

HOW WELL ARE THE POOR COVERED FOR HEALTH CONTINGENCIES IN INDIA?

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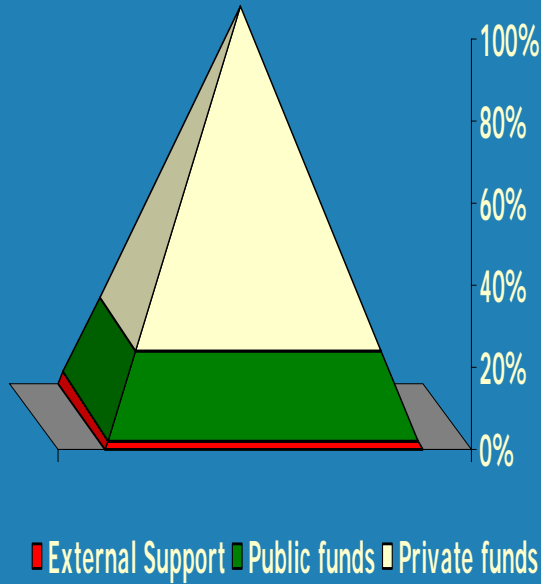
- **Links between economic status/poverty and well-being indicators like health and education have been studied empirically and documented:**
 - Poor people have worse health
 - Ill health generates poverty
 - Income and education are key determinants of health
- ***Micro* links between health and economic activity have also been looked at:**
 - Healthy workers are more productive
 - Healthy workers and family members contribute to output by reducing absenteeism
 - Ill health reduces hourly wages
 - Lower expenditure on health care by households frees up resources for other productive activities like food and education, and contributes to development

- The *micro* links logically translate into *macro* links between health and economic growth, but are less well understood
- However, evidence is increasing on these macro links as well
- A study done on India (Gupta & Mitra) indicates that:
 - Per capita health expenditure positively and unambiguously affects health status
 - Poverty declines in response to improved health status
 - Growth and health status are positively linked in a two-way relationship

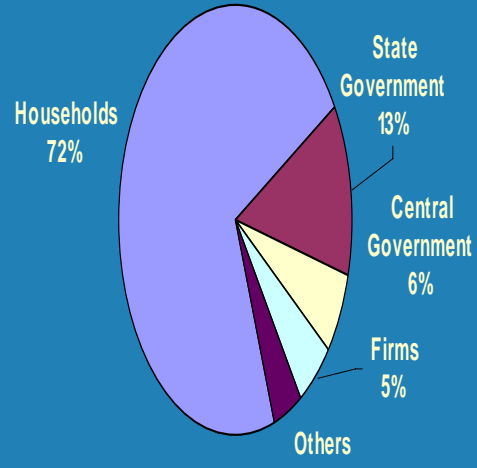
Thus, investment on health makes sense from the perspective of economic growth, reduction of poverty and improvements in the well-being of population

Health expenditure and financing in India (NHA)

