I J Pre Clin Dent Res 2014;1(3):72-76
July-September

International Journal of Preventive & Clinical Dental Research

Health Insurance in India- in a Light of Fiscal Crisis

Abstract

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. Besides, for a policy-maker, the structure of budgeting makes it impossible to identify the cost centres, where expenditure control needs to be exercised, the type of skills mix needed, which departments should be closed down and which expanded in keeping with the changing disease burden, etc. Rules and procedures for actual release of funds, appointment of persons, labour laws, procurement systems all need a thorough review. Greater decentralization of funds, aligned with functional needs and responsibilities, is necessary. However, any decentralization and financial delegation needs to be carefully calibrated and sequenced. In other words, decentralization can only be done after developing the requisite financial capability and laying down rules and procedures for accounting systems. Unless such restructuring takes place, greater absorption of funds will continue be difficult.

Key Words

Decentralization; public finance; private insurance; equity

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INTRODUCTION

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.[1] 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 care financing in India can be considered almost unique in several respects.[2] One, the share of public financing in total health care financing in the country is considerably low-just around 1% of GDP compared to the average share of 2.8% in low- and middle-income countries or even relative to India's share in disease burden. Two, the beneficiaries of this limited public health financing are not only the poor as one would expect in a limited public spending to be, but also the well-off section of the society. Third, over 80% of the total health financing is private financing, much of which takes the form of out-of-pocket payments (i.e., user charges) and not any prepayment schemes.[3] Reliance on out-of-pocket payments is not only inefficient and less accountable than other methods of financing, it is also iniquitous to the poor on whom the disease burden falls disproportionately more, who are more susceptible to disease and who are much likely to be pushed into poverty trap.[4]

THE CHOICE OF PRIVATE AND PUBLIC HEALTH INSURANCE

In financing of health services a country may, in principle, choose between public financing through general taxation or private financing through health insurance. Public financing is justified where equity

concern overrides efficiency objective. Where the opposite is true, reliance is often placed on the private insurance market. Equity considerations in private insurance market can generate inefficiency and market failure as it involves tradeoff between desired distribution and the distorted incentives that accompany such redistribution.[5] Therefore, where equity is the prime consideration it can best be achieved under public financing. In practice no health financing system is either purely public or private. Countries where private health insurance dominates, some public financing can still be observed. Similarly, some private insurance can be seen even in a public funded health system.[6] All insurance systems, public or private, must strike a balance between economic efficiency and equity.

The choice between public health financing or private insurance is hardly available to countries like India because of their governments' limited ability to marshal sufficient resources to finance health spending, and also because the nature of employment (where majority of workers are self-employed, or do not have a formal employer or steady employment) is such as to provide little scope for payroll taxes.[7] Given this, heavy reliance on private spending is necessary for financial reasons, notwithstanding the declared policy of the state to provide universal, comprehensive primary health services to the entire population. Private spending may also be desirable on efficiency grounds.[8] But the form that bulk of private spending takes need to change from out-of-pocket payments to private insurance.

EQUITY AND EFFICIENCY

Insurance or pooling of risks through prepaid schemes has a number of advantages. Besides being more equitable, it is one of the significant drivers of improvement in the healthcare provision by encouraging investment and innovation.[9-13] Also, it helps improve the quality and efficiency of public health care system by continually benchmarking it. Private insurance has certain pitfalls too such as leaving out the low-income individuals who may not be able to afford premium, denying coverage to people who are sick, and limiting the coverage for high-cost conditions or services. In a country like India where public health care suffers from poor management, low service quality, weak finances, and lack of responsiveness to patients' needs and demands, development of health insurance is likely to bring improvement in public health care system.[14] Even the private health sector in India that has grown in an undirected fashion, with virtually no effective guidance on the location and scope of practice, and without effective standards for quality of care or public disclosure on practices and pricing.[15,16] Development of health insurance will necessitate improvement in private sector as well. The pitfalls associated with private health insurance can be reduced through appropriate regulation. To the extent that certain per cent of population can be covered through private health insurance, development of health insurance will tend to reduce the need for government financing of secondary and tertiary care.[17] This would help government to develop and maintain smaller and well-targeted system of health care financing to serve people who would not have access to private insurance, and to address public health priorities such as immunizations that are quasi-public goods.[18,19]

