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Healthcare Financing Mechanisms in India: An Examination of Health Insurance

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ABSTRACT

The paper seeks to examine various healthcare financing mechanisms in India with special reference to health insurance. The raising out-of pocket expenditures is grave concern for the country today. An examination of healthcare financing mechanisms particularly health insurance is essential as the emphasis is firmly placed on moving towards universal coverage. Government has been putting serious efforts to provide health insurance to the poor and vulnerable sections of the society. But the most important is insurance covers only the cost of hospitalisation and not the cost of outpatient care. Moreover, majority of the people are self employed, universal coverage will remain a mirage. Many villages in India do not have a hospital worth the name within accessible distance. What would be insurance cover for people living there? Given the heterogeneity of different regions in India and the regional specifications, there is a need to gather information about the population to be targeted under an insurance scheme at various geographical regions and to develop options for different population groups.

I Motivations and Rationale

Promoting and protecting health is essential to human welfare and sustained economic and social development. This is recognized more than 30 years ago by the Alma-Ata Declaration signatories, who noted that Health for All would contribute both to a better quality of life and also to global peace and security. The ability of the health system of a country to meet the emerging challenges and cater effectively and adequately to the health needs of the population depends crucially on the financing mechanisms of public health services. Hence, the financing mechanisms of healthcare need to be reviewed and analyzed to facilitate better understanding and prioritize allocation optimally.

The way in which health care is financed is critical for equity in access to healthcare. At present the proportion of public resources allocated to healthcare in India is one of the lowest in the world (Duggal, 2007). It is further reported that even this small public expenditure is skewed towards the richer groups particularly those living in urban area (NCAER, 2002). India has large-scale poverty and yet the main source of financing healthcare is out-of-pocket (OOP) expenditure. Out-of-pocket spending on healthcare as a mode of financing is both regressive and iniquitous, especially for poor households (Garg and Karan, 2009).

If India is to improve health outcomes and equity in access, increasing the role of public health expenditure will be critical. There is a need to curtial the growing OOP financing of the healthcare system and replace this with a combination of public finance and various collective financing options such as insurance (Duggal, 2007). Many scholars in recent years have been suggesting that health insurance is the alternative mechanism to finance healthcare in the country. Some questions are pertinent in this regard: why healthcare financing in India is still predominantly based on out-of-pocket payment? Is it due to lack of prepayment mechanism like insurance? Is India having adequate health infrastructure to meet the health needs of its population? Is India having adequate organised sector to focus the target group? Is health insurance a panacea for the inefficient public health delivery system?

Given this scenario, the challenge before policy makers is to find ways to improve upon the situation in the health sector and to make equitable, affordable and quality healthcare accessible to the population, especially the poor and the vulnerable sections of the society. It is obvious need to identify the options for raising sufficient resources and removing financial barriers to access healthcare, especially for the poor.

The need for guidance on healthcare financing mechanisms particularly health insurance is essential as the emphasis is firmly placed on moving towards universal coverage, a goal currently at the centre of debates about health service provision. It has become all the more pressing at a time characterised by both economic downturn and rising healthcare costs, as population age, chronic diseases increase, and new and more expensive treatments becomes available. The growing demand for access to high-quality, affordable care further increases the pressure to make wise policy choices (WHO, 2010).

It is beyond the scope of the paper to provide discussion to the issues raised above. In this connection, the paper seeks to analyse the healthcare financing mechanisms in India with special reference to health insurance. The paper consists of four sections. Motivations and rationale of the study along with objective is presented in Section I. Section II provides various healthcare financing mechanisms in India. Critical discussion of health insurance models in India presented in Section III and the last section concludes the paper.

