Insurance, Health care and Ayushman Bharat

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ABSTRACT

There is growing awareness of the fact that ill-health perpetuates poverty. In order to prevent the negative downward spiral of poverty and illness, developing countries in recent years are increasingly implementing various models of health insurance to increase access to health care for poor households.

While there is consistent evidence that health insurance schemes have caused an increase in access to health generally, the debate regarding the most appropriate health insurance scheme that suits the poor continues unabated.

Policy makers and planners need to pay attention to these important dimensions when making decisions regarding health insurance and health care services utilization to ensure that the peculiar needs of the poor are taken on board.

Key words: Access, Developing countries, Health insurance models, universal health coverage

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Back Ground:

Over the last 70 years India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators. In case of government funded health care system, the quality and access of services has always remained major concern. A very rapidly growing private health market has developed in India. This private sector bridges most of the gaps between what government offers and what people need. However, with proliferation of various health care technologies and general price rise, the cost of care has also become very expensive and unaffordable to large segment of population. The government and people have started exploring various health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases.

Models of Health Insurance

Most countries around the world are committed to developing an effective health insurance system for the purpose of achieving universal coverage. Yet, there is an on-going debate on the relative advantages of different forms of health insurance. The purposes of health financing are to mobilize resources for the health system, to set the right financial incentives for providers, and to ensure that all individuals have access to effective health care.

1. Private Health Insurance (PHI)

Private health insurance (PHI) is becoming more prevalent in both developed and developing countries, yet it plays a limited role increasing access to health care in
developing countries. Out of the 154 developing countries, only 11 fund more than 10 percent of their health care through PHI.

Some commentators have observed that while PHI can increase financial protection and access to quality health services to the well-off, without subsidies however, the poor cannot afford to pay PHI premiums. PHI does not support risk
sharing, it rather employs the cream-skimming strategy – a practice where insurance policies are designed to target people with lower-than-average risks and exclude those with high risks. This practice deprives vulnerable groups including women, the elderly and people living with HIV access to care

Given this lack of equity and efficiency, PHI systems alone do not seem to have a solution to the health problems facing developing countries. Whereas PHI models have run alongside complement tax-based or SHI complementarily in developed countries, on its own, however, it is not an appropriate financing option to achieve UHC in developing countries whose population are mostly poor, sick and cannot afford risk-related premiums.

2. Community Based Health Insurance (CBHI)

Community-based health insurance is the most common form of health care financing in many developing.

It comes as a result of governments' inability to reach the informal sector and rural populations, requiring communities to mobilize and secure financial protection against the cost of illness for groups of individuals and households not covered by existing insurance schemes. A variety of community-based health financing arrangements have emerged over the past decade, including micro insurance, community health funds, mutual health organizations, rural health insurance, revolving drugs funds, and community involvement in user-fee management . Regardless of the arrangement, a common feature is that they facilitate explicit or implicit involvement of community members in the design and implementation process that limits abuse and fraud and contributes to trust and confidence in the scheme.

Research has given evidence that community financing arrangements provide financial protection by reducing out of pocket (OOP) spending and by increasing access to health services; improved access to drugs, primary care, including more advanced hospital care. However, the very low and shrinking population coverage rates cast doubts over the validity of this finding. Most often, low premiums are charged and yet the cost of collecting premiums can be high. As such, these schemes are unable to generate the required amount of revenue to provide subsidy for the poor.

The CBHI do not have large risk pools. New evidence suggests that out of 258 schemes reviewed; only 2% had more than 100,000 members, more than half of them had less than 500 members. With limited revenue at their disposal CBHI schemes tend to cover a limited number of services, severely limiting the financial protection offered.

3. Social Health Insurance (SHI)

SHI schemes are often financed through mandatory earnings related contributions levied on formal sector workers. Though people with higher contributions are not entitled to more health care, non-contributors may have different entitlements to contributors. In some cases too people contributing to different schemes may have different entitlements from one another.

