explicitly excluded from the coverage under ESIS Act. Only the employees earning their basic salary of less than
Rs.3000 (recently enhanced to Rs.6500) per month are eligible for the ESIS coverage.

The premiums for the ESIS are paid through a payroll tax of 4 percent levied on the employers and a tax of 1.5 percent levied on the employees (recently charged 4.75 percent and 1.75 percent respectively for the employers and employees). The primary way in which the medical benefits are provided under the ESIS is through the facilities dedicated to those on the rolls of this scheme (Subrahmanya, 1995). Patients requiring treatment from the specialist doctors not available at the ESIS specified hospitals are entitled to have the required special facilities from outside and the expenses are reimbursed under the ESIS programme (Shariff, 1995).

The programme has come under serious criticisms from the users, internal review committees and outside researchers. The main criticism laid against the scheme was that the medical benefits provided have not kept up with the standard of facilities provided by the private clinics and diagnostic centers. Ratnam (1995) opined “the operation of the ESIS and administration of the hospitals and dispensaries under the scheme are also seriously faulted and scarred by both the employees and employers”.

5.3.3. Mediclaim Policy

The General Insurance Corporation (GIC) was set up by the Government in 1973 as a public sector organization to market a range of ‘insurance services including hospitalizations cover’. It introduced the
standard ‘Mediclaim’ health insurance scheme in 1986 and became operational in 1987. This policy was modified in 1996 to allow for differentials in premium for six age groups. This policy designed by the GIC applies to both groups and individuals. Before the GIC came into existence, a number of private insurance companies had launched schemes of offering group health insurance cover to most corporate bodies. After the formation of GIC, these companies were merged into four of its subsidiaries. They offer a full range of insurance types, with health accounting for a very small share of their total business.

The standard Mediclaim policy covers only hospital care and domiciliary hospitalization benefits. Some insurance companies previously reimbursed the cost of treatments made by the insurer directly to the hospitals. Other providers reimbursed the cost of treatments directly to the insurer. The ‘enrollees’ are reimbursed for their medical claims only after the payments have been made out-of-pocket to the providers (Phadke, 1994).

The GIC prescribes premiums, the eligibility criteria and the benefit coverage for all the four subsidiaries so that they do not compete along any of these dimensions. All four firms make delays in claim processing. The present study in the district of Birbhum shows that the surveyed insured households have more favourable and user attitude to Mediclaim than that in other to other schemes.

One of the basic weaknesses of this policy is that it only covers hospitalization and domiciliary expenses, leaving out routine outpatient care.
Moreover, there is also limit on the coverage and restriction on the eligibility criteria. A further criticism of the Mediclaim policy is that the premiums are high in relation to the claim payments. Many of the surveyed insured households in the district of Birbhum in the context of this study spoke to mention incidents in which either the claim for medical expense was disallowed or only a partial reimbursement was made.

5.3.4. **Employer Managed Facilities (EMF)**

The policy of ‘Employer Managed Facilities’ (EMF) and the reimbursements of the health expenses by the employers was launched in India as ways to insure the households against the risk of illness. These facilities are common for large public and private enterprises.

Nearly half of the public sector companies did not specify financial limits because almost all public sector manufacturing enterprises covered. These public sector manufacturing enterprises, which are large enough in terms of size of employment, do invariably have their own dispensaries and hospitals and provide medicines, medical machines and equipments etc. across the counter usually within the premises of the company. This is also applicable to large private sector companies, which too have similar facilities and practices for their employees (Krishnamurthy, 1995).

Similarly, the plantation sector and the railways also maintain an extensive set of clinics and hospitals for their employees and their dependents. The mining sector provides medical and other facilities to its
employees. In particular, we can refer to the mica mines and the iron ore, manganese ore, Chrome ore, limestone and dolomite mines in this context (Ministry of Health and family Welfare, 1992).

Another segment of public sector, which maintains its own medical services, is the defense set up along with other security forces. For the educational institute like the university such type of medical facilities are also available for the staff. These facilities no doubt compete with other public facilities for staff and financial resources.

5.3.5. Employers’ Reimbursement of Health Expenses

The health insurance system in India comprises numerous reimbursement plans offered by the employers for private medical expenses in the private sector as well as in autonomous institutions and organizations including commercial banks. For many workers this is the only form of insurance other than public facilities. The contributions for their schemes are voluntary, but in most cases they are not. The coverage for out patient expenditure is more common than the coverage for hospitalization expenses.

The other common system of reimbursement is an employer self-insurance system, generally known as the medical benefit or medical allowance scheme. Under this arrangement the employees incurring medical expenses are required to submit claims to their employers for reimbursement, and reimbursements are not linked with individual’s
contribution. In general, such programmes have coverage limits, which may vary according to the employee’s salary or job category (Ratnam, 1995).

5.3.6. Specialized Insurance Scheme

The life insurance corporation (LIC) of India introduced a special insurance programme in 1993, which covered medical expenses for all dreaded diseases. By definition, it is very limited in scope. Though it is functioning in the market, it does not therefore, serve to reduce the risk of financial burdens to any significant extent. But, the scheme provided by the LIC did not appear so much attractive to the households in the district of Birbhum.

It is specially designed for offering medical reimbursement to people on an individual basis. The annual premium for the group of younger people is only Rs.70 as against the coverage limit of Rs.5000 per annum. Higher premiums are charged for older persons or those with spouse or dependents. Yet the premiums remain low in relation to the maximum coverage. Another advantage of the scheme is that it also covers maternity expenses. The Jan Arogya Bima Policy of GIC, however, is a scheme not widely circulated amongst the people in the district of Birbhum.

