# CAN CATASTROPHIC OUT-OF-POCKET MEDICAL EXPENSES BE REDUCED BY INSURANCE AND GOVERNMENT SCHEMES?

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**ABSTRACT**

*This abstract explores the potential for government health insurance and schemes to mitigate catastrophic out-of-pocket expenses, examining their impact on healthcare affordability and accessibility. By analyzing existing programs and their effectiveness, the study aims to contribute insights into policy measures that can alleviate financial burdens on individuals and enhance overall health system resilience. Additionally, the abstract investigates the socio-economic implications of high out-of-pocket expenses, emphasizing the disproportionate burden on vulnerable populations. Through a comparative analysis of international models and their outcomes, the research seeks to identify best practices and potential areas for improvement in implementing government-sponsored health insurance. The goal is to inform policymakers about strategies that not only reduce catastrophic healthcare costs but also promote equitable access to quality medical services.*

**KEYWORDS :** *Catastrophic, out-of-pocket, Medical Expenses, Government Schemes, Health Insurance*

## INTRODUCTION:

Catastrophic out-of-pocket (OOP) expenses, defined as healthcare costs that exceed a certain proportion of a household's income, can have a devastating financial impact on individuals and families. These expenses can lead to debt, poverty, and even death. Government health insurance and schemes can play a critical role in reducing the burden of catastrophic OOP expenses by providing financial protection and ensuring access to quality healthcare services(Technical Brief for Police Makers, n.d.).

Numerous studies have demonstrated the effectiveness of government health insurance and schemes in reducing catastrophic OOP expenses. For instance, a study published in the journal "Health Policy and Planning" found that the introduction of the Rashtriya Swasthya Bima Yojana (RSBY) in India led to a significant reduction in catastrophic OOP expenses among the poor. Similarly, a study published in the journal "PLOS Medicine" found that the expansion of Medicaid in the United States was associated with a decrease in catastrophic OOP expenses among low-income adults(Liu et al., 2019).

The mechanisms by which government health insurance and schemes reduce catastrophic OOP expenses are multifaceted. These mechanisms include:

Risk pooling: Government health insurance and schemes pool the risk of high healthcare costs across a large population, thereby reducing the financial burden on individual households.

Price negotiation: Government health insurance and schemes have the bargaining power to negotiate lower prices with healthcare providers, which can translate into lower costs for enrollees.

Prevention and early detection: Government health insurance and schemes often provide coverage for preventive care and early detection services, which can help to reduce the need for expensive treatments in the future.

Financial assistance: Government health insurance and schemes may provide subsidies or premium assistance to low-income individuals and families, making healthcare coverage more affordable**(Wagstaff & Neelsen, 2020).**

## HEALTH INSURANCE COVERAGE:

Healthcare costs in India are mostly covered out of pocket since the health sector receives the smallest share of the nation's national budget (OOP). To promote healthcare reforms and lower poverty, Indian healthcare planners have pushed for extending health insurance programs **(Gambhir et al., 2019).**

Nearly 60% of households do not have a single member covered by any health insurance program, despite a significant growth in the population eligible for state-sponsored health insurance and a surge in private health insurance businesses **(Ambade et al., 2023).** In India, the overall amount spent on healthcare is approximately thirty percent of GDP, or 1.5 percent of GDP, which is the entire amount spent by the central and state governments together on healthcare. 2 Out-of-pocket expenses account for 70% of the country's healthcare spending (OOPE) **(Kamath et al., 2022).**

Why have Indian policymakers become interested in health insurance? The high burden of illness, low public healthcare spending, high private healthcare spending (particularly OOP), and restricted coverage by the current health insurance schemes are all included (Ahlin et al., 2016). 2018 saw 16.51 percent of Indians deal with catastrophic health expenses, or CHE (at a 10 percent threshold level), while 3.3 percent of people were forced into poverty as a result of OOPE on health services **(Dubey et al., 2023).**

A household's economic standing plays a significant role in predicting the likelihood of out-of-pocket expenses. Those in better economic classes are more likely to suffer OOP expenses because of their greater ability to pay. Those from higher economic classes have an average OOPE higher than the poorest **(Mahapatro et al., 2018).**