Unlike private health insurance schemes, social health insurance contributions are usually based on ability to pay and are not risk-related, and access to services is based on need. In a typical SHI scheme, entitlements to services are usually universal and not differentiated, and contribution rates are set at a level intended to ensure that these entitlements are affordable to members. Through SHI, high-income countries such as Germany, Luxembourg, Belgium, and France have achieved formal UHC. In developing countries however, SHI schemes are found to exclude populations in the informal sector and the larger the informal sector the lager the coverage gap.

In the absence of reliable income records premiums are charged at a flat rate; mostly unfordable to the poor. And, even though exemptions exist for vulnerable groups like the elderly, children, indigent, the disabled and pregnant women, errors of exclusion and inclusion still occur, culminating in low enrolment.

In developing countries, SHI revenue can at best offer supplementary revenues for pluralistic financing of health system. The ILO observes that the success of SHI schemes is dependent on the generation of stable revenues, strong backing of the beneficiary population, provision of a broad package of services, participation of the social partners and redistribution between risk and income groups.

4. Tax-Based Systems (TBS)

Tax-based systems, sometimes referred to as national health services pay for health services out of general government revenue such as direct or indirect tax from various levels, including national and local tax.

These taxes are often used for various forms of health insurance funding. Aside from financing national health services, vouchers or conditional cash benefits, taxes are used as subsidies for mixed health insurance programmes such as national health insurances, whereby government revenues are used to subsidize the poor. In addition, taxes may be used as subsidies for social health insurance, community-based mutual health and private health insurance schemes. Subsidies from government revenue might cover costs for the poor, deficits, specific services, and start-up or investment costs.

Impact of Health insurance on structure and quality of private provision

The experiences in liberalizing the private health insurance suggest that it has undesirable effects on the costs of health care. The costs of care generally go up. Given the present system of fee for service and current scenario of health infrastructure in private sector, the development of insurance will need improvements in quality and change in structure. The new investments to improve quality will result into high cost and therefore increase in prices of insurance products. There would be developments in the direction of exploring options of managed care, which would help in reducing the costs. The developments would be needed in the direction of strong information base and accreditation system for providers. The structure of the health sector will have to change from multiple-single doctor hospitals and clinics to larger hospitals and polyclinics, which provide services of multiple specialities and can operate at larger scale. This will allow them to provide high quality professional care at competitive prices. As one of the responses to these issues Third Party Administrators (TPA) are rapidly emerging in India. Here we can learn from the models, which have emerged elsewhere. But their applicability to Indian situation needs to be examined carefully. These aspects of the health sector will need detailed study.

The insurance mechanism prevalent in many developed countries has their history. Health reforms experiences in many countries are replete with the suggestion that the systems cannot be replicated easily. Self-regulation is an important in any market driven system. The regulation from outside does not work. Implementation of regulation in this sector is difficult. We significantly lack mechanisms and institutions, which would ensure self- regulation and continuing education of provides and various stakeholders. The accreditation systems are hard to implement without mechanisms to self-regulate. For example it took 35 years in US to put the accreditation system effectively in place. For example, it has been difficult for many States in India to put nursing homes legislation in place. Given the deterioration on standards in medical education, lack of regulation by medical council and rising expectations of the community it is difficulty to ensure quality standards in Indian health care system. Given this situation health insurance systems will have to deal with this complex issue of quality of care in years to come.

Role of regulators in India

The government has established Insurance Regulatory and Development Authority (IRDA) which is the statutory body for regulation of the whole insurance industry. They would be granting licenses to private companies and will regulate the insurance business. As the health insurance is in its very early phase, the role of IRDA is very crucial. They have to ensure that the sector develops rapidly and the benefit of the insurance goes to the consumers. But it has to guard against the ill effects of private insurance.

