Health Insurance in India

Prognosis and Prospectus

There is growing evidence that the level of health care spending in India – currently at over 6 per cent of its total GDP – is considerably higher than that in many other developing countries. This evidence also suggests that more than three-quarters of this spending includes private 'out-of-pocket expenses'. Despite such a high share of expenditure by individuals, the provision of health care, that is adequate in terms of quality and access, is becoming more and more problematic. Particularly, public delivery of health care is poor in quality, presumably for reasons of inadequate financing. This highlights the need for alternative finances, including provision for medical insurance at a much wider level. The paper attempts to review a variety of health insurance systems in India (defined here as any mechanism which covers the risks of payment for health care at the time of its requirement), their limitations and the role of the General Insurance Corporation as an important insurer agency. It also attempts to develop a prospectus of strategy for greater regulation and increased health insurance coverage by making suitable changes – particularly in claim settlements and the exclusion clause. Also highlighted is the need for a competitive environment (which is at present completely missing), and an opening up of the insurance sector.

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I Introduction

Since independence, the health care system in India has been expanded and modernised considerably, with dramatic improvements in life expectancy and the availability of modern health care facilities and better training of medical personnel. At the same time, however, much remains to be done. Several recent papers and reports have critically reviewed the Indian health delivery and financing system [Berman and Khan 1993; World Bank 1995; Ministry of Health and Family Welfare 1995; Planning Commission 1996, etc]. These studies have documented many serious problems with respect to the accessibility, efficiency and quality of the health delivery system. They have also made several policy recommendations to alleviate these problems.

One aspect of this ongoing has centred on health expenditure and health financing. As shown in the *World Development Report 1993*, health expenditure in India as a percentage of its GDP was 6 per cent in 1990 which is higher than the level in many other developing countries in the Asian region. Evidence indicates that this higher level of spending is not only due to price differences but also represents a real difference in health care spending [Berman 1996]. A very revealing calculation by Berman about sectoral shares in the total health spending indicates that in a break-up of this 6 per cent, as much as 4.7 per cent of the expenditure is accounted for by the private sector (Table 1). Moreover, of the 4.7 per cent, around 4.5 per cent comprises out-of-pocket expenditures of the households. The remaining 0.2 per cent includes contributions from private employers and other non-government organisations. Almost all of this private spending is on curative care: consultations, diagnostics and in-patient care.

Most of the discussions on health care financing in India have centred on the financial constraints of the public sector and the efficiency of resource allocation by the government. 'Health for all' has been seen as the central assumption of the health sector debate, thus making the government the central player. While we admit that the 'health for all' objectives are laudable, the overwhelming focus on a public health care delivery system appears somewhat unrealistic – particularly in view of the fact that health spending in India is mostly private.

This paper is devoted to one particular aspect of health care financing in India – namely, the enormous financial burden faced by individuals in the form of out-of-pocket expenses to pay for curative health care. These financial burdens are pervasive, and both contribute to many other problems which face India's health care delivery system and are reinforced by them. Evidence indicates that Indians tend to use health care services more frequently [Duggal and Amin 1989; Berman 1996]. Supply-side reasons include greater availability of health practitioners both because of the several branches of medicine unique to India and because of the easy and almost unregulated entry of a very large number of private practitioners in each of these branches every year. However, these reasons can at best be a small part of the explanation. Howsoever easily available health care is, no rational consumer is expected to spend large amounts of his or her income without very good reasons for it.

Excessive financial burdens on households arise for a variety of reasons. At one level, they can be blamed on India's public health care system, which is underfunded and suffers from quality and access problems, forcing consumers to visit the private and relatively more expensive treatments. However, as will be discussed below, recent household-level studies on utilisation of health care indicate that even

public care is not all that 'free' after all: there are many incidental expenses that consumers have to bear on their own. If all the quality and access differentials between public and private health care were to be wiped out, there would still be some very heavy financial burdens on the consumers.

We contend that these financial burdens arise because the consumers are either not insured or are insured inadequately for their health care expenses. This is the focus of our paper as the title indicates. We examine health insurance in the broadest sense by which we mean any financing arrangement in which consumers can avoid or reduce their expenditures on health services at their time of use. Thus, not only private health insurance, but also the free public provisions and reimbursements – where health care is prepaid by consumers from their own salaries – can be seen as forms of insurance.

The findings in this paper are based on a variety of sources. In addition to reviewing a substantial mass of literature on health financing in India and elsewhere, we have benefited from extended discussions with a large number of researchers and individuals from government agencies, public enterprises, private firms, international agencies, insurance companies and hospitals. We also had conversations with numerous consumers of health services. The summary data provided by the General Insurance Corporation (GIC) about the health insurance cover and its components have been immensely useful.

The remainder of the paper is organised as follows. Section II provides an overview of the existing pattern of health care financing in India, with an effort to reflect the full diversity of the financing methods currently in use. We do not attempt a comprehensive review of all the strengths and weaknesses of the system, but focus instead on the implications of the financial burden facing consumers in India. In Section III we develop a prognosis: an interpretation of the direction, strengths and weaknesses of the Indian health care system. This section focuses mostly on the health insurance policies, premiums and claims patterns of the GIC and its four subsidiaries. This focus is in view of the special role played by the GIC in insuring segments of the Indian population with the greatest ability to pay which forms a possible model for future forms of health insurance in the country. Finally, in Section IV we develop elements of a prospectus of strategy for increasing the coverage and extent of health insurance for the formal sector in India. In doing so, we apply principles from published theoretical and empirical literature on health insurance from other countries.

II
Financing of Curative Health Care in India

Recently, there have been many good reviews of India's health care financing [Berman and Khan 1993; Reddy and Selvaraju 1994; Upleker and George 1994; World Bank 1995; Alam 1998; Tulasidhar 1996]. It is beyond the scope of this paper to go into the details or summarise this literature, but we would like to highlight several recurring themes. One theme is that India's health care delivery system relies upon both public and private facilities to provide care. Another theme is that given the constraints on public resources that are available, it is desirable and appropriate for the public sector to increase its effort to subsidise, finance or provide primary health care services, and to seek other revenue sources for doing so. It has also been argued that the emphasis on preventive and promotive health services by the government has been at the expense of curative health care and that this has led to the unregulated growth of the private health care sector [Phadke 1994]. Finally, it has also been recognised that there are considerable variations across different Indian states and union territories in levels of health expenditure [Alam 1997], the respective shares of public and private health services, and the types of ailments.

Table 2 highlights two extremely important features of the Indian health care financing system. The numbers in this table are derived from Sundar (1995), who based her analysis on data obtained from a health survey conducted by the National Council of Applied Economic Research (NCAER) in 1993. Similar findings are presented in studies by Bhat (1993), Berman and Khan (1993) and Kumar, Krishna and Kanbargi (1994). These analyses consistently show that a majority of people seek care during illness from private rather than public providers for out-patient care. A slight majority of ill people seek care from public providers for in-patient care. However, given that the out-patient episodes are much more common than the in-patient ones, a clear majority of all visits in India are to the private providers.