II Healthcare Financing Mechanisms

Health care financing is concerned with how financial resources are generated, allocated and used in health systems. It is concerned with how and from where to raise sufficient funds for health, how to overcome financial barriers that exclude many poor from accessing health services, how to provide an equitable and efficient mix of health services. There are various ways of financing the health care:

- Through revenues raised from general taxation, e.g. United Kingdom, Denmark
- Through direct payments by patients, e.g. Myanmar
- Through health insurance, e.g. Germany (social health insurance) and USA (private health insurance)
- Mixed – a mixture of the above three mechanisms, e.g. India

In high income countries like United Kingdom and Australia, the main mechanism is tax based mechanism. The National Health Service (NHS) of United Kingdom is a stark example of this. Under this system, healthcare is financed through general revenues, covering whole population, care provided through public providers. Funding comes primarily from general revenues. General revenues include taxes, other public revenues from sales of natural resources, sales of government assets, public tolls, borrowing and grant assistance, earmarked taxes or funds from local authorities etc. It will provide healthcare coverage to whole population. Usually healthcare is delivered through a network of public providers. Ministry of Health heads a large network of public providers organised as a national health service. Healthcare facilities are owned by the government, and health personnel are public employers. As in the case of Scandinavian countries, the UK uses tax finances to pay 80 per cent of its healthcare spending. General revenues dominate financing in some 106 of 191 countries.

On the other hand, some high income countries like Germany and the USA are depended on the insurance based financing mechanism. Elsewhere in Europe, social insurance schemes bear most of the financial burden. Social health insurance schemes provide coverage to designated groups, financed through payroll contributions and healthcare provided through own, public, or private facilities. Over 60 countries have established social health insurance systems. The US relies on private insurance, paid for mostly by employers. Private health insurance schemes are financed through individual private health premiums, which are often voluntary, and risk rated. 'For-profit' insurance companies manage the funds. Most citizens from low income countries pay their healthcare providers directly through out-of-pocket payments. Myanmar is the best example of this. Many African countries are dependent on donors.

In case of India, though total expenditure on health is increasing steadily but its mix of public and private spending is a major cause of concern (Bhat and Nishant, 2006). The total health care spending of India is 4.2 percent of GDP. This is comparable to other economies which have attained better status of health (See Table 1). However, government expenditure on health is 32.4 per cent. This makes India one of the highly privatised health systems in the world where household Out-Of-Pocket(OOP) direct payments account for almost three-quarters of the total health expenditure (see NCMH, 2005; Government of India 2005; Mahal et al.,2010; also see, O'Donnell et al., 2008; Van Doorslaer et al., 2007). India is a low income country with 37.2 percent (Tendulkar estimates) of population living below poverty line and 26 per cent illiterate population with skewed health risks. Health care needs of these disadvantaged groups are primarily met through out-of-pocket expenditure on services provided by the public and private sectors. This means that payment is made at the point of accessing health services. Table 1 shows health expenditure ratios for the years 2008. The total expenditure on health as percentage of gross state domestic product is highest in USA and Germany where as lowest in India. The increase in OOP expenditures in almost all the countries is a grave concern for the world today.

Table 1: Health Expenditure Ratios 2008

Country	Total expenditure on health as % of GDP	Government expenditure on health as % of Total expenditure on health	Private expenditure on health as % of total expenditure on health	Out-of-pocket health expenditure as % of private expenditure on health
	2008	2008	2008	2008
India	4.2	32.4	67.6	74.4
Denmark	9.9	80.1	19.9	89
Germany	10.5	74.6	25.4	53.9
UK	8.7	82.6	17.4	63.7
Brazil	8.4	44	56.0	57.1
China	4.3	47.3	52.7	82.6
USA	15.2	47.8	52.2	24.4
Japan	8.3	80.5	19.5	80.6
Canada	9.8	69.5	30.5	50.9
South Africa	8.2	39.7	60.3	29.7
Source: World Health Statistics, 2011, World Health Organisation				

