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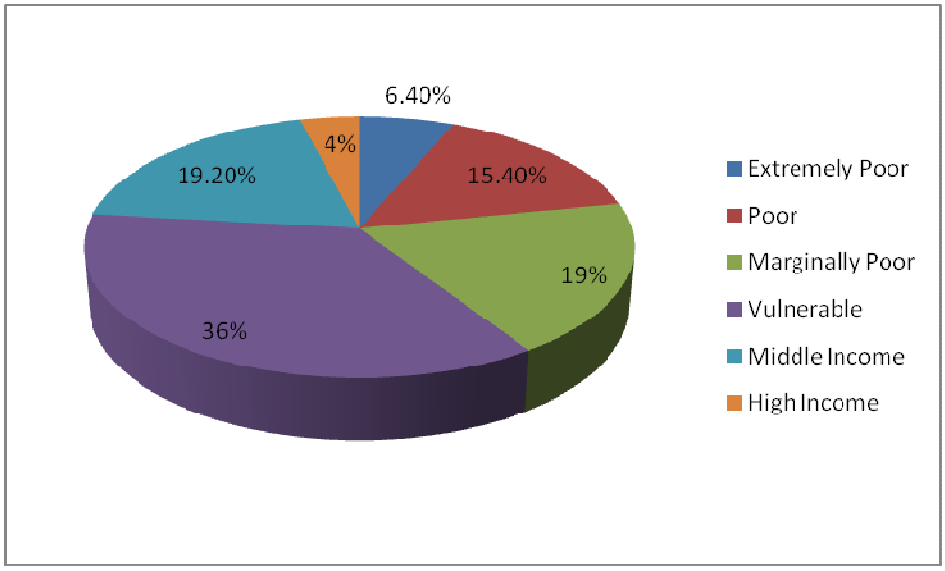
Group Health Insurance Schemes of State Governments

Over the last 50 years India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators. In case of government funded health care system, the quality and access of services has always remained major concern. The condition of health in a country like India is really bad, generally the expenses are borne by the individuals out of their pocket. The population living below poverty line is very large, and even the APL (Above Poverty Line) population is not able to bear the medical expenses. Below is the data of Indian population based on the economy:

India's Population by Different Expenditure Class, 2004-05



(NCEUS, Ministry of Labor and Employment, 2009)

We have a big poor, marginally poor and vulnerable sector, who are not able to bear their medical expenses.. Most of the low- and middle income economies till recently have relied heavily on Out-Of-Pocket (OOP) payments of households, which are regarded as

both inefficient and iniquitous. As a consequence, OOP causes financial catastrophe and impoverishment of vulnerable households. The underlying reasons are that the OOP payments preclude the conditions of prepayment, risk-pooling and cross-subsidization. So, to cater the health related needs of India's large population we have to have some instrument. Therefore, the role of Universal Health Coverage in the form of Health Insurance came into picture.

Indian economic system has been developed on paradigm of mixed economy in which public and private enterprises co-exist. The past strategies of development based on socialistic thinking were focusing on the premise of restrictions, regulations and control and less on incentives and market driven forces. This affected the development process in the country in serious way. After the economic liberalization the paradigm changed from central planning, command and control to market driven development. Deregulation, decontrol, privatization, delicensing, globalization became the key strategies to implement the new framework and encourage competition. The social sectors did not remain unaffected by this change. The control of government expenditure, which became a key tool to manage fiscal deficits in early 1990s, affected the social sector spending in major way. The unintended consequences of controlling the fiscal deficits have been reduction in capital expenditure and non-salary component of many social sector programmes. This has led to severe resource constraints in the health sector in respect of non-salary expenditure and this has affected the capacity and credibility of the government health care.

The new economic policy and liberalization process followed by the Government of India since 1991 paved the way for privatization of insurance sector in the country. Health insurance, which remained highly underdeveloped and a less significant segment of the product portfolios of the nationalized insurance companies in India, is now poised for a fundamental change in its approach and management. The Insurance Regulatory and Development Authority, is consistently taking steps for the development of this sector. The privatization of insurance and constitution IRDA envisage to improve the performance of the state insurance sector in the country by increasing benefits from competition in terms of lowered costs and increased level of consumer satisfaction.

However, the implications of the entry of private insurance companies in health sector are not very clear. The cost of private companies is very high and everyone cannot afford them, especially BPL population.

Global experience, both in highly industrialized countries as well as in low- and Middle-income economies clearly demonstrate the importance of achieving universal Coverage through either a purely tax-based regime or social health insurance mechanisms or a mix of both. Although India followed a mix of these strategies since 1950s, the penetration of health insurance remained low for the next six decades. India's tryst with health insurance program goes back to the early 1950s, with the launch of Employees State Insurance Scheme (ESIS in 1952) and Central Government Health Scheme (CGHS in 1954).