Another important feature of the health care system in India is that even visits to public facilities generally involve considerable out-of-pocket expenditures. Numerous studies have shown that even consumers from the lowest income quintile often pay considerable amounts out of pocket for curative treatment by public

Table 1: Estimate of Total Health Expenditure in India, 1990-91

Source	Total (Rs Crore)	Per Capita (Rs)	Per Cent of Total	Per Cent of GDP
Public Sector				
Centre	554	6.6	2.1	0.1
States	4,981	59.3	18.6	1.1
Municipalities	126	1.5	0.5	<0.1
External aid	118	1.4	0.5	<0.1
Sub-total	5,779	68.8	21.5	1.3
Private Sector				
Out-of-pocket	20,160	240.0	75.2	4.5
Private employers	319	3.8	1.2	0.1
ESIS contributions	202	2.4	0.8	<0.1
Other sources	361	4.3	1.4	0.1
Sub-total	21,042	250.5	78.5	4.7
Total	26,821	319.3	100.0	6.0

Source: Peter Berman (1996).

Table 2: Choice of Facilities and Average Expenditures on Illness Episodes (1993)

	Percentage of All Episodes			Average Expenditures per Illness Episode (Rs)		
	Public	Private	All	Public	Private	All
Non -hospitalised illnesses						
Urban	33.9	66.1	100.0	62	152	114
Rural	41.7	58.3	100.0	49	130	90
Hospitalised illnesses						
Urban	60.1	39.9	100.0	452	2319	1197
Rural	62.0	38.0	100.0	535	1877	1044

Sources: Sundar (1995), Tables 17, 20, 29, 30, and 39, Data are from a 1993 NCAER national household survey.

providers [Upleker and George 1994; Sundar 1995; Planning Commission 1996]. These expenditures may take the form of payments for medicines, laboratory tests, dressings, linen and/or food or direct payments to providers. This is clearly borne out by Table 2. The right hand side of this table highlights that average spending per out-patient episode at the public facilities is about 40 per cent of the average expenditure on visits to the private sector, while the public in-patient treatment expenditures average about a quarter of the private in-patient treatment costs.

Taken together, these two features of the Indian system imply that treatment from both categories of facilities imposes considerable financial burdens on individuals. Estimates vary and depend upon the definitions of 'public' and 'curative'. But a consistent pattern emerges, suggesting that about three-fourths of all the expenditure for curative health services are private, and only one-quarter is public.[1]

Given the extent of the burden, there is a need for greater protection – whether through public provision, conventional insurance, public subsidies or community-based financing. The paper argues that such devices, of which India has a mix, are different types of 'insurance'. The reasoning is that any arrangement that enables the consumers to avoid, delay or reduce full payment is a form of insurance. Earlier literature on the Indian insurance system often ignored this full array of arrangements and confined itself to the formal system of insurance by companies like the GIC.

Table 3 indicates in summary form how curative services are paid for by various population groups. Each row in the table refers to different employment segments, while the first eight columns correspond to different mechanisms used to pay for the health care services. The 'X's are our best guesses of the approximate proportions of expenditures for each population segment on each type of payment system. The last column of the table estimates approximately the number of employees in that population group, while the last row at the end of table represents our estimate of the share of total expenditures arising from that payment system. We would like to reiterate that the numbers shown in this table are our best guesses based on literature review and discussions with people. The point to note about this table is that no matter what kind of insurance a person has, there is always some out-of-pocket expense (see column marked 'out of pocket'); the extent of that expense depends on the type of insurance.

The first three columns of Table 3 include those components of health spending which are generally called the public sector. They add up to roughly one-quarter of the total health expenditure. Each of these systems is briefly reviewed in the discussion to follow before we turn to a consideration of private payment mechanisms.

Public Health Facilities

The best documented and largest system of health care delivery in India is the diverse network of hospitals, primary health centres, community health centres, dispensaries and speciality facilities financed and managed by the central and state local governments. These facilities are officially available to the entire population either free or for nominal charges.[2] Along with some other networks of village health workers, maternal and child health programmes and speciality disease prevention programmes these public facilities carry out a central role in India's primary health care system.

Numerous studies have indicated that these facilities are mostly underfunded, understaffed and short of drugs and essential supplies and that they sometimes suffer

Table 4: Mediclaim Statistics: 1987-1995

Year	Number of Policies Issued	Number of Covered Persons	Total Premium Revenue (Rs Million)	Claim Amount Settled (Rs Million)	Number of Claims Reported	Number of Claims Settled
Calendar year						
1987	1,08,298	1,67,726	79.9	3.3	3,812	1,759
1988	1,27,791	1,91,865	112.9	34.9	22,411	16,181
Fiscal year						
1989-90	39,288	6,49,850	240.3	74.4	42,241	34,107
1990-91	1,65,283	5,66,791	278.4	145.6	55,764	45,939
1991-92	1,91,510	6,97,018	344.7	156.0	40,567	30,630
1992-93	2,52,163	9,85,674	489.2	239.9		
1993-94	4,40,377	12,76,509	974.3	426.4		
1994-95 (partial year results)	4,88,000	17,83,00	1,146.1	569.8		
Percentage change (1989-90 to 1994-95)	250	174	377	666	–	–

Source: Tables provided by the General Insurance Corporation, 1996.

Table 3: How Curative Health Services Are Paid for in India

	Free	Central (20 mn)	Employee (29 mn)	Mediclaim (1.8 mn)	Employer (30 mn)	Employer (20 mn)	Others* (30 mn)	Private/Out of Pocket	Employees (mn)
Government employees	xx	xxx				x		xxxx	4.6
Defence, police, social services	x				xxxxxx			xx	9.5
Plantation workers	x				xxxxxx			xxx	1.2
Mine workers	x				xxxxxx			xxx	1.1
Railways	x				xxxxxx			xx	1.8
Public enterprises (private, formal sector)	x		x	x	xxx	xx		xx	2.1
Large firms (private, formal sector)	x		x	xxx	x	xx		xx	7.0
Small firms (private, informal sector)	xx		xx	x		x		xxxx	1.0
Urban (private, informal sector)	xxx					x	x	xxxxx	128.7
Rural	xxxx							xxxxxx	193.0
Percentage of total health spending	20	1	3	1	5	4	1	65	350.0 100

Notes: Each x represents approximately 10 per cent of all expenditures. All figures in the table are approximations, not necessarily based on solid evidence. Numbers shown in parentheses below column headings are estimates of the number of eligibles. * Others include all NGOs/ Voluntary organisations.

from low morale and inadequate work motivation [Upleker and George 1994; World Bank 1995]. Household surveys consistently report concern about the quality of these public facilities as one of the reasons why people seek treatment elsewhere [Duggal and Amin 1993; Sundar 1995; Shariff 1996]. Some observations also reveal that higher-income households and individuals with privileged access to other facilities avoid public health care services whenever possible. Households in the top 20 per cent of income distribution in Maharashtra make as much as 95 per cent of their visits for treatment to private facilities [Upleker and George 1994, based on Duggal and Amin 1989]. Discussion of the problems with referral hospitals is found in Sanyal and Tulasidhar (1995).

The health facilities made available to the public are managed and operated under the authority of central and state agencies. The state governments mostly own and manage the public sector delivery system and have to bear the costs of operation. But the central government plays a major role in the planning, financing and transfer of resources that determine new investment in health facilities and specialised programmes. Much of the funding for health facilities originates from the union ministry of health and family welfare and is channelled to the state governments, which retain considerable authority for the spending decisions. Virtually all decisions are made by the central and state governments – including the staffing and supply decisions, with little autonomy for the providers of health care at the lower levels. Over the years, the central government has been the main source of funds for the primary health care facilities, whereas the states bear the major responsibility of recurrent costs, especially the costs of running hospitals. This system has added to the overall inefficiency of public health facilities.

