WHO GETS HEALTH INSURANCE COVERAGE IN INDIA? : NEW FINDINGS FROM NATION-WIDE SURVEYS.

By

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Abstract

How far the coverage of health insurance available to Indians, both in rural and urban areas? Who can afford to pay for health insurance coverage? This study examines health insurance scenario of India by analyzing the trends and patterns and household characteristics of health insurance policy holders. The study utilized available data from the latest rounds of two nationally representative surveys DLHS (2007-08) and NFHS (2005-06). Only 5 percent of the households in India were covered under any kind of health insurance. Within the insurance schemes, the state owned health schemes are the most subscribed (39.2), followed by the Employee State Insurance Scheme (17 percent). Among the households belonging to the lowest economic categories, less than 3 percent were covered by any health scheme or health insurance. However, the recent trends show that the community health insurance targeting poor households are becoming much popular and it may be the most appropriate way of supporting the families vulnerable to catastrophic health spending.

Introduction

Around 100 million people are becoming poor globally every year because of high healthcare costs. In India also higher spending on health care is one of the major factors pushing people into poverty. About 3.5% of the population fall the below the poverty line and 5% households suffer catastrophic health expenditure due to unaffordable health cost (Shahrawat and Rao, 2011). It is the people belonging to the lower income classes or poor who suffer the most. In India, particularly after the liberalization, the health care cost has become almost unaffordable and has given rise to serious equity issues (Gumber and Arora, 2006).

Financial burden due to health care cost is continuing as a major issue all over the world. In this context, reducing 'out-of-pocket expenditure' through health insurance coverage is a major concern. So health insurance is emerging as an alternative of reducing the financial burden of the people. But in India, existing health insurance coverage is insufficient, still far away from achieving universal health insurance coverage. Current health insurance coverage is largely limited to small proportion of people in the organized sector (IIPS and WHO, 2006). According to Shahrawat and Rao (2011), recent social health insurance programme of India cover only hospital expenses, so these schemes will fail to adequately protect the poor from high out-of- pocket payments. Medicine cost constitute main share of the health care spending of the people. But the insurance coverage meets only the inpatient care cost. In India, where the health system is highly privatized and insurance coverage is low, it is important that people, particularly poor, are protected from high out-of-pocket payment for health care. Increasing privatization, rising cost of health care and inadequate insurance coverage (only for in-patient expenses) ensures that an increasing number of people will keep falling into poverty in the future (Shahrawat and Rao, 2011).

According to Vishwanathan (1996), "Health insurance is the one of the measures of social security by which members of the community are assured benefits of both maintenance of health and medical care when they fall sick". The health insurance movement has a history of century and half. The origin of health insurance mainly related to the industrial revolution and the revolution in the medical field.

The entry of the many private health insurance companies will surely have an impact on the cost of health care, equity in the financing of care, quality and cost-effectiveness (Mahal, 2002). However, many believe that community based health insurance, rather than market mediated or government provided insurance is an appropriate way of reaching the poor (Ahuja, 2004). The choice between public health financing or private insurance is hardly available in India because of the government's limited ability to marshal sufficient resources to finance health spending.

Health Insurance in India

After the independence of India, the health care system has been expanded and modernized to some extent, with the availability of modern health care facilities and better training of medical personnel (Ellis, et al, 2000). At the same time, one of the arguments is that the health care sector in India still mainly focused in urban areas only, even though majority of the people are living in rural areas. The paradox is that around 73 percentages of the rural people getting 20 percentages of the health care facilities, but around 27 percentages of the urban people getting remaining 80 percentages of the facilities. And infrastructure, human resources, quality inequities in availability, utilization and affordability of health care is always a matter of concern. There is a feeling among public that government health facilities are not functioning well and of poor quality. Majority of people when they are ill seek care from private sector rather than public providers for out-patient care. So in this context quality, availability and affordability of health care is very important.

In the case any form of health insurance coverage in India, only 11% of the country's populations have access to insurance policies (Sharawat and Rao, 2011). In India where majority of the curative health care spending is met from households only. Some studies revealed that around 69% of health spending is financed by out-of-pocket expenses. Consequences of the liberalization and privatization of health care system, the health care expenses also increased since 1994–95, health expenditures have grown at 14% and this growth is higher for in-patient care (Govt. of India, 2005). These financial burdens arise because the consumers are either not insured or are insured inadequately for their health care expenses.

Health Insurance in India is not much familiar among the people, so its coverage also not that satisfactory. But some evidences show that gradually health insurance coverage is increasing. It may be because of the high health care cost, entering of the private players in insurance field, government universal health

insurance policy, and intervention of community based health insurance schemes. Health insurance, as we know it today, was introduced only in 1912 when the first Insurance Act was passed (Devadasan, 2004). The current version of the Insurance Act was introduced in 1938. Since then there was little change till 1972 when the insurance industry was nationalized and 107 private insurance companies were brought under the umbrella of the General Insurance Corporation (GIC). Private and foreign entrepreneurs were allowed to enter the market with the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999 (Rao, 2004). Aftermath of the new economic policies (liberalization and globalization), some of the major national and international private insurance companies entered the insurance industry. But only few companies are working in the field of health insurance and most of them are working in the life insurance sector only. May be the main reasons behind the less coverage of health insurance in India are lack of awareness of health insurance among the people and the high cost of the private health insurance premium which majority of the people couldn't afford. Before the IRDA Act, government insurance companies like LIC and GIC were major players in the health insurance sector. The 'Mediclaim Policy' in 1986 from GIC is the first intervention of the health Insurance programme in India.

Employee's State Insurance Scheme (ESIS)

Employees State Insurance Act 1948 (ESI Act), by the parliament was the major legislation on social Security for workers in independent India. This enactment led to the formulation of Employees State Insurance Scheme. Employees' State Insurance Scheme of India is a multidimensional social security system tailored to provide socio-economic protection to worker population and their dependants covered under the scheme. It is managed by the Employees State Insurance Corporation (ESIC), a wholly government-owned enterprise (Ellis, et al, 2000). It was conceived as a compulsory social security benefit for workers in the formal sector. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits. Originally the ESIS scheme covered all power- using non -seasonal factories employing ten or more workers. Later, it was extended to cover employees working in all non-power using factories with 20 or more people (WHO, 2004).