Various studies examine the effect of OOP health expenditure on poverty head count and whether such expenses push households deeper into poverty. Adversities related to OOP spending are apparent in the form of intensified poverty and ill fare in the country. For instance, in 1995-96 an estimated 2.2% of the Indian population fell into poverty because of OOP spending (Peters et al., 2002) and it increased to around 3.2% in 1999-2000 (Garg and Karan, 2009). The World Bank (2002) found that 24 per cent of all people hospitalised in India in a single year fall below the poverty line due to hospitalisation. Households have to depend on informal networks to make health care payments For example, in Hyderabad 24 per cent of the households had to borrow to pay for health expenditure in 2006 (Banerjee and Duflo, 2007). A significant proportion of population may have had to sell their assets (productive) for inpatient care (Peters et al., 2002; Dilip and Duggal, 2002). A significant proportion of population may have had to forgo treatment all together (NSSO, 60th Round, 2004).

Many economists and scholars working in this area have been suggesting that health insurance can provide financial protection to households in the event of health shock and can reduce catastrophic out-of-pocket expenditure on health care (Joglekar, 2009). So that it can protect families from impoverishment and empower the patient to seek health care as a right (Gilson, 1998). Moreover it is equitable than out-of-pocket payments. Hence it is imperative that the health insurance coverage is increased (Bhat and Jain, 2006).

III Critical Discussion of Health Insurance Models in India

Today many countries are shifting over to health insurance as a mechanism of financing their healthcare programme. In India, we need to shift from the current predominance of out-of-pocket payments to a health insurance programme. The reasons are very clear:

- Direct out-of-pocket payments are a financial barrier to accessing health services. On the other hand, an insured patient can walk into a health facility without the fear of financial burden;
- Direct out-of-pocket payments can push families into indebtedness or poverty. Health insurance protects the patient from the burden of raising funds at the time of illness;
- Direct out-of-pocket payments are inequitable as they place the burden on the vulnerable. Insurance through its risk pooling mechanism is more equitable; and
- Direct out-of-pocket payments do not permit patient's participation in his/her treatment. On the other hand, by its collective nature, a health insurance programme can negotiate for better quality care.

Most health insurance schemes can be classified into three broad categories, social health insurance, private health insurance and community (or micro) health insurance. In India, we have a fourth category called government initiated health insurance schemes that do not fit into any of the above three categories. Each has its own specificities. However, there are some features that overlap among the three.

Social Health Insurance (SHI)

Social health insurance schemes are statutory programmes financed mainly through wage-based contributions and related to level of income. SHI schemes are mandatory for defined categories of workers and their employers. It is based on a combination of insurance and solidarity. The classical example of an SHI is the German or Belgian health insurance system. Here, employees and employers contribute to a 'mutual fund(s)' that is then used to finance the healthcare for the entire population. Citizens have to enrol compulsorily in one of these mutual funds. The government also provides significant funding to cover those who are not able to contribute.

In many low-income countries, SHI has been implemented mainly for the civil servants and the formal sector. This can lead to gross inequities. For instance in India, 18 per cent of the central government budget is used to finance an SHI for the civil servants who constitute only 0.4 per cent of the population.

In India, there are three well-known SHI schemes - the Employees' State insurance Scheme (ESIS), the Central Government Health Scheme (CGHS) and the ECHS (Ex-Servicemen's Contributory Health Scheme).

There are many advantages of SHI:

- A healthier workforce as they are covered, and so have easy access to health care.
- SHI produces a stable source of income for healthcare and which is independent of the Ministry of Finance and not subject to budget fluctuations.
- It provides additional source of funds to the health sector,

as there are contributions from the employees and the employers.
- The funds of the scheme are earmarked for healthcare. It cannot be diverted for any other purpose.
- A mandatory scheme saves money in marketing the product. Also, a mandatory scheme ensures that there is significant enrolment, minimising some of the inherent problems of health insurance, like adverse selection. SHIs with a large pool can negotiate with providers for better quality of services
- There is considerable pooling between the rich and the poor, between the sick and the healthy and between the young and the old. Being a compulsory enrolment, both the healthy and sick enrol. Similarly, the current employees and the retired employees are also part of the scheme. And finally, since the family members are also enrolled, both children and elderly are covered under this scheme. This means that there is substantial cross subsidy – from the healthy to the sick, from the young adult to the children and elderly and also from the rich to the poor.
- Many SHI schemes receive grants from the governments. This further stabilises the fund and makes it financially sustainable.
- There is more equity, because of the income-rated premiums – the premiums are collected in terms of ability to pay, rather than the need for health services

