7. Tax Financed Health Insurance in India: Illusion of Financial Protection

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INTRODUCTION

Health financing in India is typically characterised by lack of financial protection. Financial protection can be achieved through progressive health financial arrangements which need to have three critical elements-risk pooling, pre-payment and cross subsidisation. Since there is an uncertainty of individual health care needs and there are risks and high costs of care associated with falling ill, if households are left to manage health care expenses, the consequences become severe - people forgo or delay care, die of avoidable deaths or face financial hardships associated with care seeking. Risk pooling and prepayments are effective means to protect people from disastrous financial consequences of illness, while cross-subsidisation brings in progressivity in financial arrangements. Risk pooling, which essentially means bringing people with various risks together is the insurance function. Financing mechanisms like social insurance or private health insurance are explicitly insurance based models where risk pooling is achieved through enrolment of people with varying risks into the scheme. Contrary to carefully constructed myth, where risk pooling is associated with formal insurance designs, like social insurance or private voluntary insurance; even general tax financed systems where health care is directly provided to all the citizens, risk pooling is a central attribute (Roberts 2008).

While tax funded health system has remained chronically underfunded in India, private sector flourished through proactive support of various forms from government, which were all banded under 'health sector reforms'. The essential feature of the reforms was to gradually withdraw the state from funding services other than a small group of services including preventive health care and immunisation (Ravindran 2010). The other element was promotion of private sector participation in the health sector, especially in areas which are comparatively more profitable like super-specialty hospitals; contracting-out clinical and non-clinical services and introducing user charges for various out-patient and in-patient services for the non-poor.

As a result people had to increasingly depend on private sector for utilisation of health care and bear health care expenses. It has been documented well in the past that overdependence on OOP expenditure in India is marked by high

inequity (Peters *et al* 2002; MOHFW 2005; Garg and Karan 2009; and Selvaraj and Karan 2009), which could result in catastrophic circumstances and impoverishment (van Doorslaer*et al* 2006; Selvaraj and Karan 2009 and Ghosh 2011). Since the middle of the last decade globally there has been a consensus of sort that health financing has to move away from household OOP expenses to various progressive forms, which would be essentially funded by government exchequer. Though there are various forms of financing systems, including tax funded and public systems providing 'Universal Health Coverage' in various nations, global institutions have been univocal in their efforts to push insurance based systems (People's Health Movement 2014).

SOCIAL AND TAX FUNDED INSURANCE IN INDIA

India's engagement with social health insurance (SHI) programmes goes back to the early 1950s. SHI was introduced with the launch of Employees' State Insurance Scheme (ESIS) in 1952 and the Central Government Health Scheme (CGHS) in 1954. While ESIS covers all employers with more than 10 employees in 'notified areas', and all employees with monthly salary of Rs 15,000 or less; CGHS on the other hand is available to all central government employees (both working and retired), and their families, and other representatives associated with the central government. As of 2014, ESIS alone had some 19.5 million workers and their families enrolled (ESIS 2014)[1]. Around 0.8 million more families are enrolled under CGHS (La Forgia and Nagpal 2012).

However, India has witnessed a plethora of publicly-financed insurance schemes being introduced both at the national and state level. *Yeshasvini* started as an insurance scheme for workers cooperative in 2003 in Karnataka, including all rural co-operative society members, members of Self-Help Groups / *Sthree Shakti* (Women's Empowerment) Groups and their family members (including joint family). The *Rajiv Aarogyasri Scheme* (RAS), the first of this class targeting below-the-poverty-line (BPL) population of Andhra Pradesh was introduced in 2007. It is interesting to observe that a scheme, which was originally planned to be focussed on BPL families, went ahead to cover almost the entire population of the state. The RSBY that was launched in 2008 is on the other end of the spectrum. It is also voluntary in enrolment, was initiated by the

[1] By 2009, ESIS had presence in 29 states, with 148 main hospitals and 42 annex facilities run by ESIS with total bed strength of around 28000. Moreover, there were around 1400 dispensaries and 8000 Medical officers and specialists enrolled across 783 centres. Some 50 million beneficiaries were covered, including 12.5 million workers from 0.39 million employers. (ESIS 2011)

Central Government (Ministry of Labour and Employment) as a national health insurance scheme targeting the BPL population. Other notable state sponsored schemes include Chief Minister's Health Insurance Scheme (CMHIS) in Tamil Nadu (2009) and *Vajpayee Aarogyasri* (2009) in Karnataka.

In this paper we would like to comment on the various aspects of effectiveness of tax funded health insurance programmes in the country, with special emphasis on financial protection as these schemes were essentially introduced to protect households from financial hardship.

