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Health Finance and Health Insurance in India

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ABSTRACT *Today the world stresses on economic growth, globalization and privatization; a silent section of the society seems to slip through all safety nets. In India, one is talking about at least 26% of the population who fit into this category. The percentage varies from state to state. In most of the northern states poverty seems to be increasing and if you further disaggregate from urban to rural, you will find that 40% of the rural population in 10 states in India are below the poverty line. The main objective of a health care system is to maintain or improve the health status of the population. This is accomplished mainly by preventing disease and illness. Health insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called premium.'*

Introduction

We have to accept the fact that there is a segment in our society, and we are talking about 260 million Indians, who are surviving on less than 2,400 calories everyday.[3] Health care systems are a prominent focus for national leaders and policy makers in most countries today. This reflects concerns about the availability of necessary health services for the population, as well as about the efficiency and costs of current health systems in delivering those services. The degree of importance of this issue in any given country is directly related to the size of the health care system relative to the national economy. Nearly all decisions of policy makers about national health systems must be based on the quantitative aspects of the options available, and the impact of any decisions taken. A quantitative description of the current health system and projection of the impact of changes to the system through new policy initiatives is also critical to reform. Hence, the ability to quantitatively describe health systems as well as to create a range of "what if" scenarios based on new directions for those systems is increasingly important in all countries.[4]

Regardless of the ability of the individual to pay, the national or social health care system aims at guarantying access to health services for the entire population. Because of their extent of access to care and high quality of that care many health care systems are succeeded in Africa, Asia, Europe, Latin America and North America.

Financing of Health in India

Financing is the most critical of all determinants of a health system. The nature of financing defines the structure, the behaviour of different stakeholders and quality of outcomes. It is closely and indivisibly linked to the provisioning of services and helps define the outer boundaries of the system's capability to achieve its stated goals. Health financing is by a number of sources:

(i) the tax-based public sector that comprises local, State and Central Governments, in addition to numerous autonomous public sector bodies;
(ii) the private sector including the not-for-profit sector, organizing and financing, directly or through insurance, the health care of their employees and target populations;
(iii) households through out-of-pocket expenditures, including user fees paid in public facilities;
(iv) other insurance-social and community- based; and
(v) external financing (through grants and loans).[5]

India has registered significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and material mortality over the last few decades. In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. An estimated 5 million people in the country are living with HIV/AIDS, a threat which has the potential to undermine the health and developmental gains India has made since its independence. Premature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India. The inequity is also reflected in the skewed availability of public resources between the advanced and less developed states[6]

Central and State Governments towards Health Finance

The government health financing landscape is changing fast in India. There is a strong political commitment at the highest level to increasing public spending on health from about 1% of GDP to 2-3% of GDP by 2012. In keeping with this goal, the central government has increased its health spending substantially in the last 3 fiscal years, mainly for the national flagship program, the National Rural Health Mission (NRHM), that provides increased finances to states for existing programs as well as funding for several new initiatives.[7]

In India, states contribute the bulk of government health financing, which is in consonance with India's constitutional decentralization whereby health is a –state subject. While the goal of 2-3% of GDP is voiced by the central government, achieving the goal would not be possible without the active involvement of states. Even if this commitment is center-led, which is implied in the strategy of raising the central share from less than 30% in 2005 to 40% in total government health spending by 2012, the states would still have to substantially increase their contributions to reach the goal. Given that the states' role is crucial to achieving the goal, how credible is the overall commitment by the center? Do states attach the same priority to health as shown by the center? Even if, in principle, states attach similar priority, what demand does this goal places on state level funding? Can states mobilize the kinds of resources needed to achieve the goal?

One articulation of the central government's pledged increase in public spending on health in India has been the introduction in 2005 of the National Rural Health Mission (NRHM). NRHM is designed as an umbrella program – consolidating existing programs as well as adding some new ones – with a flexible, bottom-up perspective whereby dis-

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trict and village level health plans are aggregated up to the state level which are then annually submitted to and financed by the center, with some proposed matching of funds by the states to be introduced during the course of the implementation of the program.

Health Care – Public and Private Partnership

Health care in India has a long tradition of voluntarism. For centuries, traditional healers have taken care of the health needs of their own community as a part of their social responsibility. They have used knowledge that has passed down the generations, regarding the medicinal value of locally available herbs and plants. This tradition still continues, particularly in the tribal pockets of the country.[8]

After Independence, until the mid-sixties, voluntary effort in health care was again limited to hospital-based health care by rich family charities or religious institutions.