But there are also some disadvantages:
- Since these schemes only target the formal sector, the large majority of population in low-income countries are not covered. For example, in India, only 10 per cent of the adult population is employed in the formal sector.
- If the scheme is not managed properly, there is scope for abuse as is seen in the CGHS.
- Quality of care can be low, especially if the scheme has its own facilities and employs doctors as salaried professionals. This is the common complaint with the ESIS.

Favourable conditions for a successful SHI programme:
- Political will
- A reasonably large formal sector that can contribute
- A legal framework to manage the funds
- The country should have the administrative capacity to manage the scheme
- A high population density with considerable urbanisation
- Reasonable per capita income, with a high economic growth

However, recent experiences suggest that these are desirable but not essential conditions. Vietnam, which is a low-income country, has introduced SHI and successfully covered most of its population. The same goes for the Philippines, which has managed to cover more than 50 per cent of its population in a short time. Kenya and Tanzania are also embarking on ambitious plans of SHI to cover their population.

Private Health Insurance (PHI)
Private health insurance refers to insurance schemes that are financed through individual private health premiums, which are often voluntary, and risk rated. 'For-profit' insurance companies manage the funds.In low-income countries like India, they provide primary insurance cover, i.e. they insure hospitalisations. On the other hand, in high-income countries, they usually provide supplementary secondary insurance cover.

In Belgium, private health insurance is used to cover services not provided by the SHI, e.g. a private room, or dental services. In the USA and in some countries in Latin America, the private health insurance is the main actor in financing healthcare. Being a voluntary health insurance, it has the potential for adverse selection. People who have a pre-existing illness may enrol in larger numbers, thus endangering the financial viability. Most PHIs use risk-rated premiums as a measure to overcome this.

Community Health Insurance (CHI)
Community health insurance is "any not-for-profit insurance scheme aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management".The important point to note is that in CHI, the local community takes the initiative in establishing a health insurance scheme, usually to improve access to healthcare as well as protect against high medical expenses. The solidarity element is strongest in CHIs as most of the members know each other.

Community health insurance as a movement is quite active in sub-Saharan Africa. Even in Asia, we have examples from India, the Philippines, Indonesia, Cambodia, Bangladesh, etc. Their main strengths are:

- Their closeness to the people. This allows people to have a say in the design and management of the health insurance scheme and thereby in the delivery of their healthcare.
- Their ability to cover the informal sector – the farmers, the peasants, the self-employed and the landless workers. These sections of society are usually not covered by other forms of health insurance.
- Their ability to design schemes that meet the people felt needs, keeping the premiums affordable and the benefit package acceptable.

However, some of their weaknesses are:
- Their size. Most CHIs are small and do not have significant risk pooling. It is limited to risk sharing between the healthy and the sick.
- This small size and the fact that the insured are poor means that the benefit package is limited in scope and may not cover the entire needs of the community.

Government-initiated Health Insurance Schemes (GHI)
As stated earlier, India has a fourth category that is not usually seen in other countries. This is the 'GHI'. The specificity of this is that the government introduces a health insurance programme, usually for the poorest and vulnerable sections of the community. In many of the schemes, the premium is totally subsidised by the government (from tax-based revenues) and is paid directly to the insurance company. Rarely, the community may be expected to pay a token amount. The insurance company or an independent body is the organiser of the scheme. These schemes last for a couple of years, depending on the political will and longevity of the government. These are seen more as populist welfare schemes rather than a long-lasting intervention.