In India, various kinds of health insurance schemes exist. Health insurance is categorized as follows:

- Government-sponsored health insurance programs
- Market-driven insurance
- Plans for insurance offered by the employer
- Cooperative NGO Based

Different insurance plans, such as family floaters, senior citizens, critical sickness, and maternity insurance, are offered by all insurance firms **(Gupta, 2017).**

The three business classes that make up the health insurance industry are government-sponsored, group, and individual. Regarding the number of lives covered, roughly 59% were covered by government-sponsored health insurance programs, roughly 31% in group companies, and the remaining roughly 10% were covered by individual plans from general and health insurers. Group business received the largest portion of the premium (50.42 %), followed by individual business (41.12 %) and government business (8.46 %) **(Source: IRDAI Annual Report 2021-22)**

Policies, Lives Covered, and Premiums under Health Insurance Business of General and Health Insurers

| Class of business | No. of Policies (lakhs) | | No. of Lives Covered (lakhs) | |
|---|---|---|---|---|
| | 2020-21 | 2021-22 | 2020-21 | 2021-22 |
| Government-sponsored business | 0.001 (-53.50) | 0.001 (0.00) | 3,429.14 (-5.26) | 3,065.08 (-10.62) |

| | | | | |
|---|---|---|---|---|
| Group Business | 9.09 (19.49) | 7.00 (-36.30) | 1,186.95 (26.92) | 1,622.88 (36.73) |
| Individual Business | 228.30 (32.95) | 219.25 (-3.96) | 5,31.39 (22.94) | 516.23 (-2.85) |
| Total | 237.39 (32.38) | 226.25 (-5.20) | 5,147.47 (3.22) | 5,204.19 (1.10) |

Source: IRDAI Annual Report 2021-22

The medical care industry includes health insurance and healthcare, and the two are interdependent. Therefore, a fuller understanding of the health insurance sector's performance requires considering the healthcare industry, which continuously experiences losses. Therefore, if earnings are not being made, new ideas must be implemented to minimize losses.
The insurance firms' opportunity in this market is to create cutting-edge goods, services, and means of distribution **(Dutta, 2020).**

## GOVERNMENT HEALTH SCHEMES:

The Indian health system is a complicated fusion of commercial enterprises, nongovernmental organizations, and different tiers of government decision-makers and providers. Large portions of the nation are underserved due to a persistent scarcity of physicians and other healthcare professionals, who are typically concentrated in urban areas **(Angell et al., 2019).**

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana:

The largest health insurance program in the world, Pradhan Mantri Jan Arogya Yojana (PM-JAY), offers 500,000 INR (about USD 6,800) in health coverage per family year. About 500 million of the poorest households in India receive financial assistance for secondary and tertiary care hospitalization costs through a variety of insurance plans, with care provided by state and privately impaneled providers **(Joseph et al., 2021).**

Ayushman Bharat for a New India 2022 was unveiled in the 2018 budget speech, and it featured two significant initiatives: the development of health and wellness(HWCs) and a comprehensive National Health Protection Program (NHPS) **(Editorial Commentary, 2018).**

Rashtriya Swasthya Bima Yojana:

Over 36 million families in the majority of India's states now have access to secondary-level healthcare services because of the Rashtriya Swasthya Bima Yojana (RSBY) initiative. The Government of India (GOI) launched this specific health insurance program to protect the poor and disenfranchised Indian populace as well as homes that are in financial danger from hospitalization and daily living expenses **(Malhi et al., 2020).**

Pradhan Mantri Jan Dhan Yojana:

On June 1st, 2015, the Pradhan Mantri Suraksha Bima Yojana was launched to offer all Indian citizens financial support in the form of less expensive term insurance. Under this, accident insurance is offered for a predetermined term (period) and amount in exchange for a predetermined premium **(Yadav & Sarvesh Mohania, n.d.)**

Conclusion:

These programs are a blessing for low-income families who cannot afford expensive prescription drugs or specialized medical care. While it has the potential to alleviate India's healthcare problems, the biggest obstacles are ensuring its seamless implementation through an IT platform, educating healthcare personnel, and continuously streamlining and updating treatment packages **(Singh et al., n.d.).**

## UNIVERSAL HEALTHCARE SYSTEM:

The massive unused public health infrastructure in India and the largely unregulated private market are the two main features of the health system. Access to healthcare is hampered by high out-of-pocket (OOP) medical expenses. The disastrous consequence of OOP healthcare expenses pushes approximately 25% of hospitalized patients below the poverty level **(Prinja et al., 2012)**.