5.3.7. The NGO Sector

In India, an important part of private health insurance is the service provided by the voluntary and charitable organizations. The Ford
Foundation under its Anubhab Project has provided a review of non-Governmental approaches to community health insurance. Some of the important NGOs offering health services are Child in Need Institute (CINI), Self-Employed Women’s Association (SEWA), Streehitkari and Parivar Seva Sanstha.

Most of the NGOs offer comprehensive assistance packages with the underlying assumption that health is only the aspect of development and should therefore be tackled along with other social problems in a holistic fashion. The Government has encouraged these NGOs through cooperation and assistance. The Government has used the health sector NGOs for two main purposes; namely, (i) to train its functionaries and (ii) implement its health care delivery programmes (Sundar, 1995). CINI and SEWA are good examples of such cooperation.

It is to be noted that NGOs are providing valuable health services in different parts of India, especially in the rural areas and to the disadvantaged section of people. It remains clear that despite its growing role, the NGOs have not yet reached a level where it can make a significant dent in private on curative care in India.

5.3.8. Recent Developments

Health insurance for the low-income people could be community based or non-community based like the Jan Arogya Bima Policy of the
Government. The community based health insurance in India is of two types; namely,

- an NGO acting as an intermediary between a formal insurance provider and the insured community, e.g., SEWA in Ahemadabad, Action for Community Organization, Rehabilitation and Development (ACCORD) in the Nilgiris; and
- the NGO itself providing insurance to the target community, where an NGO itself insures the target population. The NGO may also be the health insurance provider, for example, Sewagram Hospital; or the NGO may have arrangement with the health service provider, for example, Tribhuvandas Foundation. All these forms currently exist in India, but only in few pockets and need to be explored.

In recent past (2003 – 2004) two new initiatives such as – Universal Health Insurance Scheme (UHIS) and the unorganized sector workers’ “Social Security Scheme” (SSS) in the social sector has launched in India. The scheme basically offers a package of insurance cover for a limited reimbursement of hospitalization expenses to an individual/family, subject to specific sub-limits relating to room/bed expenses, specialist/nursing expenses, maximum reimbursement for a single illness etc. (Chaudhury, 2004).

Unlike the most OECD countries where private/social health insurance is the main source of health care financing, in India, more generally in developing countries, most private insurance is a supplementary
service (Ahuja, 2004). Health insurance, whether social or private, whether formal or informal, is extremely limited in India. After the liberalization of the insurance market in 2000, a number of private insurance companies entered in the market. But, there is no significant change in health insurance observed in terms of new health insurance products or in terms of the volume of business. As Mediclaim for the general public and Jan Arogya for the poor remain the same in both terms of offer and product liberalization (Government of India, 2002).

5.4. Reforming the Health Insurance Sector

It is necessary to focus on the problems and prospects and the consequent reform measures in order to propel the health insurance sector to the forefront in India. Taking a look at the various steps and strategies that are required to be followed by the companies that hope to establish an Indian health insurance market. It has been observed that the challenges facing the insurance sector are product innovation, distribution, customer services and investments. Unit linked personal insurance products might find greater acceptability with rising customer awareness about customized, personalized and flexible products. Flexible products and new technology will play a crucial role in reducing the cost and therefore the price of insurance products.

It cannot be denied that the product market for insurance buyers is tremendous in India and offers great scope for growth. While estimating the potentials of the Indian insurance market we are often tempted to look at it
from the prospective of macro economic variables like the ratio of premiums to GDP, which is comparatively low in India. But, the fact is that the number of potential buyers of insurance in India is certainly attractable. However, this ignores the difficulties of approaching the population. Also much of the demand may not be accessible because of poor distribution, large distances or high cost relative to returns.

It has been observed that most of the new companies have a tendency to target the business of existing companies rather than expanding the market. This will intensify competition for the new companies and their effort is spent on trying to capture the existing customers by offering better services or other advantages. Yet the benefits of this strategy are likely to be limited. The GIC have captured a large portion of demand from the corporate sector and the company receives good service because of their size and rates that are tariff governed. Also in terms of volume of profitability there is much scope for expansion of insurance markets. A better approach may be to examine specific riches where demand can be met or stimulated, like targeting the chief wage earned and more importantly, moving to rural India.

In order to expand the insurance markets in India, the target of new entrants should be to stimulate demand in areas that is currently not yet explored at all. Whereas the general insurance focuses on the manufacturing segment, there is a greater scope in the service sector. This sector has not yet having taken full sight, still takes up a large and growing share of India’s
GDP. This offers immense opportunity for expansion of insurance business in India.

The products, which are prevalent in different markets other than India, can be customized to the Indian markets and used to expand the health insurance markets. The LIC is a good example for which products have to compete with savings and mutual funds and hence should offer various dimensions of risk/return/flexibility so that they can be linked to stock market indices, inflation etc. This motive makes them more competitive and appropriate risk/return appetite for different investors at present – at present there are no such products. A similar situation exists with health insurance.

In India, health insurance policies are inflexible. They compete with investments and saving options like mutual funds. It is imperative that they should offer comparable returns and flexibility and there is immense scope of developing health insurance products with flexibility. So the salient features of reforming health insurance sector in India are mentioned below.

- Need for building administration network by the insurance companies.
- Worldwide insurance products move along a continuum from service products to pure commodity products.
- Need to area that for the public sector health insurance players, liberalization is theoretically an excellent concept.
- Companies will have to bring together various related but separate providers into their systems to ensure seamless servicing.
Last but not the least it is important to make it clear that health insurance is closely linked to health care provision, interventions required to correct problems, call for a coordination with other arms of the Government such as the ministry of health and family welfare, bodies like the Medical Council of India and the regulators.