Differences in the four categories
While we have presented the four types of health insurance as separate entities, there is considerable overlap amongst the four in many aspects. While we have presented the four types of health insurance as separate entities, there is considerable overlap amongst the four in many aspects.

- **Source of funds –** While SHI raises its funds from pay roll deductions; both CHI and PHI are dependent on voluntary contributions from individuals/groups. On the other hand, the GHI is funded from tax-based revenues.

- **Pooling –** SHI uses state bodies to pool the money, e.g. the ESI Corporation. Switzerland is an exception, where private 'for profit' insurance companies pool the payroll deductions. In the case of CHI, this role is played by NGOs/CBOs. Private 'for profit' companies pool the money in the case of PHI. In GHI, the health insurance company plays this role.

- **Community –** SHIs usually target the formal sector, especially in low-income countries. In the European system, there is normally universal coverage, but this has taken many decades to achieve. On the other hand, CHI is probably the only category that has been successful in reaching out to the informal sector in low-income countries. The GHI schemes of course cover the poorest and the vulnerable, the BPL (below poverty level) populations.

- **Nature of health insurance –** SHI schemes are usually mandatory and supported by legal provisions. Thus those covered have to contribute regularly towards the fund. On the other hand, both CHI and PHI are usually voluntary in nature and

it is up to the individual to decide whether to join or not. GHI schemes depend on the whims and fancies of the government departments.

• **Premiums –** There are usually distinct differences in the three categories in the way premiums are calculated. SHI is the most equitable and calculates an income-rated premium, while the CHI has a community-rated premium. PHIs usually use risk-rated premium and are the most inequitable. The GHI subsidises the premium and so there is hardly any contribution from the community. Wherever they do contribute, it is on a voluntary basis.

• **Risk management –** SHI, with its third party payment, is a fertile ground for moral hazard. Patients are not aware about their bills and so have a tendency to overuse the health services. Providers also are not under any restrictions to contain costs and tend to over-prescribe. On the other hand, both CHI and PHI have the problem of adverse selection, i.e. those who need more health care tend to join. This limits risk pooling and can put the financial viability of the scheme in jeopardy. GHI on the other hand is prone to fraud and underutilisation. Insured patients may not even be aware that they are insured. And worse, the better-off may use the benefits on behalf of the poor.

Given the strengths and weaknesses of the above insurance schemes in India, the proposed health insurance to finance healthcare is neither a substitute for well-functioning, effective and efficient public healthcare system, nor, an argument for undermining higher public investments as the success of risk pooling is dependent on the provision of health care services in the public and private sectors. Most important, insurance covers only the cost of hospitalisation and not expenditure on outpatient care. National Health Accounts statistics (2001-2002) show that close to 70 per cent of the out-of-pocket expenditure of the household is for outpatient care, which will not be covered by insurance. Secondly, even in the U.S. about 15 per cent of the population do not have any health insurance cover as they do not have employers to pay their premium. In the Indian situation where majority of the people are self-employed, universal coverage will remain a mirage. Thirdly, many villages in India do not have a hospital worth the name within accessible distance. What use would insurance cover be for people living there? The wide differentials in the demographic, epidemiological status and the delivery capacity of health systems are a serious constraint to a nationally mandated health insurance.

For the same reason, even the publicly funded Rashtriya Swasthya Bima Yojana (RSBY) meant for the poor is unlikely to serve its purpose. Further, the present level of funding is sufficient to provide insurance to only a small proportion of those who need it.

IV Conclusions and Policy Implications

The healthcare financing is in a discouraging situation in India. The raising health needs particularly in the backward and low income states, sluggish health outcomes, dwindling budgetary allocations and heavy household out-of-pocket expenditure on health pose serious challenges to healthcare financing in India. It is common to consider health insurance may reduce pitfalls in the health system. But introducing health insurance may not solve most of the problems. While health insurance can improve access to healthcare, protect against catastrophic health expenditure, improve quality of services and has the potential of allowing the people to have a say in the way healthcare is delivered, there are many conditions to be met for these to be realised. Without this, health insurance is reduced to a mere financing tool that may not benefit the neediest.

