Health Service System in India
Is Insurance the Way Forward?

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Universalising health coverage is the current goal of the health service system in India. Tax-funded insurance for poor families is the method chosen for attaining this objective. The Rashtriya Swasthya Bima Yojana was rolled out in 2008 for households below the poverty line, enabling them to access health services in the public and private sectors. However, experience from different countries shows tax-funded insurance systems work well only in settings where public provisioning of healthcare services prevails. State-funded targeted insurance schemes do not seriously mitigate inequitable access to health services in a fundamentally private healthcare delivery market.

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Attainment of universal healthcare access is the present goal of the Indian health service system. An insurance-based method of facilitating access to health services has been chosen as the method for attaining this goal. The government in 2008 launched the Rashtriya Swasthya Bima Yojana (RSBY), or the national health insurance scheme, covering all households falling below the state-mandated poverty line. It enlisted the services of the private and public sectors to cater for enrolled households. There further exists a commitment of expanding insurance to cover India's vast unorganised sector.

This article assesses the practicability of an insurance-based model for attaining universal healthcare access in India. It begins with a brief look at the nature of the health service system in the country, and the expansion of the private sector in the healthcare market in recent times. It then looks at the examples of different countries, which have adopted insurance-based models in their healthcare provisioning systems, followed by a section on the performance of the RSBY in India. It concludes with a mention of the US and Cuban health service systems to help gauge the pitfalls of an insurance-based model vis-à-vis adopting a primary care approach.

1 Insurance-Based Methods

India has one of the most privatised health sectors in the world. Decades of underinvestment and political indifference to the public health service system have led to a burgeoning of the private healthcare market in the country. The increased proliferation of the largely unregulated private sector in the past couple of decades has coincided with declining investments in the public health service delivery system in the country, as mandated by the structural adjustment policies of the early 1990s (Duggal 2011).

The private sector received further impetus to expand in the new millennium when the public-private partnership (PPP) model received official endorsement in the Tenth Five-Year Plan (2002-2007) to improve healthcare accessibility among the people (Raman and Bjorkman 2008). In 2008, it received even bigger encouragement with the launch of the RSBY. This government-funded insurance scheme for below the poverty line (BPL) families included private providers in the list of empanelled hospitals where enrolled households could avail themselves of treatment. Thus, though the scheme was financed by public money, both public and private hospitals could be approached for treatment. However, since a larger number of private hospitals were empanelled than public ones, it seemed to make them the preferred mode for delivery of services.

Looking back, the RSBY has been an important landmark for the health service sector in India. Its introduction signalled a change of intent by the government in its approach to the health sector. Rather than committing itself to improving public services to facilitate greater access to the population, it paved the way for the public to utilise private services and removed the affordability constraint that had previously hindered access to them.

Despite the seemingly sound rationale behind the scheme, reservations were expressed against an insurance-based model for improving access among the poor. But the government went ahead with it nonetheless. It was led by the high-level expert group on universal health coverage instituted by the Planning Commission, which recommended strengthening the public and primary healthcare network as an important means of attaining universal healthcare access, albeit alongside tax-funded insurance (GOI 2011: 20-29). It even put forth examples of countries such as Thailand and Sri Lanka, among others, which have performed better than India. In both these instances, it maintained that public provisioning of services was strong, which ultimately paved the way

for near universal access. A strong base of primary care services even in rural areas was the key to improving health outcomes in both these countries. Such a system mandated a higher level of public investment for it to be even moderately successful, and in both these instances the governments showed a strong political commitment to achieving their goal. Thailand spent 14.2% and Sri Lanka 7.9% of their total public expenditure on health in 2011, the report noted. The figure for India was 4.4% in 2011 (GoI 2011: 191).