Finally, the Governments' role in promoting or impeding private health related investment is a key element in the growth of private health insurance and delivery as a part of reforms in insurance sector in India. Unless these issues are dealt with, one cannot expect any significant development to take place in the health insurance business in the country (Ahuja, 2004).

5.5. Government Policy for Improving Health

Countries at all levels of income have achieved great advances in health. Decline in poverty has enabled the households to increase their consumption of food as per calorie requirement, use of clean water for drinking and residing in a hygienic shelter necessary for good health. With the rising education levels people have been able to apply new scientific knowledge to promote their own and their families' health through an expanded and useful supply of services that offer increasingly potent interventions.

India and other developing countries, especially the poor countries suffer a heavy burden of disease, much of which could be inexpensively
prevented or cured. The country also faces the problems of increasing health costs. So in order to improve the health and health financing system in the country some steps, as follows, should be followed.

• Governments need to foster an economic environment that enables households to improve their own health. Growth policies that ensure gains for the poor are necessary. It can also be done through expanded investment in schooling, particularly for girls.

• Government spending on health should be redirected to most cost effective programmes that do more to help the poor. The annual health care expenditure has been increased, which accounts a large proportion to specialized care in tertiary facilities that provides little gain for the money spent. Too little goes to low-cost highly effective programmes such as control and treatment of infections diseases and malnutrition.

• Government needs to promote greater diversity and competition in the financing and delivery of health cares and services in India. Government financing of public health and essential clinical services would leave the services to private finance, usually medicated through insurance or to social insurance. The regulation propagated by the Government can strengthen private insurance markets by improving incentives for wide coverage and for cost control. Even for the publicly financed clinical services, Governments can encourage competition and private sector involvement in service sector by generalizing and disseminating key information. The combination of
these measures will improve health outcomes and health financing to the population of India.

- Government action may be needed to compensate for problems generated by uncertainty and insurance market failure. The great uncertainties surrounding the probability of illness and the efficacy of care give rise both to strong demand for health insurance and to shortcoming in the operation of private markets in the country.

So, the Government can take a vital role in providing health cares and services and financing the health care expenditure by reforming the existing system in the country. Whereas the community financing system provides insurance to the target people, the insurance sector reforms do not directly affect the formation of such scheme, though the appropriate regulatory changes designed to encourage such grouping may positively affect their formation. Insurance reforms do affect the non-community based schemes – where the Government directs the public insurance companies to offer a product to the poor with or without some subsidy from the Government. The health care financing can also be provided to the people by regulating privately provided health insurance, or in mandating alternatives such as social insurance, in order to ensure widespread coverage and hold down costs.

5.6. Policy Guidelines and Implications

The empirical research basically addresses the demand for health insurance and the factors affecting it. Based on the findings of our study in
the district of Birbhum we can prescribe economic policies such that both the consumers as well as the providers of the health insurance schemes are in the position of balance in the long run. The policies that come out as a result of the study in the district of Birbhum may be presented below.

First, in the district of Birbhum during the time of our survey we have noted that a majority of population remains outside the health insurance system. The lack of information on the part of the consumers is one of the important causes of this picture in the district of Birbhum. In some cases, the mechanism used by the providers of the health insurance schemes does not seem suitable to the population of the said district. Further the low level of health insurance coverage is due to the fact that the Government policies have been designed to provide health services free of costs through the public sector health care agencies, although these services both in terms of quality and quantity are insufficient in the district of Birbhum. During our survey it came up to us further that some form of health insurance through central Government health insurance scheme, Employees State Insurance Scheme, covers no household. It has been also observed that the public insurance companies so far have paid very little attention to voluntary insurance because of low-level profitability and high risk coupled with deficient marketing and management strategies. There is also ignorance about the policy Jan Arogya in the district of Birbhum, where the majority of the population belongs to the low-income category.

In a health insurance scheme, exchange of information is required between the scheme officials and the elements in the environments such as
members protected by health insurance, providers of health care and the Government. This is very much necessary in establishing an understanding of the obligations and benefits between members and the scheme. Also lack of information is an important factor in the district of Birbhum for the inadequate expansion of the demand for health insurance. So in extending the demand for health insurance the spreading of information through different media and discussion is necessary in both the rural and urban areas of the district by the health insurance companies.

Second, we felt that the Mediclaim, which is at present the most widely preached public sector health insurance scheme in the district of Birbhum, should grab the opportunity of serving their customers better by making the process of filing claims swift, neat and clean; and therefore the easy and quick settlement of the claims in the district would be possible. Again there are possibilities and prospects of many other emerging issues as far as future health insurance schemes are concerned. The low-income people do basically expect from a new health insurance scheme the specialization about the coverage of illness, coverage of services, amount of premiums to be paid as well as procedural aspects. The easy settlement of claims and other related administrative procedures, which are desired by the beneficiaries are necessary for extending the demand for health insurance in the district of Birbhum. Hence, the range of services expected to be covered, include hospitalization, maternal and outpatient facilities. Since the scheme does not cover maternal and outpatient facilities to the customers, the scheme needs to be modified and reformed for stimulating the demand for health insurance. Further the need for education for the slum dwellers in the
rural and urban areas of the district should not be neglected, since the education creates consciousness about the diseases and thus helps in extending the demand for health insurance and also extending its coverage.