However, India's landscape of health insurance has undergone tremendous changes in the last three years with the launch of several more health insurance schemes in the country, largely initiated by central and state governments. It is fascinating to observe the rapid and significant change in the geometry of health insurance coverage in the country. The country that has been witness to three health insurance programs until 2007 (ESIS, CGHS and Private Health Insurance - PHI), is now swamped by a plethora of insurance programs, in less than three years time the breadth, depth and height of health insurance coverage has witnessed enormous leap during this period, which includes Health Insurance programmes run by state governments.
For example some of them are:
Rajiv Arogyasri by A.P.Govt.
Kalaignar Scheme by Tamil Nadu Govt.,
other govt. like Karnatka, Shillong etc are also running these types of schemes.
Coverage of Government Run Schemes:

The breadth of the coverage- denoted by the percentage of population covered by the insurance scheme – has accelerated from about 75 million people covered (roughly about 16 million family beneficiaries) in 2007, to an estimated 302 million people in 2010, about one-fourth of the population. Thanks to four important initiatives, by the

central government (through Rashtriya Swasthya Bima Yojana - RSBY) and state sponsored schemes, as in Andhra Pradesh, Tamil Nadu, and Karnataka. Three of the giant schemes (RSBY, Rajiv Aarogyasri and Kalaignar) in a span of three years have covered roughly 247 million, over one-fifth of India's population. Comparatively, the breadth of the coverage is by any global standards quite breath-taking and occurred at a rapid rate in a span of three years, and this feat could be achieved even among the vulnerable population and informal workers, where the penetration is otherwise difficult till recently. The commitment to equity and access to poor people is clearly visible, especially in the case of Andhra Pradesh, as it covers over 85% of the states' population. The realisation among the leadership for the commitment to cover nearly all of the population despite their socio-economic status is quite commendable, since evidence clearly suggests that in India, it's not only the poor but a large sections of above poverty line (APL) population also end up paying catastrophic payments and suffer impoverishment (transitory poverty) due to illness.

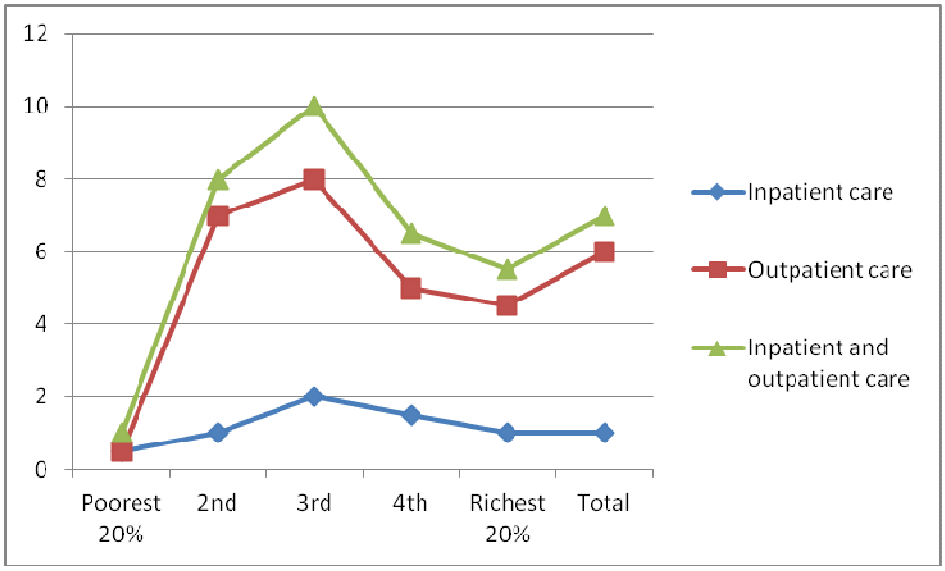
The depth of the coverage - relates to the extent of benefit packages offered in the scheme, whether the scheme covers only hospitalization, or both inpatient and Outpatient care, does it include or exclude pre-existing conditions and what is maximum amount of coverage, etc. Except ESIS and CGHS, all the other schemes provide only hospitalization cover to the beneficiaries. In terms of benefit-packages, the sharp distinction between various schemes is visible as their priorities appear to be weighed due to different considerations and perceptions. While RSBY's package has been very moderate with limited mandate that it had set itself, Rajiv Aarogyasri and Kalaignar's scheme has been the most ambitious of all the programs. The disproportionate thrust of these programs lies on tertiary care. For instance, CGHS, which currently covers about 3 million population in the country during 2009-10, spent nearly Rs. 16,000 million, as against Rajiv Aarogyasri, which spent to the tune of Rs. 12,000 million for population coverage of about 85% (out of 84 million total population) of the population of Andhra Pradesh. Similarly, the Tamil Nadu's model again covers only high-end surgical procedures to its 13.6 million families, accounting roughly to over 50 million population (out of 67 million total population) with a total outlay of over Rs. 5,173 million during 2009-10.

The Height of the coverage indicates the share of health care costs to prepayment and risk pooling (especially public subsidy of cost of care). As far as the health care cost is concerned, the major thrust of the current health insurance schemes are on inpatient care. Except the commercial insurance sector, where households and employers contribute to cover the costs of premium, in other schemes such as ESIS and CGHS, contributions from employees and employers are obtained. Therefore, the issue of prepayment and risk pooling, which is central to any health financing functions, are taken into account significantly in these two programs. Similarly, in all the other publicly funded schemes, the contribution is made by the government – central or state governments depending on the schemes. And thus, there is an element of prepayment and risk pooling, and so the share of entire burden of specialized hospital care for the covered population is borne by the government. To that level, the risk of paying catastrophic costs on illness and the likelihood of being impoverished due to hospitalization (surgical care) is reduced to some extent. That leaves a huge burden still been borne by households. In the case of RSBY, even the hospitalization relates only to secondary care, leaving a huge burden still on households, while state-based schemes ignore primary and secondary care completely.