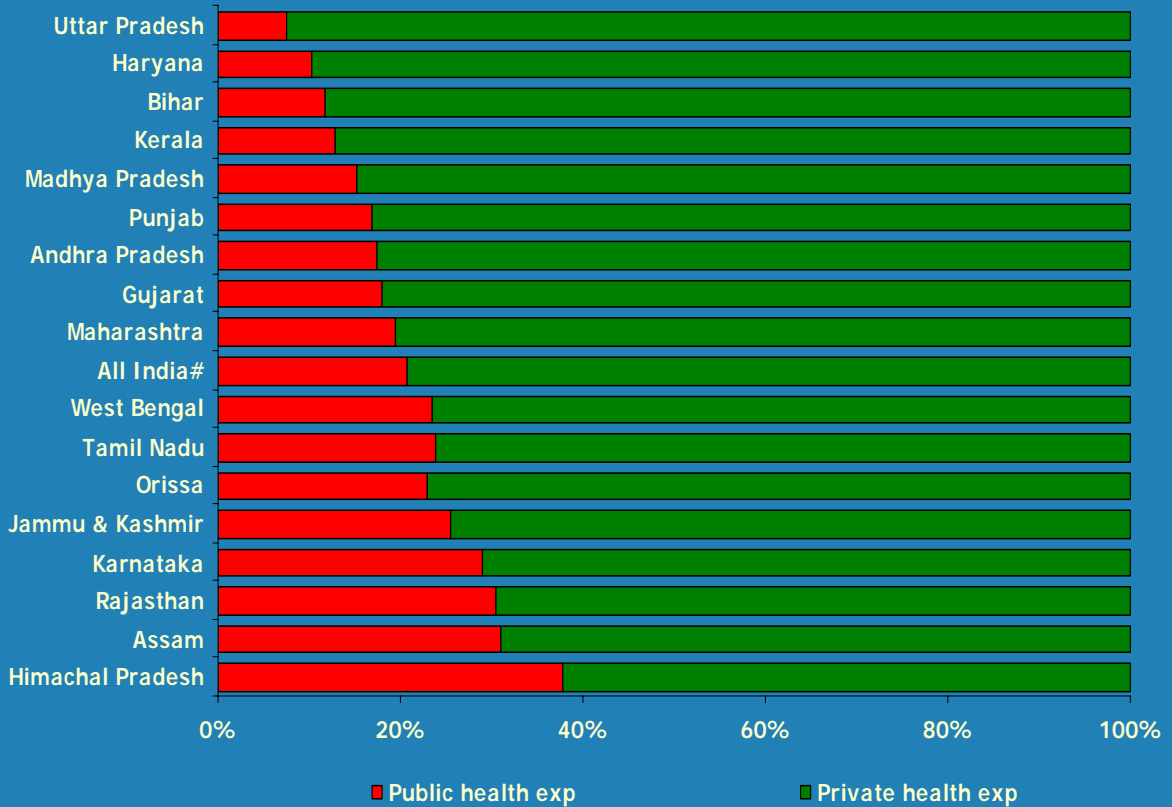
Source of health expenditure in India



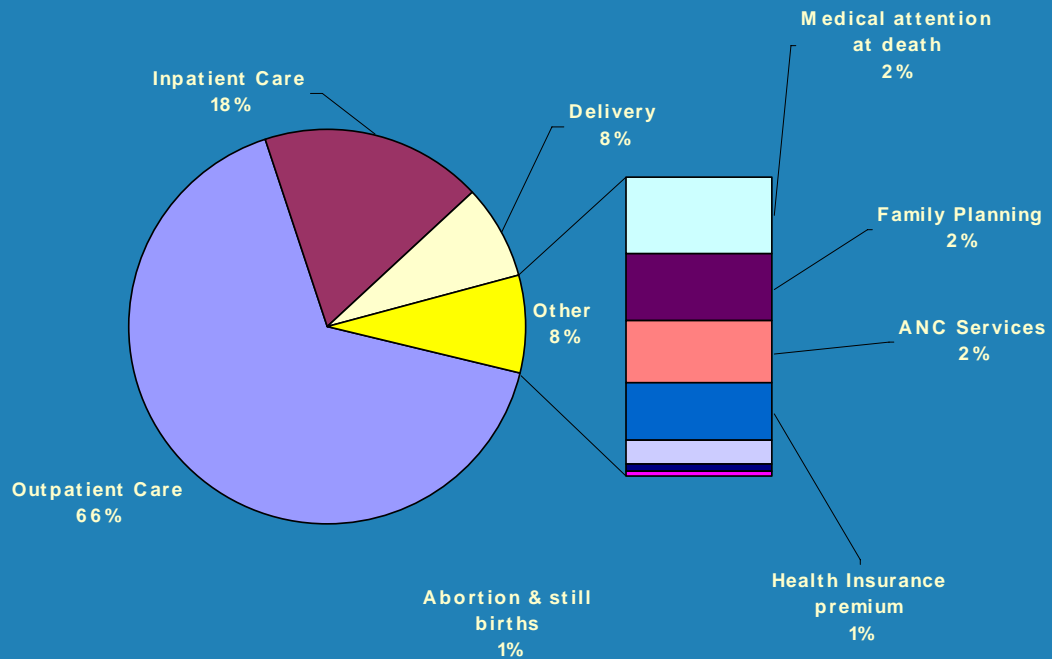
Source of health expenditure in India



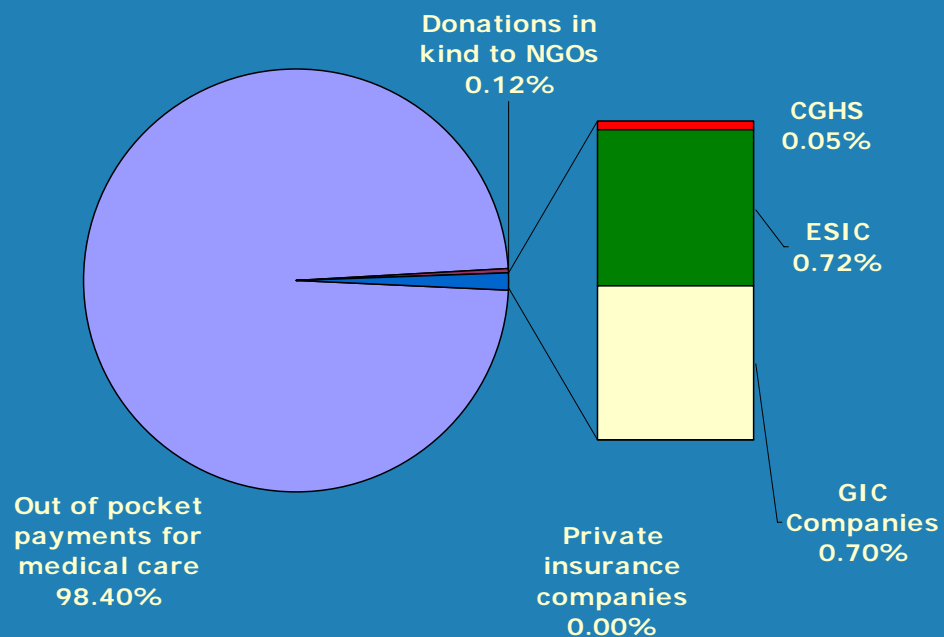
Distribution of health expenditure in Indian states



Household expenditure on healthcare services



Health expenditure by HH in India



Findings...

- Almost the entire health expenditure of the households in India comprise out-of-pocket expenses at the point of service use.
- Expenditure on health insurance premiums in the public and private sector is almost negligible (less than 2 % of total household expenditure)
- 66 % of the household expenditure is on OPD services, and 18 % on in-patient services
- 88 % of all household expenditure is on curative care services, of which about half is on primary care services; the rest are on secondary and tertiary care services.

Some facts.....

1. The poor are much less likely to get hospitalized than the rich, mainly because of the inability to pay and lack of insurance; those above the poverty line have more than double the hospitalization rates of the poor
2. Those hospitalized spend 58 percent of their total annual expenditure on health care
3. More than 40 percent of the hospitalized people borrow money or sell assets to cover expenses
4. One quarter of hospitalized individuals fall below the poverty line because of hospital expenses

- *A majority of Indians bear huge financial burden of health care –especially curative health care– in India, and need protection against out-of-pocket spending*
- *Lack of health coverage results in lower than optimal treatment-seeking behaviour, especially for the poor*