RAPID EXPANSION

Coverage under tax funded insurance has increased from about 75 million people (roughly about 16 million family beneficiaries) in 2007, to an estimated 302 million people in 2010. RSBY alone currently covers approximately 41.3 million families across the country today (RSBY 2016), covering approximately a third of target population. In 2011, approximately 22.9 million families and 72 million beneficiaries were covered by the RAS scheme, which is about 85 percent of the total population of the Andhra Pradesh (*Aarogyasri* Health Care Trust 2012). Three giant schemes (RSBY, RAS in Andhra Pradesh and CMHIS in Tamil Nadu) have, in a span of 7-8 years, covered roughly 247 million or over one-fifth of India's population. By any standard this breadth of coverage is impressive, and occurred at a rapid rate within 7-8 years.

Except for ESIS and CGHS, the publicly-funded schemes provide only hospitalisation cover to the beneficiaries. In terms of benefit packages, there are sharp differences between the various schemes in accordance with their different priorities. While RSBY's package is modest, with a limited mandate which it had set itself, RAS in Andhra Pradesh and CMHIS in Tamil Nadu schemes are the most ambitious programmes. The differences in the programmes are reflected in tertiary care. For instance, in 2009-10 CGHS spent nearly Rs16,000 million on covering a population of three million in the country, whereas RAS, spent Rs12,000 million on covering about 85 per cent of the population of Andhra Pradesh, which had a total population of 84 million. Similarly, in 2009-10 the Tamil Nadu model covered only high-end surgical procedures for a 50 million population, with a total outlay of Rs5,173 million (PHFI 2011).

The major thrust of the current health insurance schemes is on inpatient care. In the commercial insurance sector, households and employers contribute to cover the costs of the premium, and in other schemes such as ESIS and

CGHS, contributions from employees and employers are collected. Therefore, the issues of prepayment and risk pooling, which are central to any health financing functions, are taken into account in these two programmes. Similarly, in all the other publicly funded schemes, the contribution is made by the government – central or state – depending on the scheme, and thus the entire burden of specialised hospital care for the covered population is borne by the government. In this case, the risk of making catastrophic payments for illnesses and the likelihood of being impoverished due to hospitalisation (surgical care) is reduced to some extent. But despite this, a huge burden is left to be borne by the households. In the case of RSBY, even hospitalisation relates only to secondary care, still leaving a huge burden on households, while state-based schemes ignore primary and secondary care completely.

LIMITED EFFECTIVE COVERAGE AND LACK OF FINANCIAL PROTECTION

Despite its intention to providing financial cushion to patients suffering from illness, the track records of such insurance models are poor in securing financial risk protection (Wagstaff and Lindelow 2008; Wagstaff *et al.* 2009). Such models are target-specific and designed to address low-frequency high-value hospitalisation expenses. Target-oriented approaches (BPL population) have never worked in the past due to several reasons. Identification of beneficiaries has never been so easy. The state of Andhra Pradesh, for instance, has rolled out insurance schemes for almost 85 per cent of the population, while in several states BPL population has been inadequately covered. Unfortunately, provision of health care has been turned into another poverty-reduction programme. While improving population health could have major dent on poverty, there are other key dimensions of health sector including providing financial risk protection. By providing financial risk protection to the BPL population, it is assumed that APL population does not face catastrophic payments and impoverishment. With only a thin line that separates BPL from APL, it is myopic to plan and make policies for BPL population involving health care.

Couple of studies have tried to measure impact of insurance on aggregate OOP expenditure by households at district level (Selvaraj and Karan 2012; Selvaraj *et al* 2015; Hooda 2015). These studies have categorised districts into two groups: districts with insurance coverage (intervention districts) and those without insurance (control districts) and compared the impact of insurance over a period of time. Evidences from these studies indicate that the share of

households' expenditure has increased sharply between 2004-05 and 2011-12[2]. For instance, between 2000 and 2012, in rural areas, share of health in household expenditure has increased from 6.05 per cent to 7.73 per cent. The real rise in OOP expenses of households' appears to be largely due to sharper increase in hospitalisation expenditure while outpatient and drugs expenditure have grown at a slow pace. Further, there is considerable increase in hospitalisation cost of the poorer sections, clearly demonstrating the limitations of the scheme in terms of effective financial protection (Selvaraj *et al* 2015). Similar findings have been observed by Hooda (2015). Households' OOP expenses, by all categories – inpatient, outpatient and drugs, were reportedly higher in intervention districts as against non-intervention districts, even before insurance schemes were introduced. This disparity continued to exist in the post-insurance years as well. However, it is apparent that the disparity in spending has relatively become significant in hospitalisation expenditure. As far as the share of hospitalisation expenses goes, it is not only relatively higher in intervention districts, but both intervention and non-intervention districts experienced rise in its share in the post-insurance years and intervention districts have experienced sharper increase