The main danger in the health insurance business we see is that the private companies will cover the risk of middle class who can afford to pay high premiums. Unregulated reimbursement of medical costs by the insurance companies will push up the prices of private care. So large section of India's population who are not insured will be at a relative disadvantage as they will, in future, have to pay much more for the private care. Thus checking increase in the costs of medical care will be very important role of the IRDA.

Secondly, IRDA will need to evolve mechanisms by which it puts some kind of statue in place that private insurance companies do not skim the market by focusing on rich and upper- class clients and in the process neglect a major section of India's population. They must ensure that companies develop products for such poorer segments of the community and possibly build an element of cross-subsidy for them. Government companies can take the lead in this matter and catalyze new products for the poor and lower middle class as they have done in the past.

Thirdly the regulators should also encourage NGOs, Co-operatives and other collectives to inter into the health insurance business and develop products for the poor as well as for the middle class employed in the services sector such as education, transportation, retailing etc and the self employed. This could be run as no-profit-no loss basis similar to the scheme pioneered by Indian Medical Association for its members. Special licenses will have to be given to NGO for this purpose without insisting on the minimum capital norms, which are for commercial insurance companies.

Ayushman Bharat

Background:

India is one of the developing countries in the world having 1.3 billion populations, of which 70% and 30% population lives in rural and urban area respectively. Currently, India in a state of epidemiological health transition i.e. India is facing dual health problem of communicable diseases as well as non-communicable diseases which remain a threat to health and economic security. This health transition is due to change in demography of population, global warming (globalization and urbanization), changes social and economic determinants of health. In India, many people are dying because of lack of access and poor quality of medical treatment. In this developing country, day by day the expenses on healthcare are increasing especially in people living in rural areas and in smaller urban towns and the annual health-related expenditures ranged from a few hundred rupees to a maximum of 10 lakh rupees. Also, in these areas the individual are travelling long distances to access and avail the comprehensive health care services.

Statistics

In India, the average annual total medical expenditure is about Rs.9,373.00 according to India Consumer Economy 360 Survey. Average annual expenditure on health is Rs 13,198 by household in towns (<1 million populations) while Rs. 11,387 medical expenditure for a Metros household and Rs. 6,371 for an underdeveloped rural household. It is seen that due to financial constraints, the 30% of the rural population did not avail any medical treatment and in most of hospital admission in rural or urban area, the people are paid by either by taking loans or sale by their assets. The India, the health profile report released by WHO in 2014 shows that because of high Out Of Pocket (OOP) expenditure, the annually 3.2% Indians falling below the poverty line and also the report pointed out that three forth Indians spending their entire income on health care and purchasing drugs.

Rationale

Insurance Regulatory and Development Authority (IRDA) said that in the year 2017, 76% of the population do not have any health insurance that put financial burden to family that results in high rate of out of pocket (OOP) expenditure on health. On the basis of above facts, the government of India announced a

Ayushman Bharat Yojana- National Health Protection Scheme (AB-NHPM) in the year 2018 was rolled out across all states/UTs in all districts of the country.

Goal

The aim of this programme is to providing a service to create a healthy, capable and content new India and it has two goals:

1. To creating a network of health and wellness infrastructure across the nation to deliver comprehensive primary healthcare services;
2. To provide health insurance cover to at least 40% of India's population which is deprived of secondary and tertiary care services. Under this scheme all types of medical treatments will be provided except organ transplantation for those eligible families.

Benefit

The benefit cover will also include pre and post-hospitalization expenses and there will be no restriction on the size and age of the covered beneficiary family. The payment for medical treatment will be done on package rate (to be defined by the Government in advance) basis. The package rates will include all costs associated with treatment and transactions of money to the beneficiary will be paperless and cashless. The beneficiaries can avail benefits in both public and empanelled private hospitals. The estimated cost for the scheme is about Rs.250 billion over 2018-19 and 2019-20 years for both centre and states. One of the core principles of AB-NHPM is to co-operative federalism and flexibility to states.