HEALTH INSURANCE FOR THE POOR

Before launching any major health initiative, there ought to be a well articulated vision of health care system for the country, and public health policy must be devised to realise that vision. Ideally, certain basic health services, including inpatient care, must be made available to every member of the society.[20] These services must be paid through insurance, which means that every member must have health insurance cover or at least have *access* to health insurance, with government subsidizing insurance premium, in full or in part, for those who cannot afford it. For the upper-and middle-income people, private health insurance market with effective and sound regulation can take care of health financing.[21] However, with the development of private insurance market, only half the country's population can at best be reached. The other half, which consists of low- income population (30% of the population below the poverty line and add to it another 20% living dangerously close to this line) is likely to remain outside the ambit of private health insurance unless there is an explicit social obligation in this respect which can come only from insurance regulator.[22,23] In the current debate on health security for the poor, health insurance is made out to be panacea for all the ills facing the poor. Health insurance, no doubt, has emerged as an important financing tool as it promises to mobilise some resources from the people themselves i.e., those who buy insurance. But health insurance, which strengthens demand side, makes sense only when the supply of health care is reasonably well

developed. Where this is not so, health insurance is meaningless. The supply of health care in the rural and remote areas of country is far from satisfactory.[24,25] Although public health care centers are pervasive, these centers have degraded overtime in most states due to lack of funds, accountability and so forth. Any attempt at introducing health insurance for the poor must also be accompanied by revival of health care facilities at these centers. The need for stepping up public health spending is endorsed by many expert studies.[26]

HEALTH INSURANCE- FISCAL CRISIS

On the insurance regulation side too there are some issues affecting the development of the market. For example, the minimum capital norm for exclusive health insurers is deemed to be lower than what is currently prescribed.[27,28] Similarly, solvency margins and reinsurance requirement appropriate to health insurance which is less volatile than property and casualty insurance are deemed to be different from those applicable to other lines of general insurance business. Currently, such requirements that apply to general insurance business apply to health insurance as well.[29] Similarly, there are no minimum capital requirement and solvency norms for health care providers interested in establishing and running managed care schemes. Once the entry barriers are removed, additional regulations need to be put in place for the smooth functioning of health insurance business. Even though, insurance regulations meant to ensure fairness, efficiency, and financial accountability in health insurance are similar to those applicable to general insurance business, health insurance business always involves additional regulations. These relate to meeting social objectives of access, adequate benefits, and consumer responsiveness. Typically insurers tend to develop a number of underwriting and pricing practices to avoid accepting high risk people. This kind of market segmentation is economically efficient but may be considered socially unacceptable. Often regulators ensure that equal access is available to the payers of health care, that companies cannot exclude high-risk individuals or costly preexisting conditions.[30, 31] Moreover, health insurance contracts are typically more complex than other insurance contracts. Regulators need to ensure that consumers understand the provisions of the contracts and that contract are written in a manner understood by the buyers.[32-35]

CONCLUSION

The poor might benefit from the expansion of private providers if the supply of health care expands due to increase in affordability resulting from health insurance. However, if prices grow faster than delivery capacity, cost escalation may even expand the existing gap between the poor and the required access to health care. All this is unpredictable, since it depends on the supply response of health care and the model of health insurance implemented in the country. Regarding the latter, it is clear that an indemnity/fee-for-service system will unavoidably result in a severe cost escalation whereas a managed care which coordinates financing and delivery of healthcare would probably be capable of maintaining costs under control. Managed care by containing of unnecessary treatment helps in containment of costs and thereby makes health insurance more affordable to larger number of people; provides incentives for improving healthcare delivery; promotes preventive care such as medical check ups, immunization and so on. Since fee-for-service approach to payment of health providers tends to escalate costs the government should encourage managed care models. In short, we have to stem the growing out-of-pocket financing of the healthcare system and replace this with a combination of public finance and various collective financing options such as social insurance and other forms of collective fund-raising. 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.