Third, the gender bias with males having better access to health cares and services when compared to that of females due to socio-economic and cultural reasons creates a problem as found in the district. We have noted in course of our survey in the district of Birbhum that the females are more susceptible to illness than males. The females who belong to the poor income category are naturally more vulnerable to diseases and ill health due to unhygienic living conditions, heavy burden of child bearing, low emphasis on their own health care needs and service constraints in seeking health care for themselves. The correcting of gender differentials, which appeared in our survey has not yet been undertaken through institutional arrangements in the district of Birbhum. Most of the female members in a household in the rural areas are either self-treated or treated domestically, or neglected or ignored in the family. So, a suitable policy of health insurance could mitigate such type of problems faced by the female members in a family. In this context, the example of SEWA may be put forward in the district of Birbhum and this could be an important mean of improving the access of the females to effective health cares and services amongst the women especially amongst the women of the disadvantaged section of the society. Obviously, it is also true that the health care expenditure of the females is theoretically very high than that of the males due to the natural proneness of the females more to illness and maternity and such related
diseases. So a proper health insurance for the females is very urgent for easier access to qualitative health cares and services.

Fourth, it appeared in our survey in the district of Birbhum that there are some evidences of literacy levels having benign interaction with the mortality, morbidity, access to health cares and services and the demand for health insurance. It should be noted in this connection that literacy levels of the scheduled tribes are invariably at a level far behind that of the community as a whole, including the scheduled castes and other backward communities. It may be necessary to qualify the possible benign interrelationship of the literacy levels by the obvious fact that in the district of Birbhum where we carried out the survey, the tribes had a much less significant presence. The present content and framework of basic education is largely irrelevant for the tribal in particular in the district of Birbhum.

In the context of the interaction of the life situation of village communities with the education system the perceptions of these village communities regarding the public agencies as a whole have to be assessed. So, education among people may perhaps increase extensive use of health cares and services through public or private sector without neglecting any disease and members in a household and this will expand the demand for health insurance in the district.

It is to be noted that the female education is very much relevant for health cares and services and demand for health insurance. Because an educated female take both preventive and curative health care not only for
her own children but also for all members of the family. Thus, the society as a whole improves. But, our study in the district of Birbhum shows that a proportion of female population predominantly in the rural areas is illiterate. Therefore, providing access to schools and eliminating cultural barriers that keep the girls out of education, which are required for the betterment of the society. For the sake of enrollments in education, the combination of high-level political commitments to universal primary education and information programme that create stronger demand on the part of the parents is required in the district of Birbhum.

Fifth, the health education programme should have to be conducted by the health workers. These programmes should be led by the officers in rural projects with social science background. This will make the people aware of various diseases, which could be checked by preventive or curative measures. The religious faith, which creates obstacle in taking preventive measures, should have to be removed through different agencies and social workers. The objective of the health education programme should be made clear to rural individuals and especially to women; and this will create better result. The health education will surely increase the access of the households to more utilization of health cares and services. It will also improve utilization of health cares. Through health education, people will be informed of the importance and usefulness of new and advanced method of treatment and the resultant costs thereof. They will naturally think of alternative source of finance. So the information about the health insurance scheme to such people can create further expansion of demand for health insurance. At the same time, health education needs to be emphasized for
promoting the situation of health care and empowering the women to face and ultimately reverse the adverse social and economic conditions around them.

Sixth, health conscious person may enjoy a more sound and healthier life than the person who is not health conscious. The health consciousness will encourage a person to follow the preventive measures, a fact, which is generally lacking. Generally people go on for curative measures when they are ill rather than trying preventive measures. In order to increase the health consciousness of people along with the basic education, the health education is also necessary in the district of Birbhum in both the rural and urban areas. This will step up the immunization programme, which is often neglected, as we got information while collecting the data in the district of Birbhum. All health workers supported by the use of mass media can carry out the health education through personal contact. This health education will be capable of uprooting the taboos and misconception in the minds of the people relating to the immunization programme, family planning etc. and should provide information on the beneficial effects of these programmes. As a consequence of the immunization process, the babies sometimes suffer from mild illness like fever. The health education would make persons aware and conscious of the fact that this is not at all any contra-indication of immunization. Thus, if the consciousness of the people increases, the demand for health insurance will automatically increase. In order to grow and increase the health consciousness amongst the people, some measures, as follows, should be adopted in the district of Birbhum.
• To educate the people on preventive health and on environmental cleanliness.

• To educate mothers on the matters relating to antenatal, intranatal and post-natal care.

• To educate people on immunization and to organize the immunization camps.

• To educate people on common diseases, prevention of those diseases and to avail themselves of the health facilities provided by the public and private health care sectors as also referral services.

• To treat common ailment.

• To take proper care of treatment and not to use self-assumed medicine for temporary relief at low costs.

• To make the community aware of healthful living.

The main implementers of these programmes are simply the volunteers who are known as the health workers. They should be selected from the community by the local leaders and they receive training from eminent doctors and social scientists.

Seventh, the study contends that the financial burden arises because either the households are not protected by health insurance or are protected by health insurance inadequately. If the households are properly protected by health insurance they can avoid or reduce their health care expenditure at the time of use. Thus, not only the private health insurance but also the free public provision and reimbursement, where the health care is prepaid by the
households from their own earning, can be deemed as a form of health insurance.

It has been found that the premium paid for the health insurance scheme is higher than the benefits provided to the customers. That is the premium-benefit ratio is smaller than unity. So it should be set aside on the basis of market price at a justifiable minimum amount, which will enable the people to purchase the health insurance scheme. This implies that the premium should be determined and charged on the basis of level of income also. Also the benefits of the health insurance scheme must be higher in order to attract the people to purchase the scheme, which in turn expands the health insurance markets. Lowering the administrative and management costs by the companies can do this. As for example, the Indian Post and Telegraph department provides different insurance schemes and other benefits to the people by employing the same employees as also work for the same and also at a lower incentives to them. However, if the benefits contrasted with the premiums increase, this may increase the demand for health insurance.