Central Government Health Scheme (CGHS)

The Central Government Health Scheme (CGHS) was introduced in 1954 as a contributory health insurance scheme to provide comprehensive medical care to the central government employees and their families. Total beneficiaries stand at 43 lakh (10.4 lakh card holders, in 2003) across 24 cities. Benefits under the scheme include medical care at all levels and home visits/care as well as free medicines and diagnostic services. These services are provided through public facilities (including CGHS-exclusive allopathic,

ayurvedic, homeopathic and unani dispensaries) with some specialized treatment (with reimbursement ceilings) being permissible at private facilities (Rao, 2004).The CGHS is widely criticized from the point of view of quality and accessibility. Other problems included long waiting period, significant out- of -pocket costs of treatment, inadequate supplies of medicines and equipment, inadequate staff and conditions that are often unhygienic (Ellis, et al, 2000).

The Insurance Regulatory and Development Authority Act (IRDA) 1999

The IRDA was one of the major enactments passed by Parliament in 1999. This was a landmark act to allow the private insurance players into the Indian insurance sector. This enactment including health insurance, and envisages the creation of the regulatory authority. That would oversee the operations of various players in the insurance market. The IRDA is supposed to protect the interests of the policyholders, promote efficiency in the conduct of insurance, regulate the rates and terms and conditions of the policies offered by insurers and direct the maintenance of solvency margins (Mahal, 2002).

Public Health Insurance Companies and Schemes

In the public health insurance sector, there are two major corporations in India, the General Insurance Corporation (GIC) and the Life Insurance Corporation (LIC). The GIC has four subsidiary companies as given below-

1. National Insurance Corporation (NIC) ,
2. New India Assurance Company (NIA),
3. Oriental Insurance Company (OIC), and
4. United India Insurance Corporation (UIIC)

These are the major health insurance players in public sector of India. These companies offer different health insurance schemes like Ashadeep Plan II and Jeevan Asha Plan II from LIC and Personal Accident Policy, Mediclaim, Jan Arogya Bima Policy, Overseas Mediclaim Policy, Critical Illness Policy, New India Assurance Bhavishya Arogya, Dreaded Disease Policy, Cancer Insurance Policy, Raj Rajweshwari Policy from GIC. Mediclaim Insurance Scheme was introduced in 1986 by GIC. This covers reimbursement of hospitalization expenses for sickness and injuries. This is still popular among the rich people, even though there are number of private players entered in health insurance industry recently. One of the major arguments against mediclaim policy is it only covers hospitalization and other expenses and neglecting out-patient care. Another scheme Jan Arogya Bima Policy targeted for the poor but these too had limited success. Public insurance companies are leading in both life and non-life insurance sector.

The General Insurance Corporation (GIC) and its four subsidiaries and the Life Insurance Corporation (LIC) have designed a number of medical reimbursement schemes which are sold to individuals and groups. These schemes can be broadly classified into three categories:

Focus	Schemes
Individual reimbursement Schemes	Mediclaim, Jan Arogya Policy, Bhavishya Arogya Policy, LIC's Asha Deep
Group reimbursement schemes	Group Mediclaim Policy, Group Mediclaim Policy for Card Holders
Specific medical reimbursement Policies	Cancer Insurance Policy, Birthright Insurance Scheme, Overseas Mediclaim Policy

Source: Bhat and Reuben, 2001

Private Health Insurance Companies and Schemes

Since the liberalization of the insurance industry in 2000, India has been promoting private players to enter the health insurance sector. With the enactment of the IRDA, the industry now has a regulatory framework to protect the interests of policy holders. This was followed by another decision in 2001 establishing Third Party Administrators (TPAs) to facilitate speedier expansion by providing an administrative intermediary structure to the insurance industry (Rao, 2004). According to Mavalankar and Bhat (2000), the privatization of insurance sector and the constitution of IRDA improve the performance of existing public insurance by increasing benefits from competition in terms of lower premium cost and high consumer satisfaction. If private health insurance sector is not regulated and managed well, it may create negative consequences of health care.

IRDA has so far granted license to three insurance companies to operate exclusively in the health insurance segment. They are

1. Star Health and Allied Insurance,
2. Apollo Munich Health Insurance,
3. Max Bupa Health Insurance

Star Health was the first company granted registration to undertake business exclusively in health, personal accident and travel insurance segments in 2006-07. Apollo Munich is the second company to receive registration to underwrite insurance business exclusively in the health, personal accident and travel insurance segments. Max Bupa is a new entrant in the health segment and was issued certificate of registration in the

year 2009-10. Some of the other private companies also providing health insurance schemes, These companies are Bajaj Alliance, Royal Sundaram, Birla Sun Life, HDFC Standard Life, ICICI Prudential Life Insurance, Om Kotak Mahindra, Tata AIG general Insurance Company, etc.

Review of Literature

The existing literature on health insurance in India is reviewed here. These studies discuss huge health care expenses in India and its impact on poor and marginalized people in their health care and poverty. How health insurance becomes a strategy to reduce out-of-pocket payments, the lack proper health insurance coverage in India and recent interventions of enactment and emergence of private players in health insurance is the major focus of existing studies.

Low expenditure on healthcare in India has led to vast inequities in the distribution of health care services between the different strata of the society (Narayanan, 2008). Globally, every year around 150 million people face financial catastrophe and about 100 million suffer poverty due to out-of-pocket payments because of health care expenses. The majority among them (more than 90%) reside in low-income countries (Xu *et al*, 2007). India, along with Bangladesh and Vietnam, has some of the highest burdens of out-of-pocket payments for health care in Asia (van Doorslaer *et al.,* 2007). Due to low health insurance coverage and cost of curative health care services, vast majority of the health spending is financed by out-of-pocket payment in India (Shahrwat and Rao, 2011). India spends around 6 per cent of its GDP on meeting health care needs, it included private and public sector. Of these expenditures, 75 per cent is private out-of-pocket costs spent by households. The health insurance constitutes a small proportion of total financing. It is estimated that less than 10 per cent of the total financing in health sector is through various types of insurance [Bhat, and Reuben, 2001].

