HEALTH INSURANCE FOR RURAL POOR IN INDIA

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ABSTRACT

Proper health care is a universal human right. Increasing healthcare cost make it very difficult for poor people to access the even basic health care facilities. Most of the Indians live in rural area. Majority of them are too poor to afford health care services by their own pocket. These people cannot afford general health insurance policies. In this paper, we discuss health insurance schemes that have been started for these people. We also discuss the challenges these schemes have. We also suggest the steps that can be taken to improve the penetration and effectiveness of these schemes for the better health management of rural and poor Indians.

Key words: India, Health, Insurance, Policies, Rural.

I. INTRODUCTION

Health care sector has made a lot of progress in the last few year .With the people becoming more aware of health needs they are also investing in the field of health care in order to save them from the burden of financial crisis. Health insurance can be explained as an agreement or commitment where a person buys health coverage by giving a fee called premium. There are lots of policies available in the market. These policies cover the spending on medical needs which includes the expenses of hospitals and doctors and also they pay for long term care. Health insurance has very strong base worldwide. But the health insurance market lags behind in India.

India with the vast population of 1.3 billion [1] has large number of people who cannot afford the costly health services. There are various reasons why the health access in India becomes difficult for the poor people. A large number of Indians which includes women and children in large proportion die every year due to lack of health facilities. The major proportion of Indian population lives in rural areas and they do not have proper medical facilities because 75% of specialized and better services are located in urban areas. Along with this the people living in rural areas are poor and are living below the poverty line so it's difficult for them to spend in costly medical services. Even if the medical services or medicines are available free it is not possible for them to travel as the nearest primary health care centres are located far from their villages.

II. RURAL INDIA HEALTH SCENARIO

Majority of rural India people lives below poverty line and they are not capable of affording the expenses on medical needs. Health insurance is a tough task for these people. The condition of illness not only deprived them from earning but also pushes them into deep debt. The overall expenditure on health in India is 4.1% of GDP [2] in which the government contribution is only 1%. With a low spending on health from government in thickly populated country like India force people to move towards the costly, unaffordable private sector. Today, India has most privatized health system in the world with 72% of health expenditure made in private sector that presently treats 78% of outpatients and 60% of inpatients [3]. If we talk about insurance than it has been estimated that only 15% of total Indian population is covered under it. To cope with the high charging medical needs a high number of people coming below the poverty line as they cannot meet the expenses made for medical needs. Health insurance can play a crucial role in preventing people from burden of debts. Insurance can provide them support at the time of emergency and needs. Indian government has

introduced many health insurance schemes for rural people during past years with affordable prices so that they can be covered by insurance without much burden on them. Insuring people can also leads to a better health access. Along with the government policies, several non-government organizations (NGO) also introduce many schemes for the people living below the poverty line [4].

III. THE RASHTRIYA SWARTHA BIMA YOJANA

The Rashtriya Swartha BimaYojana (RSBY) is one of such schemes of Indian government in the year 2008 which serves people below the poverty line [5]. At the national level it is controlled by the Labour Ministry and at the state level it comes under both Health Ministry as well as Labour Ministry. On the funding division the contribution from centre is 75% and that of state is 25% [6]. The 12th five year plans document shows that about 33 million families are under it and 4.3 million people used hospitalization services of RSB. The state government chooses a private or public insurance company for giving health insurance to the aimed groups through bidding. The goal of RSBY is to issue security to the people of BPL households from financial stress arising out of health disturbances that involve hospitalization [7]. Regime has even fine-tuned the package rates for the hospitals for a sizably voluminous number of interventions. The recipients of RSBY are insured for hospitalization coverage up to Rs.30, 000/- which covers many diseases that required hospital care. From the day one pre-subsisting conditions are covered and there is no limit for age. This insurance covers up to 5 members of the family which includes the head of the family, spouse and three dependants. They have to pay only Rs. 30/- as registration fee as Union and State Governments pay the insurance charges to the insurer selected by the State Government on the basis of a competitive auction. In this scheme the enrolment is done through smart cards [8]. The compensation of the insurer depends on the number of Smart Cards issued, i.e. households covered. Each contract is designated on the substructure of an individual district in a state and the insurer accedes to set up an office in each district where it operates. The number of insurer is more than one in a particular state but in a single district only one can operate at any given point in time. An electronic list of appropriate BPL households is made available to the insurer for the specification purpose. Before the enrolment this list is posted in each village and advertisement is done in advance for the date and location. Mobile stations are set up at local centres (e.g., government schools). These mobile stations are having the hardware which is required to amass biometric information (dactylograms) of each member of the household covered and to print smart cards with a photo. On the spot when the beneficiary has paid the 30 rupee fee, they are provided with smart cards and pamphlets which contain information regarding the scheme and list of hospitals [9].

The process is not very long it merely takes about ten minutes to complete. The presence of three individuals is compulsory at each enrolment these are an officer at district level of state government, a dealer of smart card and the representative of insurance company. At the end of the day of enrolment, issued smart cards list of each household is sent to the state government and then it's centralized at the district level. This scheme does not cover the OPD but the consultation is free. In a condition when no hospitalization required but expenditure is there then beneficiaries have to pay it themselves [10]. Some of the common rejections are:

- State that do not need hospitalization
- Congenital external diseases
- Illness caused by alcohol and drugs
- Procedures including fertilization and infertility
- Vaccination
- Suicide
- Naturopathy, Unani, Siddha, Ayurveda

The RSBY scheme is made in such a way that it should become an ideal scheme. It has the following features;

a) It gives the clients freedom for selecting hospitals both either public or private.

b) The insurers are also paid on the number of families enrolled so they take interest in covering maximum number of families.

c) Hospitals are also paid on the numbers of client treated; even the public hospitals get benefits from it. d) The government is also on profit side as by paying only 750 Rs per year per family it is providing health facilities to large number of people.

e) Smart techniques are used in this scheme such as biometric information and smart cards are issued after it.

f) These smart cards are acceptable throughout the country for the allotted hospitals so this is helpful for those poor people who keep on moving in search of livelihood.

g) Its secure and free from fraud as only the card holder can be considered as eligible no one other than him can claim for the services.

h) The scheme is based on online process and no need of paperwork required. However in spite of so many advantages cover in the schemes there are certain negative aspects of this schemes, several surveys shows that a large number of cardholders are not aware of the benefits of the scheme.

They even don't know about the allotted public and private hospitals. These drawbacks can be overcome by educating people and making publicity. Before this RSBY scheme many schemes were introduce by Indian government. The national Universal Health Insurance (UHI) [11] scheme was one of the schemes which were launched by the Indian government in July 2003. The aim of this scheme was to overcome the financial spending on states for health care (as health is a state subject) by insuring the poor class people in their specific states. The goal was to cover maximum number of poor people under it [12].

The following are the features of this scheme:

a) It is introduced for people living below the poverty line.

b) It gives the payment up to Rs 30,000/- in the hospitalization cases for the entire family

c) If death occur due to accident then compensation is Rs 25000/

d) If they have loss earning then compensation was Rs 50/ per day for 15 days.

e) The beneficiaries have to pay Rs 200 individually, for a family of 5 it is Rs 300 and Rs 400 for 7 members in a family.

The target of the policy was to cover 10 million poor people during the first year. But the target was unable to cover such a large number and only 4 lakhs people were covered in which 48% were the people from rural areas. It was failed to meet