- *Properly designed health insurance can significantly reduce the burden of health care costs and increase access to health care*

India has a multiplicity of schemes that could be defined as health insurance in its broadest connotation.

Health coverage in India

- **Public health facilities**
- **Mandatory or social health insurance schemes**
 - CGHS and ESIS
- **Employer managed facilities/insurance in the private and public sector**
- **Voluntary insurance**
 - Public and private sector insurance companies
- **NGO/voluntary sector schemes**
 - Community financing

Health insurance coverage in India

Schemes	Beneficiaries (In million)
The Employees State Insurance Scheme (ESIS)	30.7
Central Government Health Scheme (CGHS)	5
Railways Health Scheme	8
Defense employees	6.6
Ex-servicemen	7.5
Mining and plantations (public sector)	4
Health insurance (Public sector non-life companies)	16.3
Health insurance (Private sector non-life companies)	3.5
Health segment of Life insurance companies (Public and private sector)	1
State sponsored schemes	<0.5
Employer run facilities/reimbursement schemes of private sector	6
Employer run facilities/reimbursement schemes of public sector	<8
Community health schemes	7.5
Total	~104.6

Current scenario

- Only about 10 percent of Indians are covered by any form of health insurance
- While the public health facilities are open to all, there are serious quality and accessibility issues
- SHI and employment based health benefits are constrained by the extent of organized sector employment (about 7%)
- CHI is limited by organizational and technical constraints
- Private (voluntary insurance) is currently limited due to both demand and supply side issues
- The existing schemes are not efficiently pooling either risks or income