The financial burden due to health care expenditure India is enormous and growing day by day. Alam and Gupta (2000) discussed in their paper, almost all segments of the Indian community faced some direct or indirect out-of-pocket expenses for the utilization of the health care services. The heaviest burden is borne by the people engaged in non-formal rural and urban activities. Bhat and Saha (2004) found that new economic policy, like liberalization and globalization, rapid growth of medical technology and a rising middle class have led to a huge increase in the private medical care expenditures in India. Mavalankar and Bhat (2000) argued that, with proliferation of various health care technologies and general price rise, the cost of health care has also become very expensive and unaffordable to large segment of our population. After the liberalization of the Indian economy and important enactments like the Insurance Regulatory and Development Authority Act 1999 (IRDA Act) to allow private health insurance players in Indian market had considerable impact.

According to Bhat and Reuben (2001), “Health insurance can be broadly defined as financial mechanisms that exist to provide protection to individuals and households from the costs of health care incurred as a result of unexpected illness or injury. Under this mechanism insurer agrees to compensate or agrees to guarantee the insured person against loss by specified contingent event and provide financial coverage. Against this protection the insured party pays a premium and the insurer provides required services or pays the agreed sum spent on hospitalization in case of illness of insured person.” Health insurance can be defined in very narrow sense where individual or group purchases in advance health coverage by paying a fee called "premium". But it can be also defined broadly by including all financing arrangements where consumers can avoid or reduce their expenditures at time of use of services (Mavalankar and Bhat, 2000).

Health insurance is very well established in many countries. But in India it is a new concept except for the organized sector employees. Health insurance needed to be given higher priority in India because of the rising cost in health care and financial burden of the people to meet health care. One of the important points needs to be understood is that health insurance per se is just a financing mechanism and does not in any way ensure that health services are delivered efficiently and effectively (Ahuja, 2004). The similar observation was made by Bhat and Saha (2004) stating that expanding the insurance services without considering whether medical services are available or sufficient may not serve any purpose. And cost and quality of these services are also important. Another important issue in this context is who will regulate the practices of insurance providers? Government is trying to divert the attention from inefficient healthcare delivery system in India and use health insurance 'mantra' as if it is going to solve all problems related to health care financing in India. Rao (2000) points out that such high priority accorded to health insurance in these days could have some reasons- (1) push of the private, including the corporate and for profit sector, which is unable to maximize returns due to lack of effective demand; (2) enhance FDI by promoting India as a health destination for foreign clientele; (3) pull of the private insurance companies and third party administrators to deepen the insurance market through financial incentives such as tax exemptions and subsidies for premiums; and(4) protect the poor from impoverishment due to high medical costs.

Mushrooming of private health care facilities, the increasing cost of health care services, financial burden due to health care cost among the poor and marginalized people, and changing epidemiological pattern of diseases influence the attitude of the people and government. So the government and people have started exploring various health financing options like health insurance to manage health care financing (Mavalankar and Bhat,2000). The lack of development of health insurance is partly because of the lack of standardization of healthcare provision and partly because of absence of database on the basis of which insurance companies can design health insurance products (Ahuja, 2004). The competition among these companies has already visible in the insurance market in terms of wide range of products, aggressive marketing and better customer care.

Need for the Study

The financial burden due to health care expenditure is a major issue still facing India. Day by day health care cost is increasing both for out-patient and in-patient care. Changing pattern of diseases, mainly from communicable to non-communicable diseases, and the increasing proportion of the old age people, India have no sufficient social security system to tackle these issues. Health insurance system is one of the solutions. How far the coverage of health insurance available to Indians, both in rural and urban areas? Who can afford to pay for health insurance coverage? These issues are rarely included in the large scale surveys. There is a need to look into the nature and magnitude of health insurance coverage in India, which is expected to grow rapidly in coming years.

Objectives of the Study

There are two specific objectives in this study:

1. To examine health insurance scenario of India by examining the trends and patterns.
2. To analyze the household characteristics of health insurance policy holders for India and major states.

Data Source and Methodology

The study utilized available information from various sources. The latest rounds of DLHS (2007-08) and NFHS (2005-06) are used. The data available from insurance companies and organizations were also analyzed here.

The District Level Household and Facility Survey (DLHS) is one of the largest ever demographic and health surveys carried out in India, with sample size of over seven lakh households covering all districts of the country.DLHS-3 provides estimates on maternal and child health, family planning and other reproductive indicators and also provides information relate to the programmes under the National Rural Health Mission (NRHM). National Family Health Survey (NFHS) provides information related to fertility, mortality, family planning, nutrition, and health care. NFHS-3 collected information from a nationally representative sample of 109,041 households.

DLHS-3 (2007-08) and NFHS-3 (2005-06) asked the respondents (in Household Questionnaire) about health insurance coverage. The questions are:

1. Is any usual member of this household covered by a health scheme or health insurance?

2. What type of health cover/ health scheme/ health insurance?

Options : a) Employees State Insurance Scheme (ESIS), b) Central Government Health Scheme (CGHS), c) Community Health Insurance Programme, d) Other health insurance through employer, e) Medical reimbursement from employer ,f) Other privately purchased commercial health insurance, g) Other.

However, in DLHS-3, the options for the question No.2 is slightly different. They are-

a) Employees State Health Insurance Scheme (ESIS), b) Central/ State Government Health scheme, c) Medical reimbursement from employer, d) Community Health Insurance programme, e) Mediclaim, f) Other privately purchased, g) Other.

Trends and Patterns in Health Insurance Coverage

Community Health Insurance (CHI)

Community health insurance usually runs by Non –Governmental Organizations (NGOs) or cooperative sectors. In India, community health insurance started in Kolkata 1952 as part of student's movement. Student Health Home in Kolkata, SEWA in Gujarat, Yeshasvini in Karnataka and Voluntary Health Services in Tamil Nadu are some of the popular CHIs. Community health insurance has emerged as an alternative finance to improve the health care access among the low income groups and protecting the poor from high financial burden due to health care or medical expenditures (Devadasan, 2004). Community health insurance schemes always help low income and poor people to protect against the financial catastrophe and in improving their health access. CHI schemes are generally targeted at low strata or low-income populations. But there is no empirical evidence to know whether the CHI schemes have improved health care availability and affordability of low income people and in reducing their financial burden (Devadasan, Ranson, Damme and Criel, 2004).