Central Government Health Scheme

The Central Government Health Scheme (CGHS) was introduced in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families. It was basically designed to replace the cumbersome and expensive system of reimbursements (ministry of health and family welfare, *Annual Report 1993-94*). Separate dispensaries are maintained for the exclusive use of the central government employees covered by the scheme. Over the years the coverage has grown substantially with provision for the non-allopathic systems of medicine as well as for allopathy. By 1993, there were a total of about 308 dispensaries – of which 230 were allopathic dispensaries. In addition, there were several polyclinics, laboratories and dental units under the scheme. The total number of beneficiaries was 4.5 million by 1993. In addition, the CGHS reimburses patients for part of their out of pocket costs on treatment at the government hospitals and some other facilities. The list of beneficiaries includes all categories of current as well as former government employees, members of parliament and so on. Since the large central bureaucracy in India definitely belongs to the middle-income and high-income categories, they are likely to make above-average use of health services.

The CGHS is widely criticised from the point of view of quality and accessibility. A study by the NCAER (1993) on public hospitals in Delhi highlights many such problems. For instance, it suggests that people used hospitals disproportionately for access to specialist consultants and notes that individuals showed up without any referrals in 83 per cent of these cases. Other problems included long waiting periods, significant out of pocket costs of treatment (Rs 1,507 for first treatment in an episode), inadequate supplies of medicines and equipment, inadequate staff and conditions that are often unhygienic.

Employees State Insurance Scheme

Established in 1948, the Employees State Insurance Scheme (ESIS) is an insurance system which provides both the cash and the medical benefits. It is managed by the Employees State Insurance Corporation (ESIC), a wholly government-owned enterprise. It was conceived as a compulsory social security benefit for workers in the formal sector. The original legislation creating the scheme allowed it to cover only factories which have been 'using power' and employing 10 or more workers. However, since 1989 the scheme has been expanded, and it now includes all such factories which are 'not using power' and employing 20 or more persons. A useful overview of the ESIC programme is provided in Subrahmanya (1995). Mines and plantations are explicitly excluded from coverage under the ESIS Act. As of January 1995, the programme covered 1,62,191 employers employing 6.6 million people, or altogether 29 million employees and dependents. Only employees earning basic salaries of less than Rs 3,000 (recently enhanced to Rs 6,500) per month are eligible for ESIS cover. Any establishment offering benefits similar to or better than the ESIS is exempt. However, it is not clear how many persons are currently being exempted [Subrahmanya 1995].

The premiums for the ESIS are paid through a payroll tax of 4 per cent levied on the employer and a tax of 1.5 per cent levied on the employee (recently changed to 4.75 per cent and 1.75 per cent respectively). As of 1993-94, medical benefits have comprised nearly 70 per cent of the total benefits provided under the scheme which also include cash payment for illness, maternity, temporary or permanent disablement, survivorship and funeral expenses. Health-benefit expenses grew 82 per cent from 1992-93 to 1993-94, as against a small decline in the number of employees covered [Subrahmanya 1995].

The primary way in which the medical benefits are provided under the ESIS is through the facilities dedicated to those on the rolls of this scheme. As of 1993-94, there were 1,427 dispensaries with 5,320 doctors, and 23,348 hospital beds (4.5 per cent of the national total) in 118 dedicated hospitals and 42 hospital annexes [Subrahmanya 1995]. Patients requiring treatment from specialists not available at the ESIS hospitals can receive them at the speciality facilities, with the ESIS programme bearing the expenses [Shariff 1995].

The programme has come under serious criticism from users, internal review committees and outside researchers. Subrahmanya (1995) quotes extensively from several such reviews and studies. A three-part article in the *Times of India* (Bombay, May 14-16, 1995) described the ESIS in Maharashtra as "falling to pieces in more ways than one". A committee for review of the scheme noted that "the criticism has been persistent and scathing" and that "the medical benefits provided have not kept up with the standard of facilities provided by the private clinics and diagnostic centres". A similar opinion was expressed by Ratnam (1995), who notes that "the operation of the ESI scheme and administration of hospitals and dispensaries under the scheme are also seriously faulted and scorned by both the employees and employers".

A report based on detailed patient surveys in Gujarat [Shariff 1994] found that more than half of those covered did not seek care from the ESIS facilities. The dominant reason given in the report was the

"unsatisfactory nature of ESI services (which includes low quality drugs and long waiting periods)". This report has also revealed "impudent behaviour of ESIS personnel, lack of interest on the part of employers and low awareness of ESI procedures". The same study found instances in which employers deprive workers of their rights to coverage by not informing them of the necessary details, disallowing injury claims by changing eligibility conditions with retrospective effect, and manipulation of the work schedules of part-time employees so as to make them ineligible for ESIS coverage [Shariff 1994].

These reviews are consistent with our discussions with private and public firms in preparation of this note. One private firm dismissed the ESIS by saying that a person has to be "dead or unconscious before he will visit an ESIS facility". Other respondents indicate that their employees avoid ESIS coverage at all costs, even if it means reporting additional taxable income so as to become ineligible for the programme.

Mediclaim Policy of the GIC

The GIC was set up by the government in 1973 as a public sector organisation to market a range of insurance services, including hospitalisation cover. It introduced the standard 'Mediclaim' health insurance scheme in 1986, and became operational in 1987. This policy was modified in 1996 to allow for differentials in premium for six age groups: 5-45, 46-55, 56-65, 66-70, 71-75 and 76 plus. This policy was framed by the GIC for both groups and individuals.

Before the GIC came into existence, a number of private insurance companies were engaged in offering group health insurance cover to most corporate bodies. With the formation of the GIC these companies were merged into four of its subsidiaries: the National Insurance Corporation (Calcutta), New India Assurance Company (Bombay), Oriental Insurance Company (New Delhi) and United Insurance Company (Madras). All the four companies operate nationally, although each has a regional concentration reflective of the location of its home office. They offer a full range of insurance types, with health accounting for a very small share of their total business.

One purpose of the merger of all the insurance companies was to standardise the coverage and various medical benefits. This was indeed accomplished.

The standard Mediclaim policy covers only hospital care and domiciliary hospitalisation benefits. Although some insurance companies have earlier experimented with direct reimbursement to hospitals and other providers, at present all that is offered is reimbursement insurance. With this the 'enrollees' are reimbursed for their medical claims only after the payments have been made out of pocket to the provider.

The GIC so prescribes premiums, eligibility and benefit coverage for all the four subsidiaries that they do not compete along any of these dimensions. All four firms have significant delays in claims processing. We discuss these delays and other related issues below.

Detailed overviews of the Mediclaim programme have been provided in studies by Ratnam (1995) and the GIC (1995). These reviews present a more favourable user attitude to Mediclaim than to ESIS. This is clearly reflected in enrolment trends. Whereas enrolment in the ESIS programme has increased by only 10 per cent over the past five years, enrolment in Mediclaim insurance has increased by 174 per cent over the same period. The number of persons covered by the Mediclaim policies at the end of 1994 was 1.8 million (see Table 4, which also provides information on policies issued, enrolments, premiums and claims reported and settled since 1987). It is striking how premium revenues have grown more than twice as fast as the number of covered lives between 1989-90 and 1994-95 and how the number of claims settled has grown even faster than premium revenues. Thus far, the premium revenue of Mediclaim has managed to keep ahead of claim payments. This, however may not hold good in future owing to the accelerating growth in amounts paid to the settled claims. It is also revealing that the claims per covered person have been growing 37.5 per cent annually between 1989-90 and 1994-95.