ESIS: some features

- The only real SHI scheme in India
- About 31% of the organized sector is covered by ESIS
- Serious quality concerns
- The scheme is a profit making one; in 2001-02 a savings of Rs. 6261 million (36 percent of total revenue) was transferred to the ESI general reserve (ESIC 2002)

CGHS: some features

- About 1 million cardholders and 4.3 million beneficiaries
- The employee contribution ranges from Rs. 15 to Rs. 150 per month depending on the salary; Pensioners can avail 'whole life card' by paying ten years' contribution at the time of retirement

Year	CHGS expenditure (in Rs.million)	Total expenditure Department of Health (in Rs.million)	CHGS expenditure as a % of total expenditure	% of total workers covered
2002-03 (RE)	3791.3	26841.7	14.12%	0.24%

SHI limited by status and type of employment

Percentage distribution by employment status

Categories	Rural	Urban	Total
Regular employees wage/salaried	6.35	36.3	12.3
Casual labours	34.55	20.8	31.85
Self employed	59.1	42.9	55.85

Distribution of total employment 2001 (million)

Categories	Organised	Unorganised	Total
Rural			312 (75.8%)
Urban			99.5 (24.2%)
Total	27.79 (6.70%)	383.71 (93.3%)	411.5 (100%)

Social Health Insurance: limitations

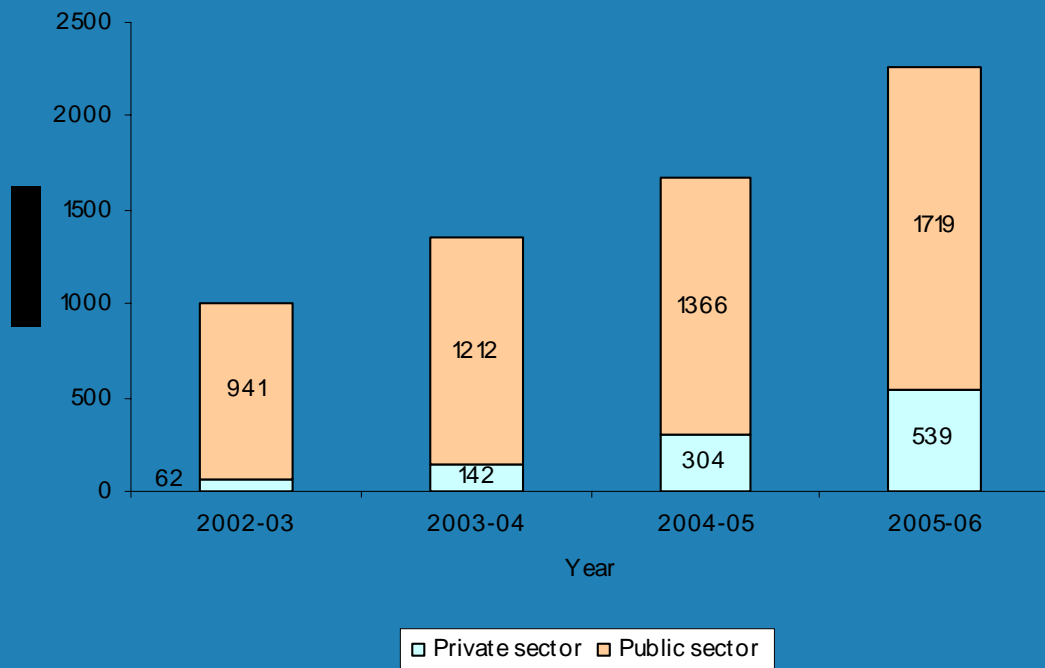
- Schemes like CGHS and ESIS can at most cover only 12 % of those employed, because these schemes work through salaried/wage employment
 - Rural percentage much smaller than urban
- 93% of employed persons are in the unorganized sector, and are difficult to reach through schemes
- 76% of employed individuals are in the rural areas

Neither CGHS nor ESIS can reach BPL population because of the very nature of these schemes

Voluntary health insurance in India

- The Insurance Regulatory and Development Authority (IRDA), is the apex body that has been created to ensure that the insurance sector operates in a fashion that is consistent with the interest of the consumers.
- In addition to the four public sector general insurance companies and the Life Insurance Corporation, India now has 16 life and 15 non-life insurers in the private sector.
- In addition, Third Party Administrators (TPAs) have been allowed to operate in the health insurance market to facilitate cashless transactions and smooth administrative functioning of the insurance market.