Beneficiaries

This scheme will cover poor below poverty line (BPL) families, deprived rural families and identified occupational category for urban families as per 2011 Socio-Economic Caste Census (SECC) data. This scheme will be covering over 10 crore families (approx. 50 crore citizens) across the country with a health insurance coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization.

The inclusion criteria are: families with only one room with kucha walls and kucha roof, households without shelter, destitute, living on alms, manual scavenger families, primitive tribal groups, legally released bonded labour, families with no able-bodied adult member; SC/ST households, families with no adult member between the ages of 16 and 59, to female-headed households with no adult male member between the ages of 16 and 59. For urban areas, 11 defined occupational categories are recognized.

Implementation of AB-PMJAY

AB-NHPM is being implemented through on-going centrally sponsored health insurance schemes like Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS). This insurance scheme would provide strength to the poor and deprived classes in the society which could not afford secondary and tertiary care. Beauty of the scheme is that the beneficiaries can avail of services anywhere in India i.e. a eligible card holder family from Haryana can get surgery done even in Tamil Nadu. Ayushman Bharat scheme will lead to timely treatments, improvements in health outcomes, patient satisfaction, improvement in productivity and efficiency, job creation thus, leading to an improvement in the quality of life.

This Yojana is implemented through Health and Wellness Centres that are to be developed in the primary health centre or sub-centre in the village and that will provide preventive, promotive, and curative care for non-communicable diseases, dental, mental, geriatric care, palliative care, etc. These centres would be equipped with basic medical tests for hypertension, diabetic and cancer and they are connected to the district hospital for advanced tele-medical consultations. The government has aims to set up 1,50, 000 health and wellness centres across the country by the year 2022.

The strategies to implement the AB-NHPM are:

 At the national level to manage, an AB- NHPM is in place. States/ UTs implement the scheme by a dedicated entity called State Health Agency (SHA). They can either use an existing Trust/ Society/ Not for Profit Company/ State Nodal Agency (SNA) or set up a new entity to implement the scheme.

 To ensure that the funds reach SHA on time, the transfer of funds from Central Government through AB-NHPM to SHA may be done through an escrow account directly.

 States/ UTs can decide to implement the scheme through an insurance company or directly through the Trust/ Society or use an integrated model.

 State Governments are allowed to expand scheme both horizontally and vertically. They are also free to choose modalities of its implementation. They can implement through insurance company or directly through Trust/ Society or a mixed model.

Impact

This scheme will have major impact on reduction of OOP on ground of:
1. Increased benefit cover to nearly 40% of the population, (the poorest & the vulnerable)
2. Covering almost all secondary and many tertiary hospitalizations.
3. Coverage of 5 lakh for each family, (no restriction of family size or age)

Further Readings

Jütting, J. (2000) Do mutual health insurance schemes improve the access to health care? Preliminary results from a household survey in rural Senegal.

Jütting, J. P. (2004) Do community-based health insurance schemes improve poor people's access to health care? Evidence from rural Senegal. *World Development,* 32 (2), 273-288.

Kanchebe Derbile, E. and van der Geest, S. (2013) .Repackaging exemptions under National Health Insurance in Ghana: how can access to care for the poor be improved? *Health Policy and Planning,* 28 (6), 586-595.

Light, D. W. (2003) Universal health care: lessons from the British experience. *Journal Information,* 93 (1).

Mensah, J., Oppong, J. R. and Schmidt, C. M. (2010) Ghana's National Health Insurance Scheme in the context of the health MDGs: An empirical evaluation using propensity score matching. *Health economics,* 19 (S1), 95-106. NHIA (2012) *2011 Annual Report.* National Health Insurance Authority, Ghana.

Gumber A., Kulkarni V. 2000. Health Insurance for Informal Sector: Case Study of Gujarat. Economic and Political Weekly, Sep. 30.

Dholakia R. Economic reforms: Implications for Health Insurance. Presentation at One day workshop on 'Health Insurance in India'. Indian Institute of Management, Ahmedabad. Oct. 30, 1999.