One of the major weaknesses of Mediclaim is that it covers only hospitalisation and domiciliary expenses, leaving out routine out-patient care. Moreover, the coverage is subject to numerous exclusions, coverage limits and restrictions on eligibility. Many of the people that we spoke to mentioned incidents in which either the medical spending claim was disallowed or only partial reimbursement was received. A further criticism of Mediclaim is that the premiums are high in relation to the claim payments: as can be seen in Table 5, column 4, the average claim payments are only 58 per cent of average premiums. Finally, there seems to be a mutually beneficial relationship between the Mediclaim programme and most of the corporate hospitals. These hospitals get regular business from the middle and upper income segments of the population [Phadke 1994] which are now increasingly covered by Mediclaim. These and other issues will be discussed further.

Specialised Insurance Scheme

The Life Insurance Corporation of India (LIC) introduced a speciality insurance programme in 1993 which covered medical expenses for only four dreaded diseases. This programme was withdrawn subsequently, but reintroduced in 1995. By definition, it is very limited in scope. It does not, therefore, serve to reduce the risk of financial burdens to any significant extent. It also remains to be seen whether or not this programme will be a popular method of insurance.

The GIC's Jan Arogya Bima Policy is yet another scheme of medical reimbursement being offered to people on an individual basis. The annual premium for the youngest people age group is only Rs 70, as against the coverage limit of Rs 5,000 per year. Higher premiums are charged for older persons or those with spouses or dependents. Yet the premiums remain low in relation to the maximum coverage. Even this low-maximum coverage level will provide considerable coverage against low cost hospitalisations. Another significant difference is that it also covers maternity expenses. Apart from these few differences, this policy retains most of the Mediclaim features. It remains to be seen how successful is in comparison to Mediclaim.

Employer-Managed Facilities

Most discussions of health insurance in India end after the ESIS and Mediclaim are dealt with. Yet these are not the only forms of health insurance in India. "Employer-managed health facilities", and the "reimbursements of health expenses by employers" are also ways to insure people against the risk of illness. These facilities are common for large public and private enterprises. Expenses incurred on these facilities are generally not tabulated in official records. Certain observations by Ratnam (1995) on this issue are very revealing, as is this one:

Nearly half of the public sector companies did not specify financial limits because almost all public sector manufacturing enterprises covered, being large in terms of

size of employment, invariably have their own dispensary and hospitals and provide medicines, etc, across the counter, usually within the company premises/township. The same applies to large private sector companies, which too have similar facilities and practices (1995:4).

Ratnam also describes the medical benefits provided by 18 public and 99 large private establishments. In Table 3 we speculate that perhaps about 30 per cent of the expenditure incurred on curative health by the public sector employees and their dependents is provided directly by the employers. This may be about 10 per cent for the large-scale private establishments. Krishnamurthy (1995) documents another segment of the Indian population that is covered by employer-managed facilities: the plantation sector. This sector employs about 1.6 million workers, and health services are regulated by the Plantation Labour Act of 1951. This Act (and subsequent legislation) specifies minimum standards for dispensaries and hospitals. Krishnamurthy also tries to show that some plantations more than comply with the hospital standards, while others do not (1995:34).

Like the plantations, the railways also maintain an extensive set of clinics and hospitals for their employees and their dependents. The mining sector provides medical and other facilities to its employees – particularly the mica mines and the iron ore, manganese ore, chrome ore, limestone and dolomite mines (Ministry of Health and F W 1992).

Another segment of the public sector which maintains its own medical services is the defence set-up which along with other security forces (police, paramilitary forces) employs about two to three million persons. Yet another segment which provides some of these facilities to its employees comprises certain educational institutions, particularly universities. These facilities no doubt compete with other public facilities for staff and financial resources.

Although precise estimates are not possible in the absence of data, it appears that around 50 million persons would have been covered either wholly or partially by employer-managed facilities, and the expenditures on these facilities may be much larger in magnitude than that on the ESIS.

Employer Reimbursement of Health Expenses

A common but frequently-ignored segment of the health insurance system in India comprises numerous reimbursement plans offered by the employers for private medical expenses in the private sector, as well as in autonomous institutions and organisations – including commercial banks. For many workers this is the only form of insurance other than public facilities.

All the seven large firms we spoke to in Delhi said they offered reimbursement schemes in addition to GIC or ESIS cover. Two kinds of reimbursement systems are predominant. In about half the cases, the system requires employees to set apart a share of their own income to save towards medical expenses. In all such plans, employees are able to spend up to the annual level of their own contribution. Typically, limits are set which depend upon a given employee's salary. In some cases contributions are voluntary, but in most cases they are not. Coverage for outpatient expenditures is more common than coverage for hospitalisation expenses.

The other common system of reimbursement is an employer self-insurance system, generally known as the medical benefit or medical allowance scheme. Under this arrangement, employees incurring medical expenses are required to submit claims to their employers for reimbursement, and reimbursements are not linked to the individual's contribution. In general, such programmes have coverage limits which vary according to the employee's salary or job category.

Using data collected through a survey of 99 private and 18 public enterprises, Ratnam (1995) provides a very useful overview of the reimbursement systems now in vogue. He notes that employees in most private enterprises are provided with some form of medical reimbursement or medical allowance facilities and that limits and coverage features are quite variable. A few companies like Bajaj Auto Limited offer special assistance to their employees such as a programme for insuring those whose annual health care expenditures exceed Rs 20,000. In such cases, the company pays 75 per cent of the health care expenditure amounting up to Rs 1,00,000 not covered by other insurance programmes.

The NGO Sector

An important part of private health finance in India is the services provided by voluntary and charitable organisations. As noted by Berman (November 1996), while such groups do not account for a large share of health care, they are often the only source of health services, or the only trusted one, for the population they serve. While it is very difficult to estimate even approximately the exact coverage of these varied services, Berman speculates that they cover more than 5 per cent of the population.

A review of non-governmental approaches to community health has been provided by the Ford Foundation under its Anubhav project. This project has looked into all aspects of NGO involvement in the provision of health services, and may therefore be used as an important source of information about the NGOs and their activities. Some of the important NGOs offering health services are Child in Need Institute (CINI), Self-Employed Women's Association (SEWA), Streehitkarni and Parivar Seva Sanstha. Most of these NGOs offer comprehensive assistance packages with the underlying assumption that health is only one aspect of development and should therefore be tackled along with other social problems in a holistic fashion.

The government has realised quite early that NGOs could complement – the services they offer. One encouraging feature of this realisation has been the co-operation and help extended to many NGOs by the government. Each five-year plan has a stated amount for allocation to the NGO sector. For example, the Seventh Plan earmarked Rs 150 crore for them. The government has used the health sector NGOs for two main purposes: to train its functionaries and to implement its health care delivery programmes [Sundar 1995]. CINI and SEWA are good examples of such co-operation.

To sum up, NGOs are providing valuable health services in many parts of India, especially in the rural areas and to disadvantaged people. It remains clear, however, that despite its growing role this sector has not yet reached a level where it can make a significant dent in private expenditure on curative care in India.

Private Out-of-Pocket Expenses

Almost all segments of the Indian population bear some direct out-of-pocket expenses for the utilisation of the health care services (Table 3), the lightest burden being borne by workers in the public sector or those employed in large private firms. The heaviest burden is borne by the people engaged in non-formal rural and urban activities. Even government employees with other forms of coverage bear considerable out-of-pocket expenses because they use private facilities and pay for drugs and services which would otherwise be cost free. Though firm evidence does not exist,

we estimate that approximately 65 per cent of all spending on curative and diagnostic care in India consists of direct out-of-pocket expenses which are not reimbursed and which therefore impose a significant burden on consumers.