The families struggling financially, the demand for healthcare is unpredictable and disastrous. Low-income families suffer from wage loss in addition to having to pay for OOP healthcare. The annual cost of OOP healthcare bills pushes almost 50 million Indian households into poverty **(Zodpey & Farooqui, 2018).**

Every person gets access to healthcare services whenever they need them, free from financial constraints, thanks to UHC. Safe, efficient, timely, equitable, and patient-centered treatment are the goals of high-quality healthcare **(Grover et al., 2023).**

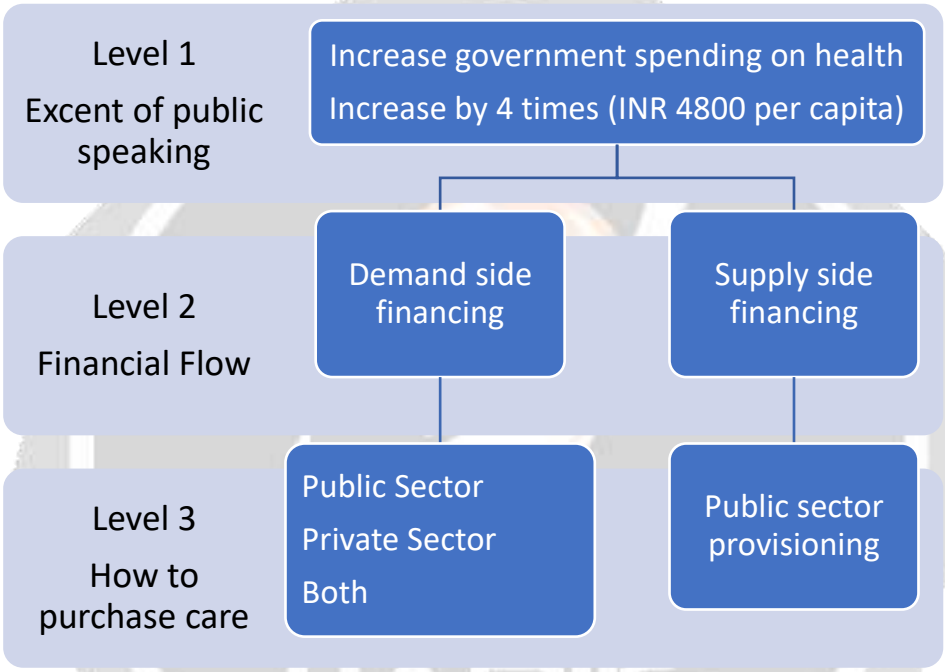



Figure: A decision framework for choices on the road toward universal health coverage (Sharma & Prinja, 2018).

Due to differences in service delivery patterns, local prices for different resources, space leasing costs, and wage rates for human resources, healthcare delivery costs differ between states and facilities **(Prinja et al., 2020).** Increasing access to healthcare facilities, raising the standard of care, and advancing health awareness and education are just a few of India's G20 programs aimed at bridging the divide between various socioeconomic classes and urban and rural locations. Particular focus is placed on the elderly, women, children, and those living in rural areas are examples of marginalized communities that frequently confront increased susceptibilities to illness **(Dwivedi et al., 2023).**

National and state health policy should provide financial security in light of the disaggregation of OOPE and CHE together with distress finance by type of provider and disease. We recommend extending health insurance coverage to include cancer therapy, heart disease treatment, and other uncommon and terminal illnesses **(Kastor & Mohanty, 2018).**

## INSURANCE MARKET COMPETITION:

The last ten years have seen a radical shift in the Indian insurance industry's paradigm due to the deregulation of the insurance sector. The sector's privatization has also made a significant contribution by raising the density of insurance and its penetration in the non-life and life insurance markets **(Growth and Development of Insurance in India, n.d.).**