The community health insurance schemes are classified into three. In type one, hospital plays dual role as provider of health care and insurer of the programme. In type two, voluntary organizations work as insurer and they purchase care from providers and giving insurance to community. In type three, voluntary organizations play the role of an agent, purchasing care from providers and insurance from companies (Devadasan, Ranson, Damme and Criel, 2004).

Table 1: Community Health Insurance (CHI) Schemes in India

Name and Location of the CHI and Year of Initiation	Target Population	Type	Remarks
ACCORD Gudalur, Nilgiri, Tamil Nadu,1992	Scheduled Tribes of Gudalur Taluk who are members of the Adivasi Munnetra Sangam (AMS)- the tribal union. (N=13,070 Individuals)	Type I	Linked with the New India Assurance Company
BAIF Uruli Kanchan, Pune, Maharashtra, 2001	Poor women members of the community banking scheme and living in the 22 villages around Uruli Kanchan Town (N=1500 women)	Type III	Linked with United India Insurance Company
BULDHANA Urban Cooperative and Credit Society, Buldhana, Maharashtra	Farmers living in Buldhana district (N=175,000)	Type III	Linked with United India Insurance Company
DHAN Foundation Kadamalai Block, Theni District, Tamil Nadu, 2000	Poor women members of the community banking scheme and living in the villages of Mayiladumparia Block (N=190,499)	Type II	No linkages. The organization operates the Scheme
Karuna Trust T Narsipur Block, Mysore District, Karnataka, 2002	Total population of T Narsipur Block and Bailhongal Block, with a focus on Schedule Tribe and Schedule Caste Population (N=634,581 individuals)	Type III	Linkage with National Insurance Company
MGIMS Hospital Wardha, Maharashtra,1981	The small farmers and land less labourers living in the 40 villages around Kasturba Hospital (N=30,000 individuals)	Type I	No linkages. The organization operates the Scheme
Navasarjan Trust Pathan district, Gujarat 1999 (discontinued in 2000)	Select scheduled Caste Individuals in two blocks of Pathan District, Norh Gujarath (N=?)	Type III	Linkage with New India Assurance Company
RAHA Raigarh, Ambikapur, Jashpur and Korba Districts of Chhattisgarh,1980	Poor people living in the Catchment area of the 92 rural health centres and hostel students (N=92,000 individuals)	Type I	Have their own providers
SEWA 11 districts of Gujarat, 1992	534,674 SEWA Union Women members (urban and rural), Plus their husbands living in 11 districts (N=1,067,348 Individuals)	Type III	Linkage with National Insurance Company
Student's Health Home Kolkata, West Bengal, 1952	Full time student in West Bengal State, from classs 5 to Unviersity level (N= 5.6 million students)	Type I	Have their own health facilities
Voluntary Health Services Centre Chennai, Tamil Nadu, 1972	Total population of the Catchment area of 14 mini health centres in the Suburbs of Chennai (N=104,247 Individuals in town blocks)	Type I	Have their own hospital and health
Yeshasvini Trust Banglore Karnataka , 2003	Members of the Cooperative societies in Karnataka (N=25 lakhs)	Type II	Operate their own programme

Source: Devadasan, et al, 2004

Universal Health Insurance Scheme

For the purpose of protection of poor people from health care financial burden, the government announced Universal Health Insurance Programme in 2003. Under this scheme, for a premium of Rs. 365 per year per person, Rs. 548 for a family of five and Rs. 730 for a family of seven, health care for an assured sum of Rs. 30,000 was provided. But this programme is not much of success because poor people are not aware about this scheme and they don't know how to get benefit (Ahuja, 2005). According to Rao (2004), there are many reasons for the failure to attract the poor people in this scheme, like lack of proper investment of the public companies, lack of people's awareness, problem of identification of the eligible family, and poor people also have some difficulties to pay the premium, and deficit of availability of provider. This programme is the basis for initiating the Rashtrya Swasthya Bima Yojana.

Rashtriya Swasthaya Bima Yojna (RSBY)

Rashtriya Swasthaya Bima Yojna is a Central Government Scheme announced by the Prime Minister in 2007. RSBY is the programme of Ministry of Labour and Employment, to provide health insurance coverage for Below Poverty Line (BPL) families with the objective of providing protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Rashtriya Swasthya Bima Yojana started from 1st April 2008 onwards. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most diseases that require hospitalization. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Governments pay the premium to the insurer selected on the basis of a competitive bidding.

Table 2: Enrollment of Beneficiaries under Rashtriya Swasthya Bima Yojana (RSBY), 2010-11

	BPL Families		Hospitals Empanelled		
States	**Total**	**Enrolled**	**Private**	**Public**	**% Enrolled**
Punjab	449123	181985	329	157	40.5
Haryana	1241785	627683	563	61	50.6
Assam	494929	204548	27	21	41.3
Arunachal Pradesh	54870	16029	NA	NA	29.2
Bihar	9645458	4884679	633	37	50.6
Chandigarh	9668	4913	8	3	50.8
Chhattisgarh	1493051	1378023	223	417	92.3
Delhi	894650	144135	111	NA	16.1
Goa	6953	NA	2	NA	-
Gujarat	2953347	1919086	780	317	65.0
Himachal Pradesh	292378	237946	42	135	81.4
Jharkhand	2766539	1329254	174	151	48.1
Karnataka	338931	157405	113	66	46.4
Kerala	2333040	1734448	157	133	74.3
Madhya Pradesh	NA	NA	NA	NA	-
Maharashtra	3920962	1557919	921	8	39.7
Manipur	27575	18259	4	NA	66.2
Meghalaya	117417	59055	7	65	50.3
Mizoram	54273	15240	10	62	28.1
Nagaland	50060	39290	6	NA	78.5
Orissa	657942	401798	47	67	61.1
Tamil Nadu	454736	NA	32	NA	-
Tripura	303335	258402	NA	29	85.2
Uttar Pradesh	10060207	4280410	1017	679	42.6
Uttarakhand	555681	300304	63	72	54.0
West Bengal	5146075	3528584	337	NA	68.6

Source: http://www.rsby.gov.in/overview.aspx

NA: Not Available

Third Party Administrators (TPA)

Third Party Administrators work as an agent or intermediaries between insurer and insurance companies. According to 2009-10 IRDA report, there are 27 major TPAs working very effectively in the insurance field. The entry of the TPAs under the IRDA Regulation Act, 2001, is a new turning point in insurance industry. TPA should be registered under the Companies Act, 1956, and licensed by IRDA. The main role of a TPA was to provide the back-office administrative set-up to insurance companies—issuing ID cards to subscribers, processing claims, making payments, etc. TPA also helps in safeguarding the interest of the

insuring company of any fraudulent claims by the provider. For all these services, the insurance companies pay 5.5% of the total amount of premium collected under the policy.