III
Prognosis

The existing structure of paying for health care in India has important implications for effective government policy and the direction of health insurance. In this section we interpret the above description of the Indian system. We call this a prognosis because it attempts to understand the causes and consequences of the problems facing our curative health care system. We defer till the next section a prospectus which seeks to suggest certain directions in which the health system in India might move.

Financial Burdens for Curative Health Care

The financial burdens of health care in India are enormous and growing. Given the constraints and difficulties in raising additional public resources and the rapid growth in spending on health care, if will be very difficult for the public health system to keep pace. We argue that even if the government decides to increase the level of public spending on health services dramatically, a substantial financial burden would still remain for users of health services. To be more precise, if direct public spending on health facilities is increased by 50 per cent – which would indeed be a remarkable achievement – it would at the most reduce the share of private expenditure on health from 75 to 62.5 per cent. It is also very likely that the additional public spending would augment private expenditures rather than replace them.

Public spending should be focused more on primary health care and treatment for those with very limited ability to pay. Already, the demand which for such services exceeds the supply [*World Development Report, 1993*]. There is enormous scope, therefore for increasing public spending on health without reducing the demand for private health services.

The public health sector is rapidly becoming the "provider of the last resort". Higher income individuals and those without chronic disabilities rely increasingly on private providers with some degree of insurance or reimbursement. As this progresses, it may result in further deterioration in the quality of public health facilities and the public support for them.

Limitations of Insurance Sector

An important conclusion emerging from the preceding discussion is that a large proportion of the population in India does not have the choice of facilities available to the workforce of the formal sector. The large number of separate networks of providers tends to make for reduce inefficiency and the choice among providers: only a limited set of providers is offered to a given employee.

A majority of the large public and private establishments are either self-insuring or provide reimbursement plans to their employees. These employers may be more than willing to switch over to private third party insurance, should it become available. This is particularly true for the large-scale enterprises which provide their own clinics and personnel. Given that the employee demand for quality treatment and specialists' care is increasing rapidly, these enterprises would find it worth their while to switch to an insurance structure.

Reforming ESIS and CGHS

Although the number of beneficiaries of the ESIS has grown modestly over time, enrolment has not kept pace with growth in the GIC, the organised sector or even the number of low-wage workers that the ESIS is supposed to cover. For reasons discussed above, employees have been reluctant to avail themselves of the ESIS facilities. Here again, the argument of improving quality of services offered under the ESIS holds.

Numerous studies have shown that the providers of treatment at ESIS and CGHS facilities do not have adequate incentive to exert themselves. These facilities generally suffer from low provider morale, understaffing and equipment shortages. Improvements in the quality of services offered by these facilities can be effected by decentralising the decision-making process and introducing reforms in financing norms. An incentive may be provided by allowing the facilities to charge user fees – even if the fees are paid by the government on the basis of the patient-load factor. An alternative strategy might be to merge the two systems of facilities with the rest of the public health system.

Lack of Incentive for Cost Optimisation

There are important signs that health insurance in India is causing a 'moral hazard' problem. In a health insurance setting, the hazard can be of two types: insurance may induce individuals either to take fewer precautions to avoid the need for treatment or to use more health services when they fall ill. Both actions tend to increase health expenditures. Increased spending when illness is the main phenomenon observed in health markets: patients and health care providers both respond to the presence of insurance by increasing the level of spending on health care. In some cases this increased spending may be socially desirable, such as spending on essential primary care or underutilised, expensive in-patient treatment. In other cases it may lead to increasing levels of inappropriate care, unnecessary treatment, excessive laboratory tests or overcharging. This moral hazard may be reduced by changing incentives either on the demand side or on the supply side.

The current structure of insurance offered in India generally steers clear of cost-sharing. While substantial cost-sharing may reduce access to medicare, low levels of cost-sharing may deter unnecessary treatment. Furthermore, if consumers do not face at least some out of pocket expenditure on health care, they may not have sufficient incentive to avoid the most expensive facilities, or the most extensive set of diagnostic tests. Results from other countries (e g, the Rand Health Experiment in the US) suggest that even nominal fees would discourage a significant amount of use. Charging higher fees or higher co-payment for more expensive facilities will encourage consumers to get referrals and become better informed about the necessity of treatment.

The lack of a governmental focus on curative care has led to almost unregulated growth in the private medical system. Phadke (1994) describes some of these problems: substandard but expensive private medical education, lack of continuing medical education and training for doctors in the private sector, irrational drug use, unnecessary medical interventions, lack of regulation and standardisation of nursing homes, etc. These features often inflate costs for the health system as well as for consumers.

Nor are supply side incentives being used to constrain expenditures. As a matter of fact, the GIC subsidiaries indirectly encourage expensive corporate hospital treatment by not devoting enough attention to the appropriateness of claims. Our reading is that it may be easier to get reimbursement if one is treated in one of these expensive and well known facilities rather than in a lesser one.

So far as the monitoring of claims is concerned the GIC subsidiaries appear to be more preoccupied with whether services are being provided with pre-existing conditions than to whether or not the fees paid are justifiable or the facility used by the claimant is qualified and the treatment appropriate. As more expensive and more complex procedures are increasingly being resorted to, it will be important for the insurers to play a more active role in claims monitoring and fraud detection. Computerising the entire claims processing system would facilitate this.

Need to Reform the GIC

There is a lot of debate on the scope for 'privatisation' of health insurance. The Mediclaim system comes closest to this concept. The system of having four dominant insurers – who generally compete on service quality but have regulated prices, eligibility and benefit features – does avoid some of the more severe problems of adverse selection and undesirable forms of benefit-feature competition. Other problems with the GIC system, however, remain.

Evidence suggests that over the past five years the GIC's claims have been growing at more than 30 per cent a year – which substantially exceeds the growth of public health-care spending or individual spending. It seems plausible that this growth is in part the moral hazard response to insurance. However, such high rates of increase imply that there is enormous potential for increased spending by other segments of the poulation, should the insurance coverage be extended to new groups.

The manner in which the GIC premiums are changed from one year to the next is clever in that it ensures that the corporation does not have to take in premiums that are persistently below claims. A further clarification on this is as under.

Even the high margin of GIC premiums over claims understates the true margins. Subsequent-year premiums are calculated on the basis of incurred claims, not on paid claims. If the claims are eventually denied the difference would apparently go unreconciled while adjusting future premiums. Besides increasing profit margins this feature builds in an incentive for the insurers to delay payment on claims. This is one of the major complaints against the GIC's Mediclaim policy.

The existing GIC programme covers only in-patient and hospital domiciliary expenses. This leaves consumers to shoulder financial burdens arising from out-patient expenses.

Finally, there is a lot of uncertainty about the amount an insurer will reimburse and the time within which it will do the needful. This discourages resort to insurance.

Unregulated Limitation of Coverage

There is considerable resentment of the current practice of permitting GIC subsidiaries to exclude from coverage a long list of specified conditions and selected chronic conditions which are pre-existing at the time of enrolment. The existing Mediclaim plan excludes all treatment costs for HIV or other sexually transmitted diseases (STDs). Such exclusions in most developed countries are regulated and not left to the decision of the insurance companies. A desirable policy might be to allow exclusions for a fixed period (say one or two years), after which the health plan enrollees may become eligible for coverage.