Given the heterogeneity of different regions in India and the regional specifications, health policy makers and health systems research institutes, in collaboration with economic policy study institutes, need to gather information about the population to be targeted under an insurance scheme at various geographical regions and to develop options for different population groups.

REFERENCE

Banerjee, A., and E. Duflo (2007),"The Economic Lives of the Poor", Journal of Economic Perspectives, 21 (1):141-168. | Bhat, R., and Jain, N., (2004)," Time Series Analysis of Private Healthcare Expenditures and GDP: Co-integration Results with Structural Breaks", Working Paper (May 2004), Indian Institute of Management Ahmadabad, India. | Bhat, R., and Jain, N., (2006),"Factors affecting the Demand for Health Insurance in a Micro Insurance Scheme", working Paper (2006-07-02), Indian Institute of Management, Ahmadabad, India. | Dilip, T.R., and Duggal, R., (2002),"Incidence of non-fatal Health Outcomes and Debt in Urban India", Draft paper presented for urban research symposium, 9-11 December 2002, at World Bank, Washington D.C. | Garg C. C., and Karan, A.K., (2009), "Reducing out-of-pocket Expenditures to Reduce Poverty: A Disaggregate Analysis at Rural Urban and State Level in India", Health Policy and Planning, 24(2):116-128. | Gilson, L (1998)," In Defence and Pursuit of Equity", Social Science Medicine, 47(12):1891-1896. | Government of India (2005),"National Health Accounts, India (2001–2002)", New Delhi: Ministry of Health and Family Welfare, Government of India. | Joe, W., and Mishra, U.S., (2009)," Household Out-of-Pocket Healthcare Expenditure in India: Levels, Patterns and Policy Concerns", Working Paper No.418, Centre for Development Study, Thiruvanantapur. Downloaded from www.cds.edu on 25th October 2010. | Joglekar, R., (2008),"Can Insurance Reduce Catastrophic Out-of-pocket Health Expenditure?" Working Paper (No.2008-016), IGIDR, Mumbai. | Mahal, A., Karan, A., Engelgau, M., (2010), "The Economic Implications of Non-Communicable Diseases for India", The International Bank for Reconstruction and Development/The World Bank, Washington DC. | Murray, C.J.L., and Frenk, J., (2000), "Framework for Assessing the Performance of Health Systems", Bulletin of World Health Organisation, 78(6):717-31. | National Commission on Macroeconomics and Health (2005),"Report of the National Commission on Macroeconomics and Health", New Delhi: Ministry of Health and Family Welfare, Government of India. | National Family Health Survey (NFHS-3, 2005-06), Ministry of Health and Family Welfare, Government of India, http://www.nfhsindia.org/nfsh3.html. | National Sample Survey Organisation (2004) 60th Round, Morbidity, Health Care and the Condition of the Aged, Ministry of Statistics and Programme Implementation Government of India. | O'Donnell O, van Doorslaer E, Rannan-Eliya R.P., et al., (2005),"Who Pays for Healthcare in Asia", Journal of Health Economics, 27(2): 460-475. | Peters, D.H., Yazbeck, A.S., Sharma, R.R., Ramana, G.N.V., Pritchett, L.H., and Wagstaff, A., (2002),"Better Health Systems for India's Poor: Findings, Analysis and Options", Washington DC: World Bank. | Van Doorslaer, E., O'Donnell, O., Rannan-Eliya, R.P., Somanathan, A., et al., (2007)," Catastrophic Payments for Health Care in Asia, Health Economics, 16 (11): 1159–1184. | World Health Organization (2010), "World Health Report: Health Systems Financing: The Path to Universal Coverage", World Health Organisation Press, Geneva. | World Health Organization (2010), "World Health Statistics," accessed from http://www.who.int/countries/ind/en on 26th November 2011. |