As far as headcount on catastrophic nature of hospitalisation is concerned, it accelerated in the post-insurance years, both in intervention and non-intervention districts. Catastrophic headcount across income/expenditure quintiles, both in the pre-insurance as well as in the post-insurance period shows a consistently higher burden in the intervention districts in comparison to the non-intervention districts (Selvaraj *et al* 2015). Further, the poorer income sections in RSBY and other state-based health insurance districts had indeed experienced a rise in catastrophic headcount, a conclusive proof that RSBY and other state-based health insurance intervention failed to provide financial risk protection. So, rising per capita health spending on hospitalisation and the associated increase in catastrophe headcount, especially among the poor

[2] The data source for this study is drawn from the unit level records of the Consumer Expenditure Surveys (CES), conducted by the National Sample Survey Organisation (NSSO), for the respective years. The two periods under study are quinquennial rounds of NSSO, where sample size is large enough, to capture the impact at state and groups of districts levels. For instance, the number of households surveyed during the period 2004-05 were 124,644 (79,298 rural & 45,346 urban households) and 101,662 households (59,695rural and 41,967urban) during 2011-12. The CES collects information on expenditure of households' consumption for about 350 items. This includes food and non-food items while the relevant non-food items that are examined here are institutional and non-institutional medical spending of households. However, there is no information on insurance coverage of households. For details of the method please refer to Selvaraj*et al* (2014).

population is reflective of continuation of the trend witnessed since the last two decades, with RSBY and state-based health insurance schemes making no impact of whatsoever.

All these previous studies have tried to measure the impact of the insurance programmes on households rather indirectly as there was no information on insurance coverage. The latest NSSO data provides us the opportunity to study the impact of insurance on households OOP expenditure (NSSO 2015). In terms of effective coverage, NSSO results show that only 12.8 per cent of households are covered under various state sponsored and social insurance schemes. Compared to government claim of coverage for some 300 million people, NSSO shows much lesser coverage in reality. This clearly points out that there is large gap in government statistics and independent evaluations; so far coverage under the scheme is concerned. These findings are in line with most other evaluations of government financed insurance schemes (Ghosh 2014; Nandi *et al*. 2014).

Several research studies have identified various gaps in RSBY implementation. These studies demonstrated the low levels of enrolment among eligible population barring few exceptions like Kerala. Furthermore, hospitalisation rates have also remained low for RSBY patients. The Ministry of Labour's own estimation suggests that average national utilisation rate increased slightly compared to NSSO (60th round) survey (PHFI, 2011). However, the same report recognises that there exists huge difference across states and districts with most of the hospitalisation happening in few states and fewer districts. Within districts, utilisation is concentrated in few villages. This clearly shows that RSBY is being used by those who already have better access and the most marginalised sections are being excluded further. The other possibility which remains to be verified is that even if poor people are reaching hospitals, they end up paying significantly. Studies have shown that awareness levels are really low among the enrolled people about different entitlements about RSBY (Ghosh 2014).

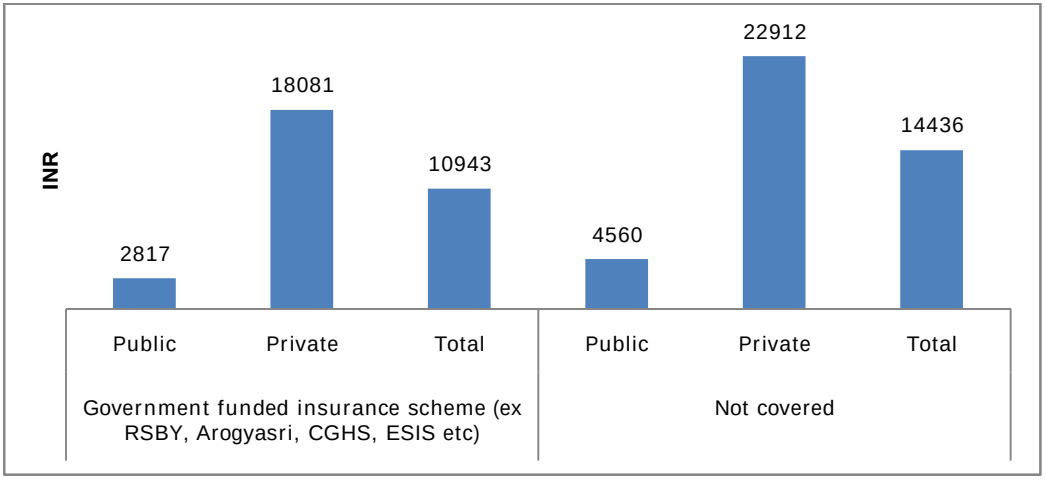
Table 7.1: Coverage of Various Insurance Schemes in India (in Percentage) (2014)