The insurance companies and some researchers might argue that disorders existing at the time of enrolment are known health risks and, therefore, not insurable events. It is true that these expenses will be predictably higher, and insurance companies will tend to lose money on these enrollees. However, if all health plans are required to cover chronic conditions on the same basis, such coverage need not create unfair losses. Also, it would be unfair on equity grounds to force those who face chronic (or selected excluded) diseases to pay for the full cost of treatment out of pocket or to shift the burden of treatment for such diseases to the public health care providers.

Regulation is also needed to ensure that the health plans do not enter into competition for attracting only profitable, low cost patients. There is danger that biased selection will undermine GIC's recent efforts to expand coverage limits. In 1996, a new benefit plan was introduced which offers substantially higher caps on coverage (up to Rs 3,00,000 versus an upper limit of Rs 33,000 under the previous system).

Although there is some evidence of biased selechon, this has so far not been a serious issue in India. The fact that group coverage predominates over individual coverage is a possible explanation. Table 5 presents the average claims paid by different age groups. It clearly suggests that the average claim expenses increase with age. The third column shows that premiums do not increase appreciably with age. Column 4 shows that while the claims paid averages only 58 per cent of the premiums collected overall this average reflects a loss on the oldest group. Moreover, this loss for the insurer is not compensated by gains from the younger age groups. Columns 5 through 10 correspond to five different categories of coverage, with category I being the lowest paid and more generous than the rest. This indicates adverse selection: if there were no biased selection there would be the same proportion of enrollees in each category. However, the problem has yet to assume a serious dimension.

Relative Neglect of Unorganised Sector Employees

The existing Mediclaim structure does not properly serve the large segment of population engaged in low-paid informal activities. There are several reasons. First, the procedure used to fix the Mediclaim premium strongly favours the large-scale public and private establishments. It is clear from Table 6 that the premiums on individual policies are substantially higher than those on group policies. This table also shows that the discount on premium for group insurance ranges from 15 per cent for a 101-500 group to 66.7 per cent for a group more than 50,000 strong. In our view, such discounting policies fail to conform to the equity criterion and appear somewhat regressive. As an outcome of

Table 5: Statistics Based on a GIC Sample of 45,169 Policies

Age Group	Claim Value Per Policy	Premiums Per Policy	Ratio of Claims/ Premiums	Categories of Coverage I Highest Coverage	II	III	IV	V	VI Lowest Coverage
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
All	1120	1922	0.58	0.55	0.11	0.12	0.06	0.03	0.03
5-45	788	1837	0.43	0.56	0.11	0.12	0.05	0.03	0.04
46-55	1313	1953	0.67	0.63	0.10	0.10	0.03	0.02	0.02
56-55	1797	2043	0.88	0.67	0.10	0.09	0.03	0.01	0.02
66-70	2025	1712	1.18	0.69	0.12	0.08	0.02	0.01	0.02
71-75	2743	1670	1.64	0.68	0.13	0.08	0.01	0.01	0.01
76+	3094	2734	1.13	0.50	0.06	0.00	0.08	0.00	0.05
Other	1010	2224	0.45	0.17	0.15	0.22	0.23	0.06	0.02

Source: GIC data.

this policy, we notice that individual coverage remains completely subdued in the entire scheme. Since the bulk of the group coverage emanates from the formal sector, the discounting norms strongly favour formal sector enterprises and leave more than 90 per cent of those engaged in informal economic activities to fend for themselves.

IV
Prospectus: Directions for the Future

In most policy debates in India, the issue of equity in the delivery of health care has been given precedence over that of efficiency. It may, however, be argued that the current system, which is a mix of different forms of insurance, has not been able to achieve even this objective to a significant extent. Nor has the system been able to utilise available public resources most efficiently. As the health system in India is complex, simple prescriptions for its improvement may not suffice. We, however, attempt to suggest some critical areas where some changes can be made at appropriate times. These recommendations are not mutually exclusive and often overlap in their policy implications.

Consolidation and Improvement in Cost-Effectiveness

At this stage, it is important to strengthen and improve the existing public-funded facilities to improve efficiency, quality and equity. We suggest the following three areas specifically related to insurance for the consideration of policy planners:

(i) *Focus on public spending on primary care and public health activities*: We mention this approach first because it remains the core of public health care spending. Reducing the burdens of disease is an important mechanism for simultaneously reducing the financial burden of treatment. It also affects the health of population directly.

(ii) *Reform ESIS and CGHS*: To go by a growing body of evidence, the CGHS and ESIS facilities are performing poorly in terms of both coverage and quality of care. It may make for greater efficiency to merge them into a single public health network or even convert them into private facilities. One strategy may be to convert coverage for those currently covered by the ESIS and the CGHS to policies similar to Mediclaim.

(iii) *Withdraw or reduce public subsidisation of services for those with ample ability to pay*: At present there are many public subsidies to health services which may be dispensed with. For example, expensive tertiary level public hospitals are subsidised to the same extent as the inexpensive primary care public facilities. Facilities such as the Apollo Hospital in New Delhi receive public loans and equipment; and corporate health insurance receives a tax subsidy even when it is so costly that only the better off can afford it. Given the paucity of public resources, there is little justification for subsidising such costly services.

One way of reducing these subsidies may be to initiate a uniform system of user fees in most of the public hospitals in the country. There should be careful studies of demand and supply conditions before a schedule for the user fees is drawn up. Such studies can be launched in West Bengal, Karnataka, Andhra Pradesh and Punjab – assisted by the World Bank recently to improve and upgrade their secondary hospitals.

Public facilities should also be permitted to recover additional fees from the privately insured patients that they treat. There is no reason for the public sector to fully subsidise those with ample ability to pay.

Table 6: Discount Structure of the GIC Group Policies by Size of Employment Group

Group Size	Discount (Per Cent)
Individual policy	0
1-100	15
101-500	20
501-1,000	25
1001-5,000	30
5,001-10,000	35
10,001-25,000	40
25,001-50,000	50
Over 50,000	66.7

Note: Discounts are applied to each group incrementally. Hence an employer with 200 employees will receive a 15 per cent discount on the first 100 and 20 per cent discount on the next 100.

Source: GIC.

Regulate Private Health Care

The private health sector will continue to be a major player in providing health services, especially curative health care. The growth of health insurance increases the need for licensing and regulating private health providers since firm and specific criteria would be needed to decide upon appropriate services and fees.

Given that private sector health care is predominant in India, that it has grown rapidly, and that it is likely to grow even more under the liberalised environment there is an urgent need for recognition of its far-reaching impact on the health of the people. Many aspects of regulation (for example, those related to drugs) have already been discussed by others [Tulsidhar 1996]. We will not go into them here except to mention the ones that have a direct impact on the out-of-pocket expenses of individuals and health insurance.

(i) *Licensing*: Implement a programme of strict licensing of all hospitals, nursing homes and medical practitioners. There are at present virtually no laws to regulate the establishment of hospitals and nursing homes in India. This not only means that there are no minimum standards, but also that insurance companies are unable to establish criteria for appropriate reimbursements for treatment at different levels of facilities.

(ii) *Fees*: Fees structure at private facilities should be formalised and monitored, mainly to avoid exploitation of uneducated patients but also to facilitate the establishment of appropriate reimbursements for specified procedures by insurers. Written itemised receipts should be made compulsory, and published rate lists should be either displayed or supplied on demand.