Generally all these schemes run by state government includes in-hostpilazation only, whereas the majority of the charges are out-patient charges.

Below are some statistics:

Percentage of Rural Households Falling BPL due to Health Care Expenditure



Percentage of Urban Households Falling BPL due to Health Care Expenditure

(Peter Berman, Rajeev Ahuja, Laveesh Bhandar, April 17 2010)

So, to cover up all the health related needs of the population we also need to think about out-patient diseases.

The coverage provided by these state govt schemes which mainly cater to BPL families are around Rs.1-1.5lakh, whereas in critical diseases it is around Rs.2lakh for the whole family. The family includes head of family,spouse,2 children,2 parents. These schemes involves insurance companies,TPA(Third Party Administrator), empanelled hospitals. These hospitals charge less as compared to their normal rates. Andhra Pradesh government has covered almost 85% of the population. The sources of fund for these schemes are:

Scheme	Beneficiary Contribution	Subsidies	Average Premium Rates
Rajiv Aarogyasri Scheme (AP)	No	100%, State	267
Kalaignar (TN)	No	100%, State	NA
Vajapayee Arogyasri Scheme (KN)	No	100%, State	469
Yeshasvini (KN)	Yes	40%, State	150
RSBY Plus (HP)	No	100%, State	NA
ASBY (DEL) (proposed)	No	100%, State	NA

(Scheme Document Report Per Family Per Year, 2010)

So here the expenses of these schemes are borne by government only in the form of premiums.

Hence, by these state run health insurance schemes we can serve the health needs of the large population, but with the increasing number of frauds in these schemes load is increasing on the state governments.

As per the data available, for the year 2009-10, the mean hospitalization expenses of the private health insurance industry stood at roughly Rs.19,637 per annum. Mean hospitalization expenses in Tamil Nadu and CGHS schemes are at around Rs. 33,720 and Rs 25,000 respectively.

The chances of frauds are there when at times hospital advice unnecessary operation, prolonged stay in hospital, and advice very expensive medicines when they come to know about insurance policy of the patient. These are known as Moral Hazards, so the chances of fraud are higher in Health schemes.

Ways should be looked out to stop these kinds of frauds in the Health Insurance schemes, like the record of paneled hospital should be checked before being empanelled. There should always be a close eye on the working of hospitals. Insurance industry should share the data with each other, so that hospitals that are practicing unethical can be blacklisted.

A proper grade for hospitals should be decided pan India by IRDA, so that rates of hospitals can be fixed in those bands only. By, these means we can reduce the load of expenses on state governments. A proper standardized format of treatment for major diseases can be made and followed, so that expensive medicines and prolonged stay can be avoided.

An investigation team should investigate the cases thoroughly, so that fraud cases can be caught.

Preventive camps should be organized in the state to increase the awareness and necessary steps taken to avoid diseases should be told to the public.

Also to increase the sum insured of the family we can use state run health insurance policies as a top-up on RSBY, which provides an insurance cover of Rs. 30000. So that basic hospitalization can be covered from this amount.
We should also look to include out-patient expenses which are more in amount than in-patient expenses, but necessary steps should be taken to control and minimize these expenses.

Summing Up: The recent growth of insurance schemes in India, in many ways, marks a new phase in India's quest to provide health care to all. The key design features of health insurance scheme, revenue collection, pooling of funds and purchasing care need government intervention in order for the schemes to be equitable, efficient and effective. In terms of revenue collection, general taxation is the main source of funds for both health insurance schemes and direct public provision of care. Government must revisit the decision to bear dual financial burden of funding the network of public hospitals and national insurance. The risk pool for most schemes is comprised of the BPL population with least ability to pay leading to segmentation of the society. If the same schemes are extended to other populations of the society, the pools will become bigger and more financially unsustainable unless the beneficiary contribution is increased as in the case of rich subsidizing the poor in typical health insurance. The benefit package and package rates are the tools of purchasing care that government can use not only to control costs but also to monitor public expenditure on health, but these two need coordinated effort by different schemes to optimize benefit for the beneficiaries.

Following are the things which we need to do for making group health schemes of states more efficient and effective:

1. Provide an outline of design features of various health insurance schemes

currently being implemented in the country;

2 .Document the institutional and organizational challenges of various schemes;

3. Identify gaps in regulatory frameworks;

4. Understand the pattern of moral hazard, adverse selection & fraud and mechanisms deployed to control imperfections in the market;

5. Examine the equity and efficiency of the existing health insurance models in India;

6. Analyze potential elements that had impeded or would facilitate significant scale up and sustainability of various health insurance schemes culminating in universal coverage;

7. Provide an outline of learning from each other programs.

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