The voluntary health effort as it exists today, can be broadly classified as follows:

- Specialized Community Health Programs: Many of them go a little beyond health, by running income-generation schemes for the poorer communities so that they can meet their basic nutritional needs.
- Integrated Development Programs: • In these programs, health is a part of integrated development activities. Consequently, their emphasis on health care may not be as systematic or as effective as that of the previous group. However, the long-term impact of their work on health and the development of the community is significant.
- Health Care for Special Groups of People: This includes education, rehabilitation and care of the handicapped. These specialized agencies are playing an important role, keeping in view the fact that hardly any government infrastructure exists in this sector of health care.
- Government Voluntary Organization: These are voluntary organizations which play the role of implementing government programs like Family Planning and Integrated Child Development Services. These bodies are marginally more efficient than the government system but their overall approach is the same.
- Health Work Sponsored by Rotary Clubs, Lions Clubs and Chambers of Commerce: They usually concentrate on eye camps – conducting cataract operations in the rural areas on a large scale with the help of various specialists, etc.
- Health Researchers and Activists: The efforts of these groups are usually directed towards writing occasional papers, organizing meetings on conceptual aspects of health care and critiquing government policy through their journals (which usually have limited circulation).
- Campaign Groups: These groups are working on specific health issues, such as a rational drug policy and amniocentesis, among others.9

According to a rough estimate, more than 7,000 voluntary organizations are working in the above areas of health care throughout the country. Voluntary agencies have played a significant role in developing alternative 'models', as well as providing low-cost and effective health services in many parts of the country.

Concept of Health Insurance in India

Health insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called premium.' In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

(1) Voluntary health insurance schemes or private-for-profit schemes;
(2) Employer-based schemes;
(3) Insurance offered by NGOs / community based health insurance, and
(4) Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).[10]

Voluntary health insurance schemes or private-for-profit schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to third party and provider institutions.

In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and the Life Insurance Corporation (LIC) of India provide voluntary insurance schemes.

Insurance offered by NGOs / community based health insurance

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services.

Community-based schemes are typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources. Such schemes are generally run by trust hospitals or non-governmental organizations (NGOs). The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations.

Some examples of community-based health insurance schemes are

- Self-Employed Women's Association (SEWA), Gujarat,
- Another CBHI scheme located in Gujarat, is that run by the Tribhuvandas Foundation (TF),
- The Mallur Milk Cooperative in Karnataka,
- The Action for Community Organization, Rehabilitation and Development (ACCORD),
- Another scheme located in Tamil Nadu is Kadamalai Kalanjia Vattara Sangam (KKVS),
- The Voluntary Health Services (VHS), Chennai,
- Raigarh Ambikapur Health Association (RAHA), Chhatisgar.[11]

Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)

Social insurance is an earmarked fund set up by government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income rather than related to health risk. The government-run schemes include the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS).

Central Government Health Scheme (CGHS)

Since 1954, all employees of the Central Government (present and retired); some autonomous and semi-government organizations, MPs, judges, freedom fighters and journalists are covered under the Central Government Health Scheme (CGHS). This scheme was designed to replace the cumbersome and expensive system of reimbursements It aims at providing comprehensive medical care to the Central Government employees and the benefits offered include all outpatient facilities, and preventive and promotive care in

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dispensaries.

Employee and State Insurance Scheme (ESIS)
The enactment of the Employees State Insurance Act in 1948 led to formulation of the Employees State Insurance Scheme. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits, preventive and promotive care and health education. Originally, the ESIS scheme covered all power-using non-seasonal factories employing 10 or more people. Later, it was extended to cover employees working in all non-power using factories with 20 or more persons. While persons working in mines and plantations, or an organization offering health benefits as good as or better than ESIS, are specifically excluded.

Recently the ESIS rules were amended to raise the monthly wage limit to Rs 15000/- which means everybody with wage below 15000/ pm will be covered. However no doctor is ready to register new members as they get very meager fees after lot of paperwork and delays from ESIS they are not interested.[12] In India, how the initiation taken by the Central government in the same context some of the State governments have taken initiative to implement the health insurance in their respective states.[13]

Conclusion
Health sector in India suffers from gross inadequacy of public finance and therefore an immediate and significant scaling- up of resources is an imperative. The undue burden on households for spending on health cannot be wished away. Further, it is also clear that there is an urgent need to restructure the budgeting system to make it more functional, amenable to review of resource use to take corrective measures in time and be flexible enough to have the capacity to respond to an emergency or local need. Rules and procedures for actual release of funds, appointment of persons, labour laws, procurement systems all need a thorough review.

Health insurance is like a knife. In the surgeon's hand it can save the patient, while in the hands of the quack, it can kill. Health insurance is going to develop rapidly in future. The main challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without negative aspects of cost increase and overuse of procedures and technology in provision of health care.

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