(iii) *Subsidies*: Reduce public subsidies of private corporate facilities. As already mentioned, subsidies to corporate facilities are not really justified, and these should be allowed to compete for funds and other resources in the market like any other commercial enterprise.

Review and Revise Mediclaim

If the objective of providing some kind of insurance to the general population is a priority area for health policy planners, a beginning can be made by carefully reviewing the mediclaim system. Some areas which need particular attention are as follows.

(i) *Premium structure*: The current premiums are too high in relation to claims payments. The current bonus and 'malus' system for adjusting claims is such that the insurer is always guaranteed at least a 20 per cent margin over the previous year's level of incurred claims. Also there does not appear to be a mechanism through which premiums are reconciled according to settled claims rather than proffered claims. Finally, the discount on group insurance for large employers is unrealistically large. Revising the premium schedules will make health insurance more accessible to individuals from lower socio-economic categories.

(ii) *Out-patient coverage*: There is a need for insurance cover to meet the growing cost of out-patient treatment. The reasons why some people pay a great deal out of pocket even when they are already covered by the GIC or the ESIS should be identified so that corrective measures could be devised.

The obtaining of referrals before going to expensive secondary and tertiary facilities can be encouraged by providing for the GIC to give lower reimbursement when higher-level care is sought without a referral.

(iii) *Limit exclusions for pre-existing conditions*: At present Mediclaim does not cover most of the chronic or pre-existing conditions. This leaves out large segments of the population who suffer from diseases like diabetes, hearing disorders and STDs. Such exclusions should be carefully reviewed and amended, for example, exclusions for pre-existing conditions can be made valid for not more than a year.

(iv) *Require greater efficiency in processing of claims*: Consumers should be given a time schedule so that there is no uncertainty about the amount of reimbursement and the time within which they can hope for reimbursed. Delays in prepayment and arbitrary denial of claims need to be minimised.

(v) *Increase visibility*: In our assessment Mediclaim is not an exceptionally popular scheme. Most prospective consumers know little or nothing about it. This should be rectified through publicity.

(vi) *Require greater monitoring of fraud and excessive fees*: The government should make it mandatory for all insurance companies to devote more resources to monitoring fraudulent claims and establishing schedules of appropriate fees for specified procedures.

Regulation of Health Insurance

The foregone points regarding a complete review of the health insurance sector are related to its regulation as well. This suggestion is applicable to all the health insurance agencies, be it the GIC or any other corporation or company. In addition to regulation of premium structure, exclusion clauses, extent of coverage, etc, the following measures may also be necessary.

(i) *Discourage 'dreaded disease' or other specialised policies*: The government should discourage schemes like the one currently offered by LIC which covers only four selected diseases. Such specialisation further segments the coverage rather than broaden it.

(ii) *Encourage health insurance for the specially vulnerable*: Health insurance cover for the elderly, unemployed, permanently disabled, etc, deserves special attention. Subsidised insurance plans for these categories of people are worth exploring. Mediclaim benefits, now available only to employees, their spouses and children, may be extended to dependent adults (perhaps just grandparents initially) for a supplementary premium. This is just one example of which can be done.

Encouraging Community-Based Health Programmes

Community-based health insurance programmes offer the best hope for reducing the financial burdens caused by sickness to a large segment of the low-income population. They would benefit from systematic review and government subsidies.

Conventional reimbursement-type insurance systems are unlikely to be effective in rural areas, where consumers have limited ability to pay. Community-based programmes need to be fostered. The SEWA insurance system, and those of other NGOs as described in Uplekar and George (1994) should be strongly promoted. These NGOs have been innovative in both raising finance and initiating community financing. For example, there are instances of user fees for selected services, pre-payment insurance schemes for curative care, and community income-generating programmes. Although, the government is already collaborating with the NGOs, there is a need to recognise the significance of their role more explicitly and give them financial, administrative and other support.

A related point to be made is that not only reimbursement type policies but also insurance plans which integrate financing and delivery of care should be encouraged. To be found in developed countries, such integrated insurers and providers are mostly able to manage care and monitor expenses.

Need for an Information Bank

This and several other studies have identified a variety of insurance issues that have not been fully documented or understood. There is an immediate need for more information on various aspects of demand for medical care (in the context of health insurance) to enable us to understand: (a) the distribution of medical expenditures, and (b) the question of who ultimately pays for them. Greater information is required for assessing the prices, quality and access of providers and their patterns of operation. Insurance companies may be encouraged to keep data in a format that is user-friendly and accessible to researchers and regulators.

Concluding Remarks

Central to the preceding discussion have been two important limitations of the present health care system and its financing in India. The first limitation is exceptionally high health care expenditure over three-fourths of which is private out-of-pocket expenditure. The other one relates to unsatisfactory outcomes of these expenses. Most of the out-of-pocket expenses are borne by households engaged in low-income informal economic activities. Those in the organised sector are covered by health plans. But the majority of the low-income people are left to suffer either from poor health-care delivery or to incur high out-of-pocket expenses, or both. Even those covered by health plans experience growing inefficiencies and low quality of services. A revamp of the health system with expanded and improved health insurance facilities, is therefore essential.

The paper comes up with a series of recommendations including improvements in delivery of health care and its financing, efficient functioning of the ESIS and the CGHS, ammending the Mediclaim system to tap the huge market potential, modification of the benefits and claims system of Mediclaim policies, alterations in the exclusion clause, enhanced competition and the possible privatisation of health insurance within a strict regulatory regime. EPW

Notes

1 Corroborating evidence that the system is disproportionately private is the estimate that 80 per cent of all registered allopathic physicians are private [Uplekar and George 1994, p 10]. An even higher estimate for the private sector appears in a report of the Planning Commission's Working Group on Health Management and Financing which estimated that household expenditures on treatment may be as much as 8.4 per cent of GDP versus public spending of only 1.1 per cent of GDP [Planning Commission 1996, p 16].

2 In recent years nominal user fees have been charged at government facilities in Andhra Pradesh, West Bengal, Punjab and Karnataka. These fees (a few rupees) remain low in comparison to both private fees and the unofficial payments which are still made at most public facilities in these states and in other parts of the country. Nonetheless, these efforts at cost recovery remain in important initiative for improving incentives, decentralising some

spending authority and augmenting resources at public health facilities.

3 Typically, the life insurance companies in India have relied on actuarial methods and life tables for fixing premia. The employment of rigorous procedures for the fixation of premia was not possible owing to paucity of the epidemiological data cross-classified by region and major socio-economic class. The GIC and its subsidiaries do not have the option of estimating probabilities associated with the vulnerability of individuals to various diseases. Hence, they have relied mainly on simplified procedures based on the information available to them from the policy documents and the claims register. Recently, however, the GIC introduced a differential system for setting premia for its Mediclaim policies which adjusts for health expenditure differences as between five age groups. Information has also been collected for differences in claims rates by age, sex, rural/urban, habitat, occupation, and income groups. The age dimension, however, remains the only criterion being used by the GIC for adjusting premia.

References

Alam, Moneer (1997): 'Health Financing by States: An Exploration', *Demography India*, 27(2), pp 177-205.

Abel-Smith, Brian (1988): 'Community Financing in Developing Countries: The Potential for Health Sector', *Health Policy and Planning*, 3(2), pp 95-108.

– (1995): 'Compulsory Health Insurance', paper prepared for International Workshop on Health Insurance in India, September 20-22, Bangalore.