Type of Insurance Coverage	Rural (%)	Urban (%)	Total (%)
Government funded insurance scheme (Eg: RSBY, RAS, CGHS,ESIS etc.)	13.1	12.0	12.8
Employer supported health protection (other than government)	0.6	2.4	1.2
Arrange by household with private insurance companies and others	0.4	3.7	1.3
Not covered	85.9	82.0	84.8
Total (N)	100 (189573)	100 (143529)	100 (333102)

Source: NSSO 2015. 71st round, Author's calculation based on unit records

Furthermore, data clearly shows that there is very little financial protection provided by the state sponsored insurance scheme. As depicted in Figure 7.1, OOP per hospitalisation episode if there is no insurance coverage, is Rs 22,912 when private hospitals are accessed. Even if a person is covered by government insurance scheme one episode of hospitalisation costs Rs 18,081 thus, rendering the claim of cashlessness of these programmes into question. Even though costs in public sector is much lower compared to private hospitals, households end up incurring OOP expenses. It has to be noted however, that costs in public and private sector cannot be strictly compared as there are explicit subsidies in public sector. It has to be also noted that those who are covered under the insurance schemes are usually poor or vulnerable whereas proportion of the richer sections would be higher among those who are not covered. Though average expenditures do not capture the effect of class, diseases, location, all of which affect cost of care, a further disaggregated analysis is required to study the implications of insurance on financial protection.

Fig. 7.1: Average Per Episode Hospitalisation Expenditure by Coverage of Insurance Schemes and Type of Provider (INR)



Source: NSSO 2015. 71st round, Author's calculation based on unit records

DRAIN OF RESOURCES FROM PRIMARY CARE AND PUBLIC SECTOR HOSPITALS

In the Union budget of 2016-17, the Finance Minister proposed to expand the coverage of RSBY further, invoking the need to tackle catastrophic health care

spending. The Finance Minister's attempt to tackle catastrophic health events is laudable, but the proposed investment of Rs15 billion is clearly inadequate. There are roughly 110 million BPL families in India. Average premium under RSBY is around Rs 400-450, including the administrative expenses. Total money required for providing insurance cover up to Rs 30 billion (under RSBY) is Rs 50-55 billion. If the coverage has to increase to Rs 100,000, the premium has to also increase. Even if the premium doubles to Rs900 per family; around Rs100 billion would be required. Against this requirement, only Rs15 billion has been allocated, which is only 15 per cent of required amount.

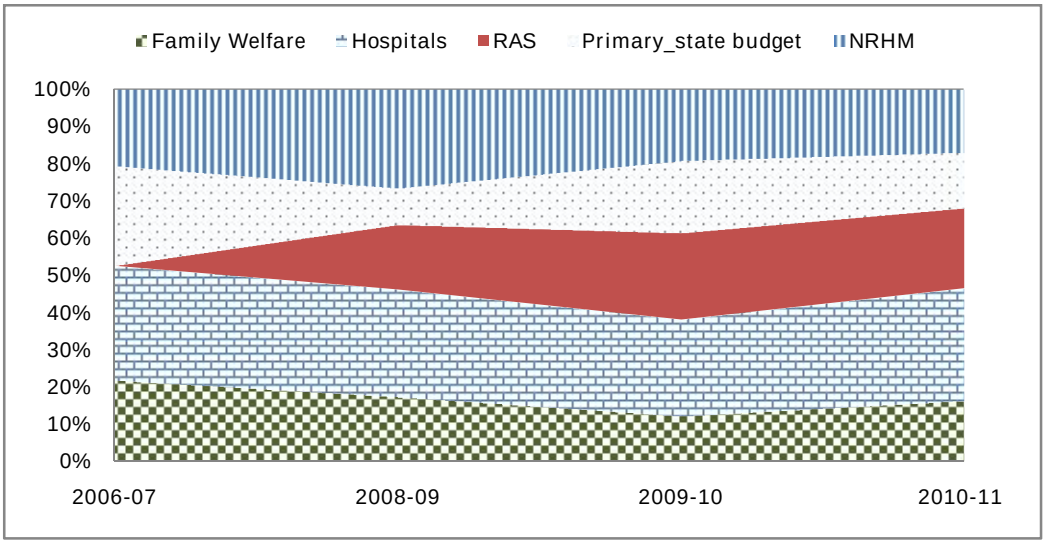
One important element of the government sponsored insurance schemes is they positioned public sector hospitals and private hospitals as competitors for insurance funds. While this can be seen as an opportunity for government hospitals to improve quality to attract more patients, in reality, this situation favours the private sector. It is important to note that competition between public and private sector is not at all fair. With little money spent on public sector hospitals in the country, apart from in-patient and out-patient care, public sector provides the entire spectrum of preventive care, shares overwhelming burden of end of life care and critical care, majority of institutional deliveries and entire medico-legal and administrative services (Sundararaman *et al.* 2016).