Growth in voluntary health insurance



Potential of voluntary commercial health insurance

- **Tremendous growth in health premium between 2003-04 and 2004-05: 148% for the private sector and 24% for the public sector**
- **An analysis of the Mediclaim data (Gupta and Trivedi 2005) indicates that**
 - **On an average about 2 individuals are covered in the households that are insured, and**
 - **Older individuals (40-59) & males still dominate the insured group**
- **The average per capita premium when compared to average expenditure on acute illnesses, indicate that it is sensible for households to go in for insurance**

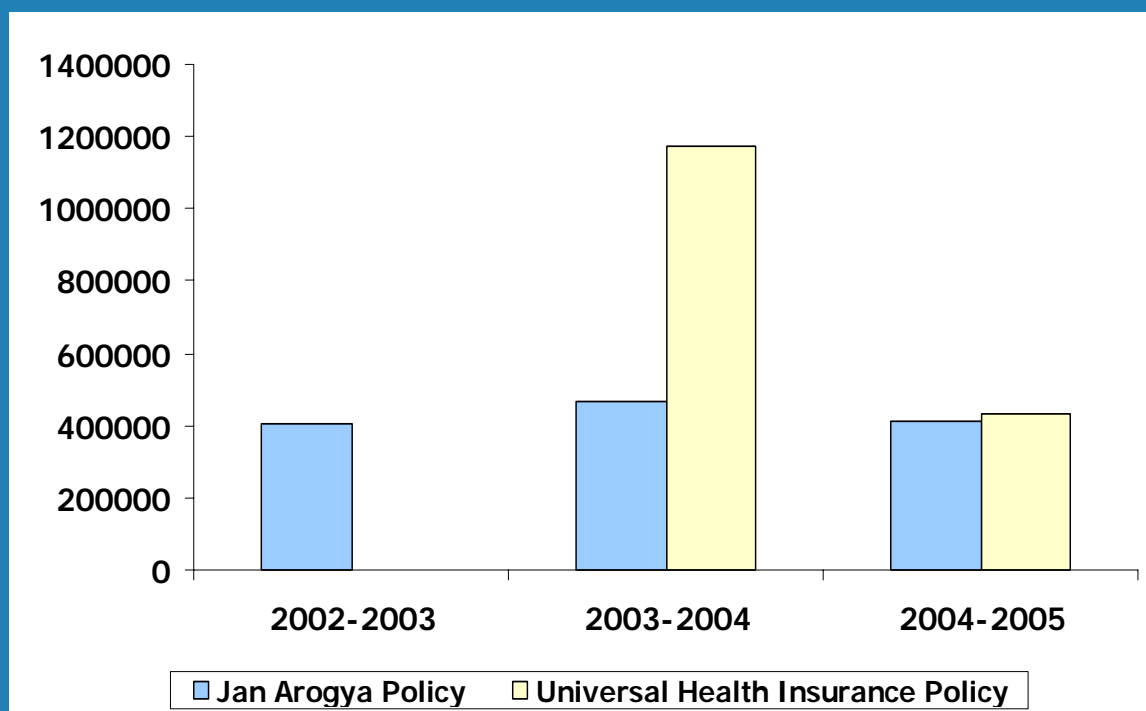
Studies indicate that...

- Those with lower ability to pay have a significant willingness to buy insurance and those with some coverage through employment – the middle class – have the least interest in purchasing additional insurance (Gupta 2002)
- The poor do understand the concept of insurance, and have demonstrated by buying low-cost insurance, whenever these have been offered effectively
- Current products not very flexible & customer-friendly
- Marketing and distribution of such products poor
- Some innovative partnerships exist that have been able to use the voluntary insurance sector, but such coverage is very low

Voluntary insurance and the poor

- Standard Mediclaim offered by public sector insurance companies not designed for the poor
- The Universal Health Scheme , Jan Arogya Scheme designed specifically for the poor, but uptake very low
- Recently, there have been initiatives taken by the insurance companies to offer low-cost products to communities, mostly in partnerships with NGOs
 - Too little and mostly due to the requirement laid down by IRDA