Banerji, Sanjay (1995): 'The Student Health Scheme: A West Bengal Experiment', paper prepared for International Workshop on Health Insurance in India.

Berman, Peter (1995): 'Financing of Rural Health Care in India: Estimates of the Resources Available and Their Distribution', paper prepared for International Workshop on Health Insurance in India.

–(1996): 'Rethinking Health Care Systems: Private Health Care Provision in India', Harvard School of Public Health Working Paper, November 1996.

– (1996): 'Health Care Expenditure in India' in Monica Dasgupta et al (eds), *Health, Poverty and Development in India*, Oxford University Press, Delhi, pp 331-58.

Berman, Peter and Priti Dave (1993): 'Financing Health Care' in *State of India's Health*, Voluntary Health Association of India, pp 341-50.

Berman, Peter and M E Khan (eds) (1993): 'Paying for India's Health Care', Sage Publications, New Delhi.

Bhat, Ramesh (1993): 'The Public/Private Mix in Health Care in India', Health Policy and Planning, 8(1), pp 43-56.

Chawla, Mukesh (199 6): 'Public-Private Interactions in the Health Sector in Developing Countries: Sharing of Labour Resources', Boston University, unpublished PhD dissertation, Department of Economics.

Duggal, Ravi and S Amin (1989): 'Cost of Health Care: A Household Survey in an Indian District', The Foundation for Research in Community Health, Bombay.

– (1993): 'Health Finance in India: A Review and an Agenda' in Peter Berman and M E Khan (eds), *Paying for India's Health Care*, Sage Publications, New Delhi.

'Health Monitor' (1994): Foundation for Research in Health System.

General Insurance Corporation of India (1995): 'Health Insurance', paper prepared for International Workshop on Health Insurance in India.

– (1996): 'Health Insurance Schemes', Bombay, India, August 12.

Gumber, Anil and Peter Berman (1995): 'Measurement and Pattern of Morbidity and Utilisation of Health Services', Gujarat Institute of Development Research, Working Paper Number 65, March, Ahmedabad.

Krishnamurthy, V (1995): 'Health and Medical Care in the Plantation Sector', paper prepared for International Workshop on Health Insurance in India.

Krishnan, T N (1995): 'Hospitalisation Insurance: A Proposal', *Economic and Political Weekly*, 31(15), pp 944-46.

Kumar, T Krishna, and Ramesh Kanbargi (1994): 'Pricing and Financing of Health Care Services in India: Problems, Priorities, and Policies', *Studies on Human Development in India*, Institute for Social and Economic Change, Bangalore, Discussion Paper Number 7, December.

Madan, T N (1980): 'Doctors and Society: Three Asian Case Studies', Vikas Publishing House, Ghaziabad.

Mahapatra, Prasanta (1996): 'Government Health Expenditures in an Indian State: Government Expenditure on Health in Andhra Pradesh since the 1980's: Has It Been Appropriate?' A report on work in progress with support from the International Health Policy Programme.

Musgrove, Philip (1996): 'Public and Private Roles in Health: Theory and Financing Patterns', World Bank working paper, April 23.

National Council for Applied Economic Research (1993): 'Users' Perceptions on the Existing Facilities in Delhi Administrative Hospitals and Central Government Hospitals of Delhi', Preliminary Report, October.

Pachauri, Saroj (ed) (1994): *Reaching India's Poor: Non-governmental Approaches to Community Health*, Sage Publications, Delhi.

Phadke, Anant (1994): 'The Private Medical Sector in India', The Foundation for Research in Community Medicine, monograph commissioned for the 1994 volume of *Health Status of the Indian People*, April.

Planning Commission (1996): 'Report of the Working Group on Health Management and Financing', draft report, October 11.

Ratnam, C S Venkata (1995): 'Health Care for Industrial Employees in Large Public-Private Sector Firms in India', paper prepared for International Workshop on Health Insurance in India.

Reddy, K N (1993): 'Alternative Sources of Financing Health Care in India – with Special Reference to Cities', National Institute of Public Finance and Policy, New Delhi, June.

–(1995): 'Feasibility of National Health Insurance in India' paper presented at 'Intercountry Consultation on Health Care Financing Reform', Bangkok, October 2-6.

Reddy, K N and V Selvaraju (1994): *Health Care Expenditure by Government of India 1974-75 to 1990-91*, Seven Hills Publications, New Delhi.

Rohde, Jon Eliot and Hema Viswanathan (1995): *The Rural Practitioner*, Oxford University Press.

Ron, Aviva, Brian Abel-Smith, and Giovanni Tamburi (1990): *Health Insurance in Developing Countries: the Social Security Approach*, International Labour Office, Geneva.

Sanyal, S K and V B Tulasidhar (1995): 'Utilisation Patterns and Financing of Public Hospitals: a Report', National Institute of Public Finance and Policy, New Delhi, August.

Satia, et al (1987): 'Study of Health Care Financing in India', Indian Institute of Management, Ahmedabad.

Self-Employed Women's Association (SEWA) (1995): Annual Report.

Shah, K R (1996): 'Issues Involved in the Privatisation of Health Services in India', Centre for Multi-Disciplinary Development Research, Karnataka, CMDR Monograph No 11, September.

Shariff, Abusaleh (1994): 'Employees' State Insurance Scheme in Gujarat: Key Results of a Survey', report prepared by the Gujarat Institute of Development Research, Ahmedabad, February 3.

– (1995): 'Health Transition in India', National Council for Applied Economic Research, Working Paper Number 57, October.

Shaw, R Paul and Martha Ainsworth (eds) (1995): 'Financing Health Services Through User Fees and Insurance: Case Studies from Sub-Saharan Africa', World Bank Discussion Paper Number 294, Africa Technical Department Series.

Subrahmanya, R K A (1995): 'Employees State Insurance Scheme', paper presented at International Workshop on Health Insurance in India.

Sundar, Ramamani (1995): 'Household Survey of Health Care Utilisation and Expenditure', National Council of Applied Economic Research, Working Paper No 53, March.

Tulasidhar, V B (1996): 'Government Health Expenditures in India: Public Financing for Health in India: Recent Trends', a report on work in progress with support from the International Health Policy programme, May.

Union Ministry of Health and Family Welfare, Rural Health Division, Directorate of Health Service (1995): *Bulletin on Rural Health Statistics in India*, December.

– (1995): *Annual Report*, 1993-94.

– (1994): 'Health Information of India', Central Bureau of Health Intelligence.

Upleker, Mukand, and Alex George (1994): 'Access to Health Care in India, Present Situation and Innovative Approaches', Studies on Human Development in India, Foundation for Research in Community Health, Discussion Paper No 12, November.

Visaria, Pravin and Anil Gumber (1992): 'Utilisation of Primary Health Care in Western India, 1980-81 to 1986-87', Gujarat Institute of Development Research, Working Paper Number 45, Ahmedabad, December.

Voluntary Health Association of India (VHAI) (1993): 'State of India's Health', published by the VHAI.

Vyas, Jayshree, and Mirai Chaterjee (1996): 'Experience of Providing Integrated Insurance to Women Workers in Informal Sector', Paper prepared for a workshop on Social Security for the Unorganised Sector, Self-Employed Women's Association, Ahmedabad, February 12.

World Bank (1993): *The World Development Report, 1993: Investing in Health*, Oxford University Press, New York.

– (1995): 'India: Policy and Finance Strategies for Strengthening Primary Health Care Services', Report No 13042-IN, May 15.