The experience of RAS in Andhra Pradesh shows that more than four-fifth of funds flow to private hospitals. As depicted in Figure 2 out of the total claims disbursed of the value of Rs 33.3 billion as much as Rs 27.16 billion have gone to private hospitals. Moreover, the growth of private hospitals, in part fuelled by the substantial insurance funds available, has increased their demand for skilled human resources. This private sector demand will likely add to the growing migration of skilled staff from government to private hospitals. Finally, there is also little harmony between state schemes and RSBY in terms of services and population covered. For instance, in states like Andhra Pradesh both the RSBY and RAS schemes are independently offered to the public. This raises obvious questions about wastefulness and efficiency.

In Andhra Pradesh, the RAS consumes around 20 per cent of the state's health budget (Figure 7.2). More than 55 per cent of funds are devoted towards secondary and tertiary care and RAS. The insurance route has exclusively focused on hospital services. Which route ultimately dominates will have

profound implications on the nature and delivery of health services in India. For instance, in Andhra Pradesh, which has been operating its insurance scheme since 2008, the government spends about three times as much on hospital services as it does on primary care. One can expect similar crowding out of funds for primary care as government insurance coverage expands and demands more resources to operate.

Fig. 7.2: Competing Priorities for the Andhra Pradesh Government



Source: Detailed Demand for Grants, AP Budget, various years

CONCLUSION

Despite the overwhelming evidence pouring on exclusions and lack of financial protection in state sponsored insurance schemes these programmes seem to be very popular among political classes. Several states have jumped in to the insurance bandwagon and introduced their own version of RSBY. The government has proposed to expand the insurance coverage. There is no doubt that household OOP expenditure can lead to financial catastrophe and impoverishment. This is a major issue and insurance cannot be the answer to impoverishment of 55 million people. Around 34 million is impoverished because they have to purchase medicines from the market. Outpatient care constitutes a

larger share of expenditure and causes impoverishment while insurance which caters to inpatient care constitutes a smaller part. Academicians from across the world have written about it. Government Commissions have noted it and advocated against expansion of insurance programmes. Such a step can only be explained by dogma in certain quarter of policy makers rather than any rational thinking. The recent National Health Policy, 2017 does not give any different view but advocates continuing with and expanding the public insurance schemeslike the RSBY where select benefit package is purchased from public and the private sector at the secondary and tertiary level.

The state has played a critical role over last three decades in the expansion of organised health care market in the country. Be it through provision of free land and electricity for setting up private hospitals; or systematic destruction of public institutions through chronic under-investment; or ensuring supply of skilled health professional to private sector through complete ban on recruitments in public sector; or through user fees and PPPs - health sector reforms have been used by the neo-liberal establishment to expand private sector in large metropolitan cities at the cost of public services. Government's persistence with insurance models epitomise the growing strength of for-profit sector which sees insurance as a vehicle to expand further in smaller towns and rural areas at the cost of public exchequer. Insurance programmes are seen as immense opportunity to 'commodify' and 'medicalise' the 'health market' in areas where the demand for health services remains low otherwise. Under the aegis of finance capital, governments are being called upon to expand their financing function so that the private provider and insurance market gets 'business', to survive and thrive, in the name of providing 'efficient' and 'quality' care.

Several key issues underlined above, calls for an urgent need to reverse this trend. An alternative pathway, based on the expansion of public provisioning and financing, rational use of technology and medicines, and expansion of preventive and curative services has been demonstrated in different parts of the world, including India. This is critical in order to protect public health system, to cap health care costs from escalating, to provide much needed financial risk protection, provision of rational care and, to improve health outcomes of the population.

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