Poor covered by public sector insurance companies



Mediclaim and other partnerships

	SEWA (1994-2000)	J & K govt. employee group mediclaim (2003-04)	BAIF Scheme (2003-04)	Mediclaim (2003-04)
Volume (In thousand)	228.6	51.6	0.9	63.6
Per Capita premium	30	2034	178	1195
Per Capita claim amount	2037	43772	2306	13148
% putting in claim	0.80%	2.30%	7.20%	12.00%
Per capita grant amount	1016	37416	2245	10929
Ratio of claim amount to premium	57%	51%	94%	129
Ratio of grant amount to premium	25%	28%	86%	86%
Rejection Ratio	55%	46%	9%	33%

CHIs have less rejection ratio, less claims ratio, and much less proportion of insured putting in claims

Community Health Insurance schemes

- CHI, though still low in terms of percentage of population covered, has been an important tool for extending coverage to vulnerable populations in many parts of India
- Different models exist of CHI schemes. Several NGOs are in partnerships with state governments, insurance companies as well as providers to extend low cost health cover to the needy
 - There is an increasing trend of forming alliances with private and public sector insurance companies that are making these schemes more viable

Examples of different partnerships

- | | |
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| <ul style="list-style-type: none">• With Government<ul style="list-style-type: none">– J & K policy<ul style="list-style-type: none">• State govt. and NIC– UHI<ul style="list-style-type: none">• Central govt. and Public Insurers– Rag picker's scheme<ul style="list-style-type: none">• Pune Municipal Corp. and NIACL– Karuna Trust<ul style="list-style-type: none">• Govt of Karnataka and NIC– Student's Health Home, Kolkata and Govt. of WB | <ul style="list-style-type: none">• W/o Government<ul style="list-style-type: none">– SEWA, Gujarat and ICICI– Mayapur Vikas Sangha, WB and OIC– BAIF, Pune and UIIC• Seba Hospital, Kolkata and NIC |
|---|--|

Newer Initiatives

- **The unorganized sector workers' social security bill, 2005**
 - **National Social Security Scheme for the unorganized sector workers**
- **Health Insurance Scheme for handloom weavers**
- *National Pharmaceuticals Policy 2006* emphasizes the need to ensure availability of essential drugs
 - **Rashtriya Swasthya Bima Yojna (National Health Insurance Scheme)**

Newer Initiatives...

- **The IRDA recently passed the Micro-Insurance Regulations 2005 that aim to promote rural insurance. Now insurers can:**
 - **issue policies with cover ranging from Rs 5,000 to a maximum of Rs 50,000 for general and life insurance, and**
 - **appoint self-help groups, micro-finance institutions and other NGOs to act as micro-insurance agents**

Choices ahead.....

- **Should India continue with a system that caters to a small percentage of population?**
 - Need to think of ways of covering the entire population
- **ESIS is the only true SHI (wage-based and separate fund).**
 - Scaling up constrained by organized sector employment
 - Quality issues
- **CGHS, Railways, Defence etc raises equity concerns**
 - Tilt towards non-rural and formal sector
 - 13% of total expenditure is spent on less than 0.3% of the workforce (CGHS)

Coverage for All as a tool to achieve Health for All

- **Tremendous potential for India to extend coverage to the entire population due to several features:**
 - Increasing awareness about health insurance both among consumers and policymakers
 - Micro insurance regulation
 - Growth in voluntary insurance
 - Growth in collaboration between insurance companies, govt bodies and NGOs/CBO
- **However, need to take an integrated instead of a piecemeal approach to health insurance**

Strategies and choices for Health Coverage for All

- Health insurance for the organized sector, the unorganized sector and the remaining population require different approaches, but need to be planned together due to public finance implications.
- Need to bring all the organized sector employees, including ESIS, all central and state government health schemes under one umbrella.
 - Employers & employees will compulsorily contribute
 - Choice in health facilities (approved) but not in health insurance; can buy additional insurance out-of-pocket

Strategies and choices for Health Coverage for All...

- For the unorganized sector, the existing successful initiatives can be brought under a formal structure with financial and administrative support wherever required.
- Replicable schemes can be initiated in a methodical fashion after a sound analysis of the gaps in coverage.

Way forward

- **Need a separate body for planning, implementing, regulating and monitoring health insurance**
- **Health coverage decisions cannot come from a multiplicity of departments**
- **Till the time this happens, India will continue to have inadequate health coverage for the majority of the population, with serious implications about accessibility of, and equity in, the distribution of health services**