Even if we examine the evidence of more countries with successful insurance-based health financing systems – be it in developed settings such as Germany, Sweden, and Canada or developing countries such as Costa Rica – it becomes obvious that equity in access seems to have been attained on the back of high levels of public spending and governmental provisioning of healthcare services and a single buyer for services. A strong regulatory mechanism to monitor functioning has also contributed to the making of an efficient system (Duggal 2011). Even in Thailand, where access is sought to be universalised through a tax-funded insurance-based system, the public sector still retains the responsibility of making available services to all sections of the people (GoI 2011: 132).

The Indian scenario could not be any more different. As mentioned, it is one of the most privatised markets in the world. Government spending on health at 1.2% of gross domestic product (GDP) is amongst the lowest in the world. Public health service provisioning is weak and has been marred by declining investments over the years. Lopsided investment has meant an undue burden on the tertiary sector in medical care. There is heavy reliance on the private sector for meeting the healthcare needs of the population, resulting in high out-of-pocket (OOP) expenditure. Of the total expenditure on healthcare, 71% is financed by OOP payments, leading to a high incidence of catastrophic payments, especially among the poorest income quintiles (Indranil 2011). Berman et al (2010) reported that in 2004, 6.2% of households fell beneath the poverty line due to the high cost of expenditure incurred in health service utilisation. It was to address this dire situation that the government selected the RSBY as a vehicle for improving the affordability of services among the poor.

2 Assessment of RSBY

This section provides a brief glimpse of the objectives of the RSBY, followed by a look at its performance, and its perceived success in meeting the goal of enhanced healthcare coverage among its targeted beneficiaries.

The RSBY was launched by the Ministry of Labour and Employment in 2008 for all BPL families. It provided them coverage for hospitalisation costs up to Rs 30,000 for five members of a family.[1] The primary objective was to provide financial security to enrolled households to prevent them from going into debt while accessing healthcare services. Reducing their OOP expenditure on healthcare was an obvious corollary, and by doing so it aimed to increase their access to health services, resulting in improved health outcomes among those enrolled (Selvaraj and Karan 2012). By bringing private health service providers under its purview, it also aimed to better the availability of services among beneficiaries, who may have previously suffered from its absence in their vicinity.

Despite its good intentions, numerous studies conducted on its functioning have highlighted discrepancies in its implementation. Beginning with enrolment, which has been irregular and is still some way off from being universal both across and within states (Narayana 2010), to reports of deceitful practices, including forced procedures and usurpation of entitlements by private practitioners (in instances with the connivance of insurance companies), much that is negative seems to have beset the functioning of this scheme (Bajpai and Saraya 2012). Another troublesome aspect of the scheme has been the low claims ratio among enrolled families, which has ranged from 0-15% in most districts, pointing to low utilisation. Its problems seem to have taken over its functioning despite it not even being a decade old, and it has begun to suffer from dwindling participation (Bajpai and Saraya 2012).

Strident criticism of the scheme has come from those against the continuing OOP expenditures of beneficiaries. Seshadri et al (2011) in their study of the functioning of the RSBY in Gujarat state that 85% of insured households incurred OOP expenditures while utilising healthcare services. In addition, there seems to be no marked variation in OOP expenses reported by beneficiaries and non-beneficiaries of the scheme. Selvaraj and Karan (2012) also report an overall increase in hospitalisation expenditure and a marked increase in the incidence of catastrophic expenditure among the two poorest income categories in the RSBY intervention districts in 2004-05 and 2009-10. Using consumer expenditure data from the 52nd and 56th rounds of the National Sample Survey (NSS), they claim that such an upward revision in expenditure points to failure of the scheme since it has not even met its basic objective of providing economic security to poor families utilising healthcare services.

The absence of a proper monitoring mechanism has proved to be a bane for the efficient and effective functioning of the RSBY. Yet this cannot take away from some very important concerns that it seems to bring with it. Conceived as a way of reducing inequitable access to healthcare among the poor, the targeted nature of the scheme opens it to the charge of excluding a large number of genuine beneficiaries. Also by excluding the above the poverty line (APL) population from it, does it mean to suggest that these people enjoy satisfactory access to health services? To assume that this population is somehow immune to catastrophic expenditure or already enjoys sufficient access is foolhardy. Exclusion of out-patient care is also an important lacuna of the scheme since this accounts for almost three-quarters of total OOP expenditure (GoI 2011: 70), and is more responsible for indebtedness than in-patient expenditure (Berman et al 2010). The financial risk protection that the RSBY speaks of is clearly incomplete and this indicates a mismatch between government policies and the needs of the population.