Eighth, higher tax exemption benefit for the servicemen may enhance the demand for health insurance. Though there is some provision of tax exemption for the servicemen on their savings and investment, the benefit is enjoyed by the high-income group people only. The people in the low-income group are deprived of such benefits of tax exemption, since their income does not come under the income tax scheme. This may also be the case that the Government tax policy relaxed them due to prescribed income
tax slab. Hence, a regulation regarding the compulsory health insurance scheme may be put forward for all formal sector employees, which may be taken through medical allowances as premium on the one hand and also encourage the health insurance market on the other hand.

Ninth, it should be noted that most of the businessmen save their earning on a daily basis through the collection agents to co-operative bank in the district of Birbhum. Similarly, the agents of the health insurance company may collect premium for their health insurance scheme on monthly basis. This scheme may be provided to businessmen along with the benefit of tax exemption on their premium money in order to persuade them to come under the umbrella of health insurance scheme.

Tenth, in the health insurance scheme there is no provision of refund of the amount premium to the insurer once paid for health insurance. And the persons who wants to be protected by health insurance needs to continue his/her premium per annum. The moment the prepayment of premiums is dropped, the person will go unprotected by health insurance. Due to such nature of the health insurance scheme, most of the households we interviewed during the time of our survey in the district of Birbhum, have expressed their dissatisfaction and unwillingness to come under the shelter of health insurance scheme. They suggested the alternative way out and that is simply like the scheme of life insurance, as it exists. Households are prepared to pay premiums per annum for some specific time period and for a fixed amount of assured sum, as set out in the policy. This assured sum need not be as high as that of an ordinary life insurance policy. During the time of
prepayment of premium and also after the period it becomes matured, they demand for being protected by health insurance. After the maturity period of the policy a part of the assured sum be refunded to insurer and the rest be kept with the provider of scheme in order to allow the insurer to be still protected by health insurance in the future period, the period for which no prepayment of the premium would be paid by the person concerned or claimed by the provider of the scheme.

Eleventh, the formal health insurance scheme only reimburses the expenses of the persons/households for hospitalization or indoor treatment. The outdoor treatment or the treatment that does not require any admission in the health care centers but involves huge amount of cost for different types of pathological, radiological or some other types of diagnostic tests for detecting actual disease does not come within the purview of the reimbursement under the health insurance scheme. And it is simply due to financial incapacity many persons or households, as we were informed during our survey in the district of Birbhum cannot in time go in for such costlier tests for the diagnosis of their diseases. As a result of such nature of the health insurance scheme, demand for health insurance was not at a significant level in the district of Birbhum as it was expected. Therefore, if the different providers of the health insurance make a provision of reimbursement of the outdoor treatments and different diagnostic tests prescribed by the registered doctors for proper diagnosis of the diseases, the demand for health insurance will obviously increase.
It was also our experience during the time of survey that the existing system of health insurance scheme that provides reimbursement for the indoor treatment or hospitalization, gives birth to some sort of dishonesty on the part of both doctors, persons or households protected by health insurance and health care centers. Many persons or households protected by health insurance in the district of Birbhum frankly confessed to us that in order to have reimbursement for the costs of treatment, which was not possible in the outdoor of any health care centers or does not at all require any hospitalization, were successful in manipulating so that their health caring doctors advised them to be hospitalized for indoor treatment. This incident has so many undesirable consequences. (i) The existing benefits of the health insurance scheme have been misused. (ii) There is a root of unfair means and foul play in the existing system of the health insurance scheme. (iii) The existing system of the health insurance scheme can result in the deprivation of hospitalization for the genuinely needy patients, since the persons who are protected by health insurance and did not in actuality need any hospitalization care occupy the limited beds of health care centers already. However, all such unfair things can be escaped if there is a provision of reimbursement for the outdoor treatment also. And naturally, we would like to prescribe to incorporate the facility of reimbursement for outdoor treatment in the health insurance scheme.

Twelfth, it was observed in the study that poor and other disadvantaged sections, such as scheduled caste and scheduled tribe people are forced to spend a higher proportion of their income for health cares and services. The burden of treatment is unduly very high when they seek
inpatient care. The high incidence of morbidity cuts their household budget
due to huge amount of money being spent for their treatment on the one
hand and due to loss of their earning that results from their involuntary
abstaining from the works during ailment on the other hand. This sort of
incident is very much true for all sorts of casual labourers. As a result they
have to borrow at a high rate of interest from the local moneylenders for
meeting the expenses of treatment and household consumption. We have
noticed in the district of Birbhum that in the process of such borrowing so
many small and marginal farmers have been turned into landless labour
ultimately. Therefore, it is sincerely felt that a voluntary comprehensive
health insurance scheme for such sections of the people in the district of
Birbhum in both the rural and urban areas is needed. In this regard, the
Government or non-Government sector should come forward with the
suitable health insurance scheme that will save such poorer section of the
society from complete perish.

Thirteenth, the district of Birbhum is predominantly rural oriented and
agriculture is the main activity for livelihood. But, the health care facilities
and provision of insurance are expanded in favour of the “creamy” layer of
the urban population. Hence, a mass population in the rural areas is deprived
of the benefits of the health insurance scheme. So something as ‘rural
insurance’ or the ‘insurance for the population in the rural areas’ should be
looked upon as an opportunity and not as an obligation. We may point out
two aspects in this context that are needed to develop so as to allow health
insurers to penetrate in the rural areas.
• A smaller bundle of innovative products in sync with rural needs and perception.
• An efficient delivery system.