The world's most lucrative insurance industry is in India thanks to its rapid economic expansion. The state-run Life Insurance Corporation of India (LIC) had a monopoly on the life insurance industry before 1999. As of right now, India is home to 24 privately held life insurance businesses. LIC's existence was in danger due to the competition posed by these enterprises **(Srivastava & Prakash, n.d.).**

The largest entrance barrier limiting the size of the life insurance industry and preventing its growth is the FDI cap. The competition will increase as a result of the market being opened to international companies, and the service will reach a larger audience, expanding the market **(Srichandan, 2013).** India spends about 6% of its GDP on health insurance, which is significantly more than most other nations at the same economic stage. Private insurance companies will be allowed to sell health insurance to many families that would like to have health care coverage but do not have it 4.7 percent is private and the remainder is public **(Dhar, 2018).**

If insurance regulations are deliberately created to meet goals of equity and redistribution, the poor may also directly benefit. For the immediate beneficiaries, the government must, at the very least, guarantee that:

i. The liberalization of the insurance market offers value for money
ii. Liberalization does not negatively impact the impoverished **(Ahuja, 2004).**

The Insurance Regulatory and Development Authority (IRDA), is responsible for regulating the whole insurance sector. They will control the insurance industry and provide licenses to private businesses. Since health insurance is still in its infancy, IRDA's involvement is important **(Mavalankar & Bhat, 2000).** Growing competition has brought about easier access to the market, greater knowledge of insurance and financial planning, competitive premium rates, a greater selection of products, alternative channels, multiple gateways for paying premiums, eye-catching physical evidence, aggressive promotional strategies, training initiatives, and employment opportunities **(Journalsresaim,+IJRESM_V3_I7_45, n.d.).**

## IMPROVED ACCESS TO QUALITY CARE DUE TO HEALTH INSURANCE:

To attain UHC, two strategies for financing healthcare are proposed-

i. There is a tax-supported finance structure for healthcare services, which are often rendered via a network of public health systems.
ii. The system of society risk pooling, in which each person pays their portion of the entire cost of healthcare **(Hooda, 2020).**

Understanding the insurance plans promotes the use of health insurance, which in turn aids in the uptake of healthcare. People typically sign up for health insurance due to word-of-mouth marketing, awareness, or their own experiences **(Reshmi et al., 2021).**

Substantial data indicates the potential efficacy of interventions in lowering rates of mother and newborn death, such as access to professional care during delivery and neonatal care. However, in many nations, both the quality and accessibility of these services are still lacking **(Comfort et al., n.d.).** The global consensus is that prepayment and fund pooling should be used to replace or minimize direct out-of-pocket expenses so that everyone has access to high-quality, reasonably priced healthcare services. But in 2009–2010, only about 26% of Indians had access to health insurance (HI), which included the Rashtriya Swasthya Bima Yojna (RSBY) **(Panda et al., 2015).**

Non-governmental organizations (NGOs) have implemented local risk-pooling mechanisms since the 1950s to provide household protection against excessive medical costs and to enhance access to high-quality care. As of right now, there are roughly 115 CHI schemes. Given the political will behind implementing a national health insurance program and working with already existing CHI programs, further research is necessary to fully understand the effects of these programs. The potential for certain programs to increase access to healthcare and offer financial security has already been examined **(Michielsen et al., 2011).**

Given the deregulated healthcare markets and the intricacies involved in processing health insurance claims, health insurance is not a practical choice for India, and the government should explicitly exclude

health insurance from its health policy. What we require is a strong public health system and more extensive, socially and tax-based health insurance funding to ensure that everyone has access to healthcare **(Economic and Political Weekly · July 2021, n.d.).**

Certain corporate and private hospitals have launched health insurance programs that allow the purchaser to receive medical care from that hospital or network of hospitals, subject to a few predetermined requirements. In India, public health spending accounts for just 1.04 percent of GDP (GDP). The estimated overall health spending as a percentage of GDP, including the contribution from the private sector, is 4%. Approximately thirty percent of the overall expenditure comes from the public sector. Getting therapy from private providers raises the expense of treatment for the entire household **(Kusuma et al., 2018).**

It is evident that the respondents want insurance plans with a wellness component and had little faith in government health care. To break into the rural health insurance market, policymakers can try using mutuals, cooperatives, and community-based groups. NGOs and other organizations like mutuals and cooperatives can be very helpful in improving rural India's access to healthcare **(Pandey & Chattoraj, 2021).**