As indicated, there are growing apprehensions that the current insurance-based access system only serves as a means to use public money to fund private sector expansion and profiteering in the lucrative Indian healthcare market. This is not a very positive outcome since it means the limited amount of government spending that is made available to the health sector is being diverted to the private sphere rather than the public sector, which is where investments are more critically needed, in provisioning of primary care, particularly in remote and underserved areas.

Further, as stated, an insurance-based system has been shown to work well in settings where public provisioning and investment in healthcare is high. To expect the private sector to address issues of equity and availability of services, and be responsible for meeting the primary healthcare needs of the population, is unprecedented. In this regard, perhaps India could be guided by the examples of other developing countries that have adopted similar pathways to healthcare financing. Their struggles are illustrative of the difficulty that exists in achieving universal healthcare access with an insurance-based model in a milieu marked by a preponderance of private healthcare practitioners. The examples of Latin American countries such as Mexico, Colombia, and Chile, where this model failed to improve access significantly but resulted in heightened profits for their private sectors, should serve as a caution to us (Laurell 2010). Even the us, which has such a system, suffers from the malady of inequitable access.

3 US Model vs Cuban Model

We take a look at the contrasting healthcare delivery models of the us and Cuba. While the former is the prime exponent of an insurance-based system of access in a healthcare market, the latter has a strong public health delivery infrastructure providing universal coverage. The comparison, it is hoped, will help highlight the dangers inherent in an insurance-based model of access in a largely privatised set-up.

The us has the highest rate of healthcare expenditure in the world – in 2011, it spent 17.6% of its GDP on health. Yet its health outcomes lacked parity with the investment made (WHO 2012) and are marked by unequal utilisation rates across different class groups. In comparison, a middle-income country like Cuba is able to attain similar health outcomes at the aggregate level with a substantially lower level of investment in its health sector.

The primary reason behind this discrepancy is the difference in the healthcare delivery models of both these countries. The us healthcare market is made up of a large number of private medical healthcare providers, where access is facilitated by an individual's insurance package. Though public insurance is provided to certain sections of the people, including the elderly and low-income groups, the targeted nature of these governmental programmes has resulted in the exclusion of a large number of genuine beneficiaries. Those without insurance have to either defer utilisation or avoid the system altogether despite their need (Oberlander 2002). In contrast, the Cuban public health service system spent a mere 5% per capita of what the us did on healthcare in 2011, yet performed more effectively compared to its profligate counterpart. Financed and structured by the government, the health service system is one which provides equitable access to all population groups irrespective of their ability to pay for services. A strong emphasis on primary care as well as promotive and preventive health measures such as sanitation, nutrition, and housing have been held responsible for its success (Cooper et al 2006).

The contrast between the health service systems of us and Cuba is illustrative of the importance of the nature of the system and its delivery mechanisms in determining access and outcomes. The example of the us is critical as it shows that on its own an insurance-based system is not equipped to ensure universal access to health services without the buffer of a strong public provisioning health service system and robust regulatory mechanisms.

In Conclusion

In summation, it must be said that the move of the Indian healthcare sector towards a targeted insurance-based system of access by enlisting the services of the private sector seems misguided. Based on the above, it cannot be said to have been guided by the needs of the public that it claims to cater for.

Even if we concede that insurance is the way forward for universalising health access, to embark on such a route without strengthening regulatory systems or restructuring the health service system towards primary care and improved public provisioning is unwise.

NOTE

1 For more on the RSBY see http://www.rsby.gov.in/about_rsby.aspx

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