Macro Indicators of Health Insurance Data- 2003-2010

Table 3: Health Insurance Policies, insured members and Claims

Year	Number of Policies	Number of Members	Number of Claims
2003-2004 *	2265451	8361629	360088
2004-2005*	2059449	8987239	555273
2005-2006*	3828495	16345575	1016785
2006-2007*	3110475	17907430	1060047
2007-2008*	3790838	24121625	1436998
2008-2009*	4575725	32710604	2081297
2009-2010**	6884687	54893453	3263597

Source:(http://iib.gov.in/IRDA/healthpub/Health_0910.pdf). Note: Member, Insured Person(s) covered in the policy, ** Policies served by TPAs only (Third Party Administers), ** Summery figures of polices served by TPAs and directly served by Insurance*

Table 3 show the increase in health insurance policy coverage from 2003 to 2010. Number of members insured increased from 83 lakhs in 2003 to 548 lakhs in 2010 and claims also increased considerably. In general, the number of insurance policies and insured people are increasing year after year. The government health insurance policies like RSBY and three private companies registered under IRDA for health insurance sector are the factors contributing this growth.

Table 4: Total Premium, Total Claim Paid and Claim Ratio

Period	Premium (Rs in Crs.)	Claims Paid (Rs in Crs.)	Claims Paid Ratio %
2003-2004*	944	785	83
2004-2005*	987	948	96
2005-2006*	1947	1777	91
2006-2007*	2820	2198	78
2007-2008*	2758	2904	105
2008-2009*	3976	4087	103
2009-2010**	7803	7456	96

Source : Insurance Information Bureau, (http://iib.gov.in/IRDA/healthpub/Health_0910.pdf)
*Note: * Policies served by TPAs only, ** Summery figures of polices served by TPAs and directly served by Insurance*

Table 4 shows premium (Rs. in crore) is increasing during the period from 2003 to 2010 (from 944 to 7803 crore rupees). Claims paid also increased from 2003 to 2010 (from 785 to 7456 crore rupees). As indicated in the Table 3, health insurance policies and number of insured people have increased, so the premium paid also showed considerable increase.

Table 5: Average Premium, Average claim Paid and Average Person insured- per policy and per Member

Period	Premium Per Policy (in Rs)	Premium Per Insured Member (in Rs)	Number of Persons insured per policy	Claim Paid Per Policy (in Rs)	Claims Paid per insured Member (in Rs)
2003-2004	4166	1129	4	3465	939
2004-2005	4792	1098	4	4606	1055
2005-2006	4892	1146	4	4642	1040
2006-2007	9067	1575	6	7066	1227
2007-2008	7275	1143	6	7661	1204
2008-2009	8689	1216	7	8932	1249
2009-2010	11333	1421	8	10910	1368

Source: Insurance Information Bureau, (http://iib.gov.in/IRDA/healthpub/Health_0910.pdf)

Table 5 shows data on premium per health insurance policy and member, number of health insured persons per policy, claims paid for per health insurance and claims paid per insured member. Premium per policy and premium per insured member are increasing. The same pattern can be seen in claims paid per policy and claims per insured member also.

Table 6: Number of Claims, Claim Paid and Average Claim Paid during 2009-2010- by Gender

Gender	Number of Claims	Claim Paid (in Rs crs.)	Average Claim Paid(in Rs)
Male	1650731	2939	17806
Female	1196467	2324	19425
Error Records	416391	2193	52655
Total	**3263597**	**7456**	**22846**

Note: Error records are those for which either the field is not filled up by TPAs or no coding was adopted by TPA. Source: Insurance Information Bureau, (http://iib.gov.in/IRDA/healthpub/Health_0910.pdf)

Table 6 shows that number of claims claim paid and average claim paid during 2009-10 by gender. Number of health insurance claims among the males is higher than the females. It may be because, females have less health insurance coverage compared to males. In India, gender based discrimination in health care is common.

Table 7: Number of Claims, Claim Paid and Average Claim Paid during 2009-2010- by Age

Age- Band (in yrs)	Number of Claims	Claim Paid (in Rs crs)	Average Claim Paid (in Rs)
<1	487288	1713	35156
1-5	156300	181	11555
6-15	141320	175	12368
16-25	322910	500	15494
26-40	787621	1429	18147
41-60	816793	1906	23338
61-65	178811	521	29139
66-70	123499	383	31036
Above 70 yrs	114597	397	34601
Age not specified	134458	251	18652
Total	**3263597**	**7456**	**22846**

Source: Insurance Information Bureau, (http://iib.gov.in/IRDA/healthpub/Health_0910.pdf)
Note: Age not Specified: - Date of birth/ Age field not filled in by the TPA I Insurer

Table 7 presents number of claims, claim paid and average claim paid during 2009-10 by age. Among the age group, 41 to 60 years have large number of claims reported. This is followed by age group 26 to 40 years

Table 8: Top 15 Disease- wise Number of Claims and Claim amount paid during 2009-2010.