Under this consideration, it is required to set up cooperative societies that will encourage targeting the rural sector in the district of Birbhum. Also insurance agents need to be trained to sell health insurance scheme to the rural people, considering that the bucolic population in the district is more susceptible to falling ill, as compared to health conscious urban one.

Fourteenth, in the district of Birbhum (and perhaps everywhere) it has been noticed that irrespective of the facts of insurance, the rates of all types of morbidity amongst the females are much higher than that amongst the males. Our estimation of the logit model for visiting hospital and using hospital services and cares shows that the females are more likely to go the health care centers due to their vulnerability to illness. The probabilistic model of the estimation of demand for health insurance reveals that the demand for health insurance by the females is much less than that by the males. It is also a significant result of our statistical analysis that it is female literacy, not the male literacy, which serves as an important factor in creating demand for health insurance for the males in the households. Thus, it comes up as something paradoxical that though the females are naturally more vulnerable to diseases, though their literacy is significant in the determination of demand for health insurance of the households, the females are not much protected by health insurance as it is desired or required. Therefore, we propose that the Government should look into this matter. As
there are now a days some special schemes like that of higher amount of standard deduction in the case of income tax computation, the special health insurance scheme for the females should also be introduced. Such special health insurance scheme for women should provide comprehensive health services to women (and it should function as the social security measures work) and ensure access of the women to health care and services at almost minimum amount of premium.

Fifteenth, we live in a time when the process of decentralization planning or participatory planning has gained wide success. Such guidelines of participatory planning or peoples’ planning may be utilized in order to provide protection of health for each and every person in the rural and urban communities. In the rural area of the district of Birbhum, the panchayat and in the urban area, the Municipality may also be entrusted responsibility by the Government to look into the matter of health and protection of health of the people of their jurisdiction. The Panchayat or the Municipality will decide how the issue of health and health insurance should be dealt with. Since through the Panchayats and the Municipalities the voice of people is better heard, so will be better tackled the health cares and services if these local administrative bodies come forward with good will in the matter of health protection. The local Government therefore should circulate and inform the inhabitants of their jurisdiction the basic need, objective and the process in which they would like to provide health insurance. The health insurance scheme that may be run by the local Government for the protection of the people in its jurisdiction should have the features as follows.
• As contrasted with other existing health insurance schemes, the health insurance scheme of the local Government is not based on voluntary membership of the local households, rather it will be compulsory membership of the local households.

• The scheme is to be cent percent peoples' participation oriented and therefore no profit motive should exist. On the other hand, as the local Government arranges for food for work programme and undertakes different developmental activities of the local areas, in the similar manner the local Government will arrange for the health insurance scheme for the people.

• The local Government should open a special cell that will look after all the matters relating to the health insurance scheme. The health insurance scheme to be introduced by the local Government is almost as like as that of the community based health insurance.

• The local Government will clarify the terms and conditions of the health insurance scheme and also clarify pre-payment of contribution into a fund and entitlement to specified benefits. The mode of pre-payment of the contribution or the premium may follow the system of installment for those who will be unable pay at a time. Further, the local Government should prepare rural calendar, depending on the peak and slack seasons of agricultural activities.
post-harvesting period when the cultivators have in their hands much money should be paid emphasis and properly marked in the rural calendar in respect of collecting the premiums for the health insurance scheme. Similarly, the sowing season when the cultivators need much money for their agricultural activities should be marked in the rural calendar for sparing them from the prepayment of their contribution of premium for the health insurance scheme.

- The local Governments plays important role in their areas (rural or urban) in the design and running of the scheme.
- The local Government should maintain the institutional relations to one or several health cares providers.

However, the success of the health insurance scheme depends totally on the efficient administration of the local Government, its transparency and real desire to do for the commons of the rural and urban areas in respect of protection by health insurance.

In this section we have presented a number of economic policies that may increase the demand for health insurance in the district of Birbhum. The policies we have suggested have automatically come out of our empirical study in the district of Birbhum. Though these policies are more suitable in the district of Birbhum, still we should point that these policies will also be applicable for any region with the same socio-economic and demographic features as we saw in the district of Birbhum.
5.7. Community Based Health Insurance: An Alternative Health Insurance Policy

In the context of severe economic constraints, political instability, lack of good governance and low income, the community based health insurance had evolved in many countries. Usually, when the Government taxation capacity is weak, formal mechanism of social protection for vulnerable population is absent, and the Government oversight of the informal health sector is lacking, the community based health insurance or the community financing schemes for the poor and the workers of the informal sectors may be prescribed as a better policy to overcome the problem of access to health cares and services against the high cost of illness.

It has been found in the district of Birbhum that the people covered by the health insurance scheme are basically involved in jobs in the organized sectors. Also, a small proportion of such people is covered by the formal health insurance schemes. In the district of Birbhum for most of the poor households, especially for those in the rural areas who reside in the backward and remote regions neither the Government facilities nor the private medical facilities are available. The rural people have to depend heavily on poor quality services provided by the local, often unqualified practitioners and faith healers. It should be noted where accessibility is not a problem, the primary health care centers are either dysfunctional or provide low quality services in the rural areas. Again a large number of people
engaged in the informal sector in both the rural and the slum urban areas are illiterate, poor and vulnerable.

In order to increase the access of the poor and the rural people the community based health insurance schemes can be suggested as an alternative important and valuable health insurance policy in the district of Birbhum. This community based health insurance scheme allows to pool risks and thereby lead to an improvement in the health care system in which most of the people otherwise have to cover health care expenditure through out-of-pocket payments. The main strength of the community based health insurance scheme is the degree of out-reach penetration achieved through community participation, their contribution to financial protection against illness and increase in the access of the low income rural people and workers of the informal sectors to health cares and services. The results and experience of the community based health insurance scheme support that the risk sharing corrects for, and may outweigh, the negative effect of overall income inequalities, suggesting that financial protection against the cost of illness may be more effective strategy for poverty alleviation that direct income support.