REFERENCES

1. Bhat R, EB Reuben. Management of Claims and Reimbursements: The Case of Mediclaim Insurance Policy. Vikalpa 2002;27(4).
2. Optimal Taxation and Social Insurance with Endogenous Private Insurance. American Economic Journal Economic Policy 2010;2:85-114
3. Estes CL, Bodenheimer T. Payingforlong-termcare. West J Med 1994;160:64-9.
4. Ball RM. Public-private solution to protection against the cost of long-term care. J Am Geriatr Soc 1990;38:156-63.
5. Creese BS, Monasch AR. Health Insurance schemes for People Outside Formal Sector

Employment. WHO: Division of Analysis. Research and Assessment 1998.
6. Smith MB. Trends in health care coverage and financing and their implications for policy. New England Journal of Medicine 1997;337:1000-3.
7. Griffin CC. Health care in Asia: a comparative study of cost and financing. Washington, DC: World Bank 1992.
8. Hamel MB. Seriously ill hospitalized adults: do we spend less on older patients? Journal of American Geriatrics Society1996;44:1043-8.
9. Hurst J. The reform of health care: a comparative analysis of seven OECD countries. Paris: OECD 1992.
10. Normand C. Economics, health and the economics of health. British Medical Journal 1991;303:1572-7.
11. Relman AS. Assessment and accountability: the third revolution in medical care. New England Journal of Medicine 1988;319:1220-2.
12. Woolhandler S, Himmelstein DU. Costs of care and administration at for-profit and other hospitals in the United States. New England Journal of Medicine 1997;336:769-74.
13. Grossman M. On the concept of health capital and the demand for health. Journal of Political Economy 1972;80:223-55.
14. Grossman M. The demand for health, 30 years later: a very personal retrospective and prospective reflection. Journal of Health Economics 2004;23:629-36.
15. Godfrey C, Maynard A. Economic aspects of tobacco use and taxation policy. British Medical Journal 1988;297:339-43.
16. Bryan S, Weatherburn G, Buxton M, Watkins J, Keen J, Muris N. Evaluation of a hospital picture archiving and communication system. Journal of Health Services Research & Policy 1999;4:204-9.
17. Schulenburg JMG. The German health care system at the crossroads. Health Economics 1994;3:301-3.
18. Shaw RP, Griffin CC. Health care in Sub-Saharan Africa through user fees and insurance. Washington, DC: World Bank 1995.
19. Patrick K. 'Non-profit Insurance Schemes for the Unorganized Sector in India'. Social Policy Division 42, Working Papers No. 22 e, GTZ 2000.
20. Health insurance in India: Current scenario. Regional Overview in South-East Asia. Annex 2.
21. Rao GV. Insurance prospects and challenges in the global scenario. Discussion paper 2, Papers on Health Financing and Contracting. WHO 2004.
22. Mahal A, Singh J, Afridi F, Lamba V, Gumber A. Who benefits from public health spending in India. New Delhi: National Council of Applied Economic Research 2001.
23. National Sample Survey Organisation (NSSO). Morbidity and treatment of ailments. Report No. 441. New Delhi: Department of Statistics, Central Statistics Organisation, Government of India 1998:A-170.
24. Prabhu KS. Social sector expenditures and human development: A study of Indian states. Bombay: Development Research Group. Reserve Bank of India 1993.
25. Selvaraju V. Health care expenditure in rural India. Working Paper No. 93. New Delhi: National Council of Applied Economic Research 2003.
26. Tanzi V, Schuknecht L. Public spending in the 20th century: Global perspective. Cambridge: Cambridge University Press; 2000.
27. World Bank. World Development Report 2004: Making services work for poor people. World Bank 2003:256-7.
28. Glied SA. Health care financing, efficiency, and equity. Working Paper National bureau of economic research. 13881 http://www.nber.org/papers/w13881
29. Ramesh B, Dileep M. 'Health Insurance in India: Opportunities, Challenges and Concerns'. Indian Institute of Management Ahmedabad 2000.
30. Ramesh B. 'A note on policy initiatives to protect the poor from high medical costs'. Indian Institute of Management Ahmedabad 1999.
31. Randal E. 'Health Insurance in India: Prognosis & Prospectus'. Economic & Political Weekly 2000:207-16.
32. David P. 'Better Health Systems for India's Poor: Findings, Analysis, and Options'. Health, Nutrition, and Population Series Washington DC: World Bank 2002.
33. Kent R, Akash A. 'Community based health insurance: The Answer to India's Risk Sharing Problems?' Health Action 2003.

34. Kent R, Matthew J. 'Developing Health Insurance in India: Background Paper', Prepared for Govt. of India Workshop on Health Insurance, 3- 4th January, New Delhi 2003.
35. Peters D, Yazbeck A. 'Raising the Sights: Better Health Systems for India's Poor', The World Bank (Health, Nutrition, Population Sector Unit) 2001:173.