## CHALLENGES AND LIMITATION IN HEALTH INSURANCE:

The difficult part is ensuring that the weak and the impoverished gain from improved coverage and health services at reduced costs without suffering from negative effects like cost increases and excessive reliance on medical procedures and technology **(Mavalankar & Bhat, 2000b).**

People in society are now more likely to be married than single, which has helped them move up the economic ladder from lower middle class to upper middle class. However, this change may also have a negative personal impact because they may find it difficult to successfully manage their personal and professional lives.
There are a lot of potential and challenges for the medical community, insurers, and other service providers in providing inexpensive health care to the billions of people living in India. Cutting-edge partnerships, technologies, and procedures developed by India beginning to close the healthcare gap are both public and private organizations
**(Khan & Banerji, 2014).**

The economics of rural society, transportation networks, and social standing have all changed because of urbanization.
Because younger people are leaving and older people are moving in, residential patterns have an impact on the health of older folks as well **(Vaishnav et al., 2022).**

The section examines the initial patterns of NRHM finance and highlights the obstacles encountered in the endeavor to augment government health expenditure in India. This section specifically looks at the challenges of sustainability, substitutability, and efficient use of public health resources since the inception of NRHM **(Berman et al., 2010).**

New issues facing the health insurance industry include evaluating network hospitals that agree to offer high-quality care at the authorized package pricing and transparently selecting the insurance scheme partner or corporation through an open tender that can supply the services at a competitive rate **(Indian Journal of Community & Family Medicine, n.d.).**

The main issues that all hospitals encountered from clients were ignorance of the specific terms and circumstances of health insurance, an unwarranted argument for a larger deduction, or a longer time frame for the TPA to process the claim **(Dave et al., 2021).**

There are several issues in the Indian health financing scenario, including:

• Rising healthcare expenditures,

• A heavy financial burden that reduces the incomes of the poor,

• Rising rates of newly discovered illnesses and health hazards, and

• The underfunding of government health care, results in the neglect of public health, primary care, and prevention initiatives **(Mavalankar & Bhat, 2000).**

## ROLE OF INFORMATION AND EDUCATION IN HEALTHCARE:

Social media's capacity to eliminate the physical boundaries that previously prevented access to healthcare resources and support has led to an increase in its use in public health education. With the increasing integration of Internet-based programming into health promotion, health education professionals are required to enhance their proficiency in computer-mediated contexts to optimize consumer health experiences in both online and offline settings **(Stellefson et al., 2020).**

While a study in rural India based on community-based health insurance coverage indicated that household education and income considerably increased enrolment, another study by the Delhi-based Rashtriya Swasthya Bima Yojana found no significant association between household income and enrollment. One of the biggest obstacles to health insurance in developing countries like India is a lack of money, followed by a lack of understanding **(Barman et al., 2023).**
In end-of-life contexts, care is either nonexistent or severely limited, and current health education places a singular emphasis on curing. This study sought to ascertain Indian undergraduate healthcare students' awareness of palliative care and evaluate whether undergraduate health education should include instruction in palliative medicine **(Sadhu et al., 2010).**

We must consider the long-term educational process that precedes attainment and its impact on health when we extend our operationalization of education beyond attainment. Education must be rethought not just as a means of achieving social success, acquiring important resources, and maintaining good health, but also as an establishment that perpetuates inequity among future generations **(Zajacova & Lawrence, 2018).** To reach these goals, the education sector is essential, and teaching health literacy is a crucial step in the process. As it is focused on both promoting successful social and political action as well as individual activities, this can contribute to significant public health goals, such as critical health literacy **(Vamos et al., 2020).**

As health professionals are being educated and trained, leadership growth, evaluation, and feedback are essential. It is possible to identify, train, and evaluate aspiring and established leaders through official leadership development programs and encouraging organizational cultures **(van Diggle et al., 2020).**

The current condition of graduate medical education's approach to creating and implementing curricula around health care disparities and cultural competency care must be evaluated. To guarantee that quality and patient satisfaction data are disseminated according to patient race, identifiable cultural group, and preferred language for communication, residency, and institutional leadership should work together **(Maldonado et al., 2014).**