Furthermore, strong community participation can facilitate health education and sensitization of members in order to promote health behaviour and the use of preventive services, as the members share a common interest in keeping the costs of health care low. For example, the members of a self-governed community based health insurance comprising several villages in Benin realized that many cases of sickness and a considerable amount of
health care costs reimbursed by the scheme originated from the villages of one particular district. In consequence, the members of the community based health insurance scheme of that village and the local nurses organized sanitization sessions on water hygiene and vaccination (Gabra and Cyr, 1998). The Members of the Kisiizi Hospital Health Society in Uganda cited health education on preventive medicine as one of the main benefits of the scheme (Musau, 1999).

The necessity of health insurance of low-income people in the rural area and informal sectors is due to the fact that neither the state nor the market is effective in providing health insurance to them. Local community based or member based institutions are better placed to harness the people in the rural area and workers in the informal sectors, monitor behaviour and enforce contracts which are either too difficult or too costly for the Government or for any private agency that is not a part of the community (Zeller and Sharma, 1998). Since a community based scheme is more likely to enjoy the support and trust of the local people, it is more likely to be successful in attracting greater membership.

It is worthwhile to mention that the informal insurance mechanism against the health shocks gives at best a partial protection. In Indonesia, it shows that severe and rare health shocks leads to substantial reduction in consumption despite the existence of informal insurance mechanism (Gertler and Gruber, 2002). Juttings also advocates for the introduction of such schemes on social security systems in low-income countries. In this respect, the cases of Self-Employed Women Association (SEWA) in India and the
Gramin Bank in Bangladesh are the most promising examples. The review of the selected experiences in the Asia and Africa regions emphasized on the diversity of the community financing arrangements that exist there. Several of these schemes appeared to improve financial protection against the cost of illness, allow better access of the poor households to essential health cares and services, and conferred greater efficiency in the collection, pooling, management and use of scarce health care resources. Hence, the community based health insurance schemes basically follows the main characteristics that are mentioned below.

- The community based health insurance scheme is based on voluntary membership of the local households.
- The scheme is not profit oriented.
- It clarifies the pre-payment of contribution into a fund and entitlement to specified benefits.
- The community based health insurance plays important role in the community in the design and running of the scheme.
- It maintains the institutional relations to one or several health cares provides.

It has been traced on the approach by the Government to support the voluntary insurance rather than to expand the existing social insurance scheme. It has been suggested that for the upper and middle income population social insurance and voluntary health insurance may be two dominant forms of financing health cares and services. The role of state is
primarily to develop an appropriate legislative framework to appoint an independent regulator and to formulate procedures and regulations to avoid well documented market failures (Misra et.al., 2003). Even for the low-income groups who are employed in the formal sectors, social insurance may be a better way of providing health protection. But for the low-income people serving in the unorganized sector and those who are below the poverty line an alternative approach of sickness fund may be put forward. The objective of this funds is to cover all the hospitalization expenses of the poor families.

In the district of Birbhum, we find two groups people, of which one group of people can afford to buy health insurance that promises a certain amount of minimum level of benefits and the other group of people cannot afford to buy minimum benefits through health insurance of their own and therefore, needs some public subsidy. The private health insurance may be enhanced by taking care of those who afford to buy health insurance. But, for those who cannot afford to bear the minimum amount of premiums, the alternative approach with some public subsidy may be prescribed in the district of Birbhum. However, while operationalizing the idea, this conceptual distinction gets blurred. The attention of the Government gets confined only to those people, who are below the poverty line (BPL). While those below the poverty line need to be covered with the Government support, the non-BPL population with low income also needs to be covered with or without Government support, since the market insurance is likely to avoid this section of the population (Ransen et.al., 2003).
So it may be effective for the introduction of the health insurance scheme for the low-income people as it has started in Tamil Nadu (Ahuja, 2004). The grounds for the introduction of community based health insurance in the district of Birbhum are as follows.

- It is being increasingly felt or realized that even low income group of people can make small periodic contribution, which can add up to a significant amount, thereby, taking some pressure off from already strained state revenues.
- The insured people should have the option of going to either a public of private service provider, which in turn would generate competition among the providers to ensure better services.
- Health insurance can be used to promote certain desirable behaviour.

So, the introduction of the community based health insurance in the district of Birbhum has a potential positive impact on the ability of the households to smooth their consumption, on the supply of labour and the labour productivity and on the health status of the people protected by health insurance. Further research should analyze and evaluate these effects, if possible within a panel data set framework. This would give policy makers a clearer idea on the social costs and benefits introducing health insurance for the poor in the district of Birbhum and elsewhere.
5.8. Overview of the Participation Constraints

The formal health insurance in the district of Birbhum has been limited due to several constraints. The most important of these constraints are economic inability of the households, lack of good governance and institutional weaknesses. Therefore, we see that the formal social protection for the vulnerable segments of the population is widely absent. In this context the community based health insurance can play an important role towards improving the access to health care and better social protection. But, still the poorest of the poor predominantly in the village in the district of Birbhum face acute difficulties to participate fully in these schemes. For the sake of overcoming the constraints and enabling the increase in the participation of poor people in the health insurance programme some options, which we are going to discuss below, may be considered. These options might help expanding the community-financing scheme in the district of Birbhum.