Disease Name	ICD Codes	Number of Claims	Claim Paid (Rs in Crs)	Average Claim Paid (in Rs)
CIRCULATORY	100-199	170619	758.04	44429
DIGESTIVE	K00-K93	243848	501.94	20584
UROLOOGY	N00-N99	220246	458.71	20827
INJURY	S00-T98	154420	448.78	29062
INFECTIOUS	A00-B99	318989	393.41	12333
NEOPLASM	C00-D48	102122	379.96	37206
EYE	H00-H59	194376	368.12	18939
ARTHROPATHIES	M00-M99	75534	322.22	42659
PREGNANCY	O00-O99	149653	317.15	21192
RESPIRATORY	J00-J99	151744	248.17	16355
CLINICAL FINDINGS	R00-R99	121904	192.22	15768
NERVOUS	G00-G99	31086	84.57	27205
ENDOCRINE	E00-E99	34675	79.6	22955
SKIN	L00-L99	34165	59.9	17533
EAR	H60-H95	21325	41.5	19461
Other Diseases combined (where disease group claim records and amount are very small/ insignificant)		70890	157.74	162654
DISEASES UNSPECIFIED		1168001	2643.99	22637
Total		**3263597**	**7456**	**22846**

Note: International Statistical Classification of Diseases and Related Health Problem 10th Revision (ICD-10) classified by World Health Organization (WHO) used for grouping the diseases. The first level (3 digit) classification is considered for the above grouping
NB 2: ICD codes not provided for –Where ICD codes have been not provided as per ICD-10 classification/ not filled in at all/ wrong codes.
NB 3: Descending order on Claim Paid
Source: Insurance Information Bureau, (http://iib.gov.in/IRDA/healthpub/Health_0910.pdf)

Table 8 shows that disease-wise number of claims and claim amount paid during 2009-10. Highest number of claims paid for infectious diseases. Both in rural and urban areas the incidences of non-communicable diseases are increasing. However for insurance coverage, only selected non-communicable diseases are included and majority of the non-communicable diseases are excluded. The total amount paid by insurance companies is highest for circulatory diseases (Rs.758 crore). Average claim paid is highest for diseases related to circulatory system, neoplasm, Arthropathies and injury.

Table 9: Number of Claims and Average Claim Paid for 2009-2010- by State

State	Number of Claims	Average Claim Paid (in Rs)
Maharashtra	296002	30885
Gujarat	162215	19004
Tamil Nadu	151058	21956
Karnataka	125617	25167
Delhi	116207	31052
West Bengal	103590	26020
Haryana	94488	13744
Andhra Pradesh	82566	25795
Kerala	60576	11486
Uttar Pradesh	41358	21127
Madhya Pradesh	23720	16418
Punjab	21946	19855
Rajasthan	20134	19632
State with< 10000 Claims	31665	11.25
Pincodes not Provided	1932455	22125
Total	**3263597**	**22846**

Note: States have been classified on the basis of postal pin codes as given in the 'hospital pin code' field.
Source: Insurance
Information Bureau, (http://iib.gov.in/IRDA/healthpub/Health_0910.pdf)

Table 9 shows as per available information, for the recent year (2009-10), the maximum number of claims reported from Maharashtra, followed by Gujarat and Tamil Nadu.

Analysis from DLHS-3 and NFHS-3

Table 10 shows the percentage of households in which at least one member is covered by a health scheme or health insurance in India and by type of health insurance coverage. Only 5 percent of households have health insurance at the national level. Higher coverage is reported among the urban households (8.8 percent). In rural area, it is only 3 percent. As expected, about 12 percent households belonging to highest wealth quintile had health insurance coverage. This is only 1.6 percent among poorest households. Education level of the head of the household has considerable influence. Among better educated, the coverage is much higher (11 percent) compared with heads of the household having no education (only 2.4 percent).

The households who reported as covered by a health insurance scheme were asked to identify the type of scheme. Among the type of those health schemes or health insurance, most people have the central or state government health scheme (39.2 percent), followed by Employee State Health Insurance Scheme (ESIS). Nearly 16 percent households have Mediclaim policy. 8 percent of households have the option of medical reimbursement from employer. About 7 percent of households have purchased commercial health insurance from private companies. Interestingly, 7 percent households have some coverage under the community health insurance programmes, being implemented in many states.

The coverage of Mediclaim and ESIS is much higher in urban areas compared to rural households. However, the coverage of community health insurance is higher in rural areas. There is not much difference among the urban and rural households in the case of privately purchased commercial insurance policies.

Table 11 shows, the coverage of health scheme or health insurance in India is only 5 percent. Among the major states in India, higher coverage of health insurance is reported in Madhya Pradesh (12 percent) and Karnataka (12 percent), followed by Andhra Pradesh (10 percent), Gujarat (6 percent) and Kerala (6 percent). In remaining states, the health insurance coverage is below the national level average. Least health insurance coverage is reported in Uttar Pradesh (0.8 percent) and Bihar (0.8 percent). Among the insured those having the community health insurance coverage are highest in Karnataka. This may be because of the popular “Yeshaswini Scheme” for farmers in the state.

Table 12 shows the percentage of households in which at least one member is covered by health scheme or health insurance in India as per the findings from NFHS-3(2005-06). Only 5 percent of households have a health scheme or health insurance. Higher coverage is reported among the urban households (10.4 percent). If we consider the educational level of the head of the household, about 19 percent households surveyed, where the educational level is higher, have health insurance. Among the non-educated head of the

households the coverage is as low as one percent. Similarly, the coverage is higher among the highest wealth quintile households (16 percent). Among the poor (those belonged to two lowest wealth quintile households), practically no health insurance coverage at all. In other words, the health insurance coverage is enjoyed mainly by a section of economically better off households, and majority of poor in India cannot afford it.

Among the type of health schemes or health insurance, most purchased one is private commercial health insurance policies (27.6 percent), followed by Employees State Insurance Scheme (26.5 percent) and Central Government Health Scheme (20.5 percent). According to NFHS-3, 12 percent of households have the provision for medical reimbursement from the employer, among the insured households.

There is not so much difference between the urban and rural households in the case of privately purchased commercial insurance coverage- in urban (27.5 percent) and in rural (28.7 percent). The health insurance coverage under the Employee State Insurance Scheme is higher among the urban households (29.2 percent) compared with rural (20.3 percent) households. The Central Government Health scheme (CGHS) is relied upon by 21.6 percent of urban households that have insurance, compared with 18 percent of rural households with insurance. The coverage of Community Health Insurance is higher among the rural households (12.1 percent) compared to urban households (2.5 percent).