As education lowers the need for medical care, and the associated costs of reliance, lost wages, and suffering, it is a crucial tool for improving people's health and well-being. Additionally, it supports and nurtures human growth, interpersonal connections, and the well-being of the individual, family, and community. Healthy lifestyles and positive choices are also promoted and maintained by it **(Feinstein et al., 2006).**

## METHODOLOGY:

The literature search was limited to articles published from 2006 - 2023. The search for articles was done online by using the search words “Catastrophic, out-of-pocket, Medical Expenses, Government Schemes, Health Insurance” in the title and keywords in research databases at Wiley, Elsevier, Taylor & Francis, ERIC, Springer, SAGE, Frontiers.

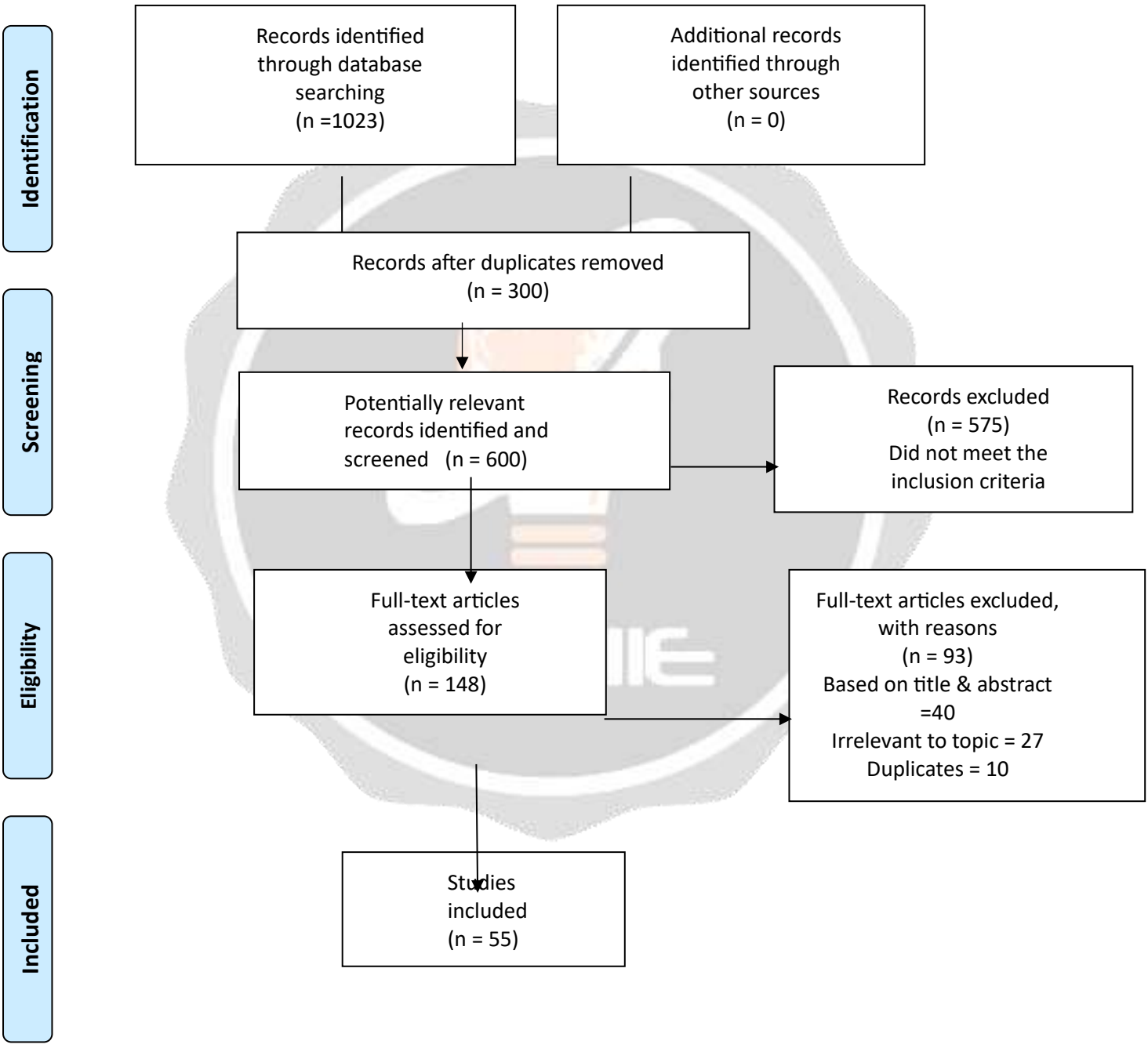
## Analysis:

The method used is the Preferred Reporting Item for Systemic Reviews and Meta Analytics (PRISMA) method. All articles that have passed the selection process were then reviewed and summarised based on the objectives, year of publication, number of citations, and suggestions for further research.

## Inclusion & Exclusion criteria:

The be included in the current study, studies must meet some criteria
(a) Studies have included some kind of selection criteria (Academic procrastination, workplace). These criteria limited the number of studies
(b) and accordingly excluded the studies in which based on irrelevant information there is no proper Title, Abstract, or review.

**PRISMA Flow Diagram**




## FINAL DATA SET:

The research database search resulted in all keyword search results obtained from 1023 research articles. After scanning the title, there was the same article in two different databases. The results after deducting

the duplicates are 3005 articles. A total of 600 articles were screened. 575 Articles excluded that they did not meet the inclusion criteria.
Articles accessed for eligibility are 148 articles. A Total number of 93 articles were excluded based on title and abstract (40) Irrelevant to the topic (27) Duplicate (10).
The final data set consists of 55 articles.

The oldest included study was published in the year 2006 and the most recent study was conducted in 2023. The Entire process is shown in the figure.

## DISCUSSION:

The discussion on whether government health insurance and schemes can effectively reduce catastrophic out-of-pocket expenses revolves around several key considerations. Firstly, empirical evidence suggests that countries with robust public health insurance programs often exhibit lower rates of catastrophic spending, indicating the potential success of such interventions. One key mechanism through which government health insurance can curtail catastrophic expenses is by spreading the financial burden across a larger pool of contributors. This collective risk-sharing minimizes the impact on individual households, especially during major health crises. Moreover, these schemes tend to negotiate favorable terms with healthcare providers, resulting in cost containment and overall expenditure reduction. However, challenges persist. The design and implementation of government health insurance programs demand careful consideration. Factors such as coverage comprehensiveness, inclusivity, and efficient administration play pivotal roles in determining their success. Insufficient coverage or administrative inefficiencies may undermine the intended benefits and leave certain populations vulnerable to high out-of-pocket costs. Moreover, the impact of cultural, social, and regional variations cannot be understated. Tailoring health insurance schemes to address specific demographic needs and considering regional disparities in healthcare access is crucial for equitable outcomes.

In conclusion, while government health insurance and schemes have shown promise in reducing catastrophic out-of-pocket expenses, the success of such initiatives hinges on thoughtful design, effective implementation, and continuous adaptation to evolving healthcare landscapes. Additionally, collaborative efforts between governments, healthcare providers, and communities are essential to address the multifaceted challenges associated with mitigating catastrophic healthcare costs.

## CONCLUSION;

In conclusion, the study underscores the significant potential of government health insurance and schemes in alleviating catastrophic out-of-pocket expenses. The analysis reveals promising outcomes in terms of increased affordability and accessibility to healthcare services. However, the effectiveness of such interventions may vary based on policy design, implementation strategies, and regional context. To maximize impact, policymakers should prioritize continuous evaluation, address potential shortcomings, and foster inclusivity, ensuring that the benefits of government health insurance programs extend comprehensively to diverse populations, ultimately contributing to a more resilient and equitable healthcare system. Furthermore, the study highlights the positive correlation between reduced out-of-pocket expenses and improved health outcomes. By lessening the financial barriers to medical care, government health insurance can enhance preventive measures and early interventions, ultimately mitigating the severity and cost of advanced illnesses. Additionally, the research underscores the role of these schemes in promoting financial stability for households, preventing catastrophic health expenditures from plunging individuals into poverty. While recognizing these benefits, the conclusion emphasizes the need for ongoing monitoring, adaptive policy adjustments, and international collaboration to refine and optimize government health insurance initiatives for sustained positive impact.

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