- **Well-Targeted Subsidies:** The payment of premiums by the poorest segments in the village could be subsidized by the Government due to non-affordability of the people who need to be protected by health insurance. The supplemented subsidy by the Government could enable them to take the benefits of access to quality services that will rescue them from their frequent health problems. With these subsidies the Government
would promote the demand side with a potentially longer lasting effect than with subsidies for public health facilities.

- **Flexibility in Payment Procedure:** Households, who cannot afford to pay the premium at a time, should be allowed to pay in installments before joining a community scheme. The timing of collection is also important. After the harvest period, the chances that the poor can afford to spend money on insurance are higher.

- **Education and Strengthening of the Management Capacity:** The technological and organizational know-how of the schemes through management and building of training institution may prove to be a cost effective way for creating local ownership and capacity. These policies can be encouraged by the Government. Specifically, it would be useful in the district of Birbhum due to a number of reasons. First, the communities could be assigned in organizing and promoting the schemes and provide information about their viability. Second, an appropriate regulatory framework could be provided in the village to encourage the scheme. Third, the financial literacy through education in the region of interest could be promoted.

So, the schemes should be attractive to all groups of population to enlarge the risk pool of insurance. The trained persons from the local areas are
necessary in handling claims and intact the target of the scheme. The information campaign is probably useful in this context.

5.9. Conclusion

In chapter four we have considered the model the demand for health insurance in terms of some probabilistic models. We have estimated the logit and probit models of demand for health insurance. This is a result of two reinforcing dynamics. First, the access to health care, either public or private, is increasing subject to significant income. Second, the individuals do increasingly rely on health insurance. These evolving patterns motivate us or stimulate our interest to carry out a micro-econometric analysis of the demand for health insurance.

The existing econometric models perform mainly the demand analysis, that is, models the overall counts of health care uses and demand for health insurance in terms of education, income, worker-population ratio, premium-benefit ratio, frequency of illness etc. The results confirmed that the demand varies with respect to these factors either significantly of insignificantly.

The empirical evidences of the models reveal that age of the members in a household, its worker population ratio, the female literacy, premium-benefit ratio, religion, caste, health care expenditure etc. have played important roles in the determination of the demand for health insurance in the district of Birbhum. Taking these results into account for the purpose of
The appropriateness of launching a new policy is justified if it is able to provide health insurance to majority of the population if not all, in different socio-economic context. The role of the national policy makers and agencies includes establishing the principle of disassociation between utilization or access and financial contributions. This will have the way for strategic policies aimed at providing financial protection through health insurance scheme. Policies supporting the substitution of health insurance for out-of-pocket payment are therefore an initial requirement. Given the socio-economic diversity among the low-income population, in the short term, the contribution into substantial insurance pools offer the greatest possibility of financial and administrative feasibility (Arhin, 1995).

The introduction of community based health insurance or the health insurance as we have suggested through the initiative of local administrative bodies (Panchayat and Municipality) is the most effective measure than the alternative arrangements of providing health insurance scheme to the low-income people in the district of Birbhum. In this context, the proposed scheme may have a good and far reaching impact on the health status of the poor people.

The existing health insurance scenario is nothing but a burden of inefficiency of a system run by the Government. Moreover, the uncontrolled and the non-innovative attitude of the Indian bureaucracy has always argued
against the private companies in the health insurance sector in India. The unnecessary prejudice has never allowed the Government to open its doors of health insurance to others. So the opening up of the Indian insurance sector is indubitably a definite step toward making this sector a healthier one.

The development of private health insurance market in the country will not bypass the poor and the people engaged in informal sectors. The insurance sector reforms can affect the low-income people through its effect on the provision of health services that is, cost, quality and access used by the low-income people as well as through its access to financing of health care. We have also explored in our study how insurance sector reforms affect the health insurance prospects of the poor in India. Further, we need to explore also what changes on the health front affecting the poor have happened or are likely to happen as result of health insurance sector reforms.

The district of Birbhum is basically rural dominated in West Bengal. A large proportion of people are engaged in agriculture and agricultural related activities and in works of casual labour. The economic condition of socially backward community and the scheduled tribe people is not at all sound. This group of people is forced to spend a large proportion of their earning on health care expenditure. So the formal health insurance is not so much effective to them and naturally is least attractive. Therefore, we have suggested, though it may come up apparently impossible, to introduce the health insurance schemes at the initiatives of the local Government. We feel that the health insurance scheme run and managed by the local Government
will surely penetrate to each and every corner of the society. It will produce better results than the community based health insurance.

We have discussed in this chapter the constraints that have hindered the attempts to design the appropriate community health insurance schemes. These constraints include the policy environment, inadequate administrative infrastructures and a shortage of trained staff to manage the schemes. Though these constraints make it difficult to launch on the part of any private agency the desired health insurance scheme, the local Government with the help of their appropriate administrative machinery can be able to eradicate these constraints and introduce the appropriate health insurance scheme for the rural people.

We would conclude that the community based health insurance or the health insurance scheme to be introduced by the local Government has to play important role and therefore need to be encouraged by the Government through the appropriate interventions. Formal insurance providers can also be able to serve the need of the low-income population, if they are properly controlled, monitored and left under the keen watch of the Government in the country in respect of disbursing the services of these private agencies to the poor. At the same time the development of the formal health insurance markets need to be guided so as to minimize the cost escalation of the health care provision.

However, whatever may be the policies prescribed in order to serve the health care needs of the population, predominantly of the population in
the low income category, the successful implementation of the policy plays a crucial role. So far, the policies prescribed in this context by the different Government and non-Government bodies and accepted for its operation, have hardly been implemented. Therefore, unless the policies are efficiently implemented in the right spirit, policy prescription remains a cry in the wilderness.