Table 13 present the health insurance coverage in major states of India. Among the major states, higher coverage of health insurance or health schemes are reported in Karnataka (10.6 percent), followed by Gujarat (10.4 percent) and Kerala (9 percent). Least health insurance coverage is reported in Bihar (1 percent) and Uttar Pradesh (1.3 percent). One- fourth of Karnataka's health insurance coverage is from the popular Community Health Insurance Scheme. Among the households covered with health insurance, the coverage of Central Government Health Scheme (CGHS) is highest in Madhya Pradesh (35.6 percent). Employee State Health Insurance Scheme (ESIS) coverage is highest in Bihar (48.3 percent) among the households with insurance.

Major Findings and Conclusions

According to both NFHS-3 and DLHS-3 surveys, only 5 percent of the households in India covered under any type of health insurance. However the recent data on health insurance (2009-10) revealed that, from 2007-08 onwards the number of health insurance policies and the number of covered members are increasing considerably. In 2008-09, the number of policies were 45, 75,725 and it increased to 68, 84,687 (serviced by TPA only) in 2009-10. Higher coverage of health insurance is reported in urban areas. The coverage in rural areas is still very low, as evident from both DLHS- 3 (3.2 percent) and NFHS-3 (2.2 percent).

According to DLHS-3, among the insured, Central or state government health scheme are the most subscribed (39.2), followed by the Employee State Insurance Scheme (17 percent). This clearly points out the dominance of the public mandatory schemes and employer based schemes, even after the entry of private players in the health insurance market. Among the households belong to the lowest three wealth quintiles, less than 3 percent were covered by any health scheme or health insurance.

Among the major states, percentage of households covered by a health scheme or health insurance is highest in Madhya Pradesh (12 percent) and Karnataka (12 percent) and lowest in Utter Pradesh and Bihar both (0.8 percent). One of the reasons of relatively high health insurance coverage of these states may be due to state government intervention on health insurance and the community based health insurance programmes. Karnataka is a good example for the state governments' intervention in health insurance programme and the popularity of a community based health insurance programme.

Who is responsible for providing health insurance cover to the people? Healthcare is an essential factor and those with diseases definitely will spend money to save their life, even it results in financial disaster. In this context, health insurance has emerged as an alternative financing tool in meeting the health care needs of the people. However this alternative financing is not reached vast sections of the people in India.

How can we achieve the universal health insurance coverage without adequate number of the health care facilities and resources? This is more critical when large proportion of our population is poor and many households were pushed into poverty trap due to catastrophic health expenditure. The private health insurance policies can be affordable only to economically better off households. The recent experiments in community health insurance schemes in some states are encouraging. The governmental agencies need to play more active role in facilitating the health insurance coverage to our population, particularly to poor.

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Table 10: Health Insurance Coverage in India, DLHS-3 (2007-08)

Percentage of households in which at least one member is covered by a health scheme or health insurance by type of health insurance coverage, according to background characteristics, India 2007-08

Background characteristics	Percentage of households covered by a health scheme or health insurance	Number of households	Type of coverage of health scheme/health insurance						
			Employee State Insurance Scheme	Central/ State Government Health Scheme	Community Health insurance programme	Mediclaim	Medical reimbursement from employer	Other privately purchased commercial Health insurance	Other
Residence									
Urban	8.2	160657	19.4	37.0	3.7	21.2	9.1	7.0	9.0
Rural	3.2	559663	13.8	42.1	11.3	8.1	7.0	6.2	14.9
Religion									
Hindu	5.4	549471	16.4	40.1	7.8	15.4	6.6	6.6	12.1
Muslim	2.6	78586	26.6	32.2	5.9	12.9	5.6	6.4	16
Christian	5.0	45977	14.3	33.3	2.4	19	22	6.3	7.2
Others	4.9	46286	18.7	40.5	2.0	16.3	16.5	8.1	4.7
Caste									
Scheduled	3.9	126769	16.2	50.5	6.6	10.2	6.0	4.3	10.3
Scheduled	3.9	138031	14.7	47.8	3.9	7.8	16.7	5.6	7.9
Other Backward	4.5	266681	17.3	37.7	10.9	11.7	6.3	7.2	13.9
Others	7.5	174612	17.8	34.0	4.9	23.3	7.6	7.2	11.1
Education									
No Education	2.4	258172	9.3	55.5	10.3	4.1	2.7	4.1	15.3
Less than 5	3.0	83359	12.2	37.9	13.0	9.1	6.3	7.0	16.5
5-9 years	3.9	209738	16.6	39.5	8.1	11.4	7.3	6.8	13.7
Higher	10.5	169051	20.0	34.4	4.9	21.4	10.4	7.3	8.9
Wealth Quintiles									
Poorest	1.6	143925	2.7	68.3	8.8	1.8	1.7	2.3	14.4
Second	2.1	144149	5.3	55.2	13.9	3.3	1.6	3.7	16.9
Middle	2.6	144038	11.0	43.3	15.4	5.1	3.1	6.3	17.1
Fourth	4.4	144038	19.6	37.2	9.4	8.9	8.6	6.6	13.5
Highest	12.0	144036	20.0	34.4	3.9	22.1	10.4	7.5	9.1
Total	**5.0**	**720320**	**17.0**	**39.2**	**7.0**	**15.5**	**8.2**	**6.7**	**11.5**

Table 11: Health Insurance Coverage in Major States, DLHS-3 (2007-08)

States	Number of households	Households Covered by a health scheme or health insurance (%)	Type of coverage of health scheme/health insurance						
			Employee State Insurance Scheme (ESIS)	Central/ State Government Health Scheme	Community Health insurance programme	Mediclaim	Medical reimbursement from employer	Other privately purchased commercial Health insurance	Other
Punjab	21933	4.7	17.1	64.6	1.7	8.3	5.2	3.6	0.6
Haryana	21406	3.7	22.9	39.3	1.1	21.3	11.7	4.3	2.6
Rajasthan	40052	3.0	25.2	52.1	1.5	13	5.1	5.3	2.3
Uttar Pradesh	90415	0.8	23.3	44.0	3.4	14.8	7.3	6.6	2.7
Bihar	47137	0.8	20.1	38.0	2.8	21.1	5.4	11.9	7.9
Assam	37836	1.4	27.5	11.2	1.5	35.6	3.7	22.1	7.2
West Bengal	22213	4.3	13.7	26.6	3.0	39.9	11.3	6.5	3.3
Orissa	33172	1.0	31.2	18.3	4.7	22.4	13.4	11.1	5.0
Madhya Pradesh	51419	12.1	6.0	64.5	7.2	2.8	2.1	3.6	15.1
Gujarat	26145	6.3	11.4	18.4	2.2	33.6	9.3	5.0	27.7
Maharashtra	37716	3.2	15.7	20.7	2.4	23.8	7.8	13.4	20.0
Andhra Pradesh	25321	10.2	7.6	74.0	1.6	2.9	3.6	4.7	10.7
Karnataka	29062	12.0	6.8	8.4	48.0	3.5	3.6	7.1	25.6
Kerala	14711	6.2	21.0	17.5	2.6	38	11.1	12.2	0.5
Tamil Nadu	32623	3.0	46.6	20.0	1.6	15.4	12.3	8.8	6.4
India	**720320**	**5.0**	**17.0**	**39.2**	**7.0**	**15.5**	**8.2**	**6.7**	**11.5**

Table 12: Health Insurance Coverage in India, NFHS-3 (2005-06)

Percentage of households in which at least one member is covered by a health scheme or health insurance by type of health insurance coverage, according to background characteristics, India, 2005-06

Background characteristics	Households covered by a health scheme or health insurance (%)	Number of households	Type of coverage of health scheme/health insurance						
			Employee State Insurance Scheme (ESIS)	Central Government Health Scheme (CGHS)	Community Health insurance programme	Other health insurance through employer	Medical reimbursement from employer	Other privately purchased commercial Health insurance	Other
Residence									
Urban	10.4	50236	29.2	21.6	2.5	6.3	13.1	27.5	2.7
Rural	2.2	58805	20.3	17.9	12.1	5.4	8.9	28.7	8.6
Religion									
Hindu	5.1	80020	26.8	20.7	5.5	6.0	11.7	27.6	4.2
Muslim	2.1	13354	28.8	15.4	6	6.0	7.1	30.9	6.8
Christian	7.3	10042	21.3	17.7	1.3	10.8	16.6	27.9	8.1
Others	8.0	5625	23.4	23.1	6.6	2.5	13.4	29	3.8
Caste									
Scheduled Castes	3.4	18251	39.0	23.6	4.7	4.6	12.8	15.7	3.3
Scheduled Tribes	2.6	14708	23.3	26.2	4.8	6.6	12.4	23.7	3.6
Other Backward Classes	3.8	34428	28.3	17.4	8.5	7.1	9.1	26.3	5.8
Others	8.1	36956	22.8	21.6	3.7	5.7	13.3	32	3.7
Education									
No Education	1.3	34119	33.6	15.1	9.1	3.3	6.3	27.6	7.2
Less than 5 years	2.4	19593	25.7	15.9	8.2	6.2	8.4	31.4	5.2
5-9 years	6.5	42197	27.7	20.4	5.7	6.4	10.8	26.4	4.7
Higher (10+)	19.1	12878	23.0	23.2	3.2	6.2	15.6	29.1	3.2
Wealth Quintiles									
Poorest	0.1	14645	34.1	18.4	6.2	8.0	12.1	15.8	7.4
Second	0.7	16576	23.4	9.5	13.4	2.6	2.9	39.3	9.4
Middle	2.2	20951	26.8	11.9	15.4	5.9	6.1	24.9	9.6
Richer	5.1	25497	34.7	15.8	9.0	6.0	8.8	22.4	5.5
Richest	16.4	31372	24.0	23.5	2.7	6.2	13.8	29.6	3.3
Total	**4.9**	**109041**	**26.5**	**20.5**	**5.4**	**6.0**	**11.8**	**27.9**	**4.5**

Table 13: Health Insurance coverage in major states, NFHS-3 (2005-06)

States	Number of households	Percentage of households covered by a health scheme or health insurance	Type of coverage of health scheme/health insurance						
			Employee State Insurance Scheme (ESIS)	Central Government Health Scheme(CGHS)	Community Health insurance programme	Other health insurance through employer	Medical reimbursement from employer	Other privately purchased commercial Health insurance	Other
Punjab	2968	6.8	44.6	21.2	7.9	4.6	8.1	12.2	3.5
Haryana	2302	6.7	23.7	31.0	0.7	2.1	22.5	19.8	2.8
Rajasthan	3282	4.5	48.4	21.9	0.0	5.3	5.1	19.3	0.6
Uttar Pradesh	10026	1.3	37.4	29.3	1.1	7.1	5.2	19.6	1.3
Bihar	3016	1.0	48.3	15.2	11.4	11.4	5.9	7.9	0.0
Assam	3437	2.3	5.9	6.7	0.0	17.8	15.5	45.7	9.1
West Bengal	5992	6.0	32.0	16.2	1.1	5.3	16.6	25.8	4.7
Orissa	3910	1.8	24.2	10.9	0.9	17.6	25.5	17.1	9.2
Madhya Pradesh	5488	4.8	25.6	35.6	3.5	2.5	19.2	16.1	0.0
Gujarat	3216	10.4	18.2	28.5	1.8	4.0	7.7	39.4	2.2
Maharashtra	8315	7.2	16.9	21.6	2.5	7.1	11.2	41.7	1.8
Andhra Pradesh	6668	3.6	42.0	13.7	1.0	4.1	19.6	23.1	1.7
Karnataka	5342	10.6	12.7	6.7	28.3	6.8	3.6	29.9	17
Kerala	3023	9.0	12.7	10.1	4.8	6.3	16.1	45.9	7.5
Tamil Nadu	6344	4.0	29.5	34.4	0.4	8.4	13.8	13.4	0.0
India	**109041**	**5.0**	**26.5**	**20.5**	**5.4**	**6.0**	**11.8**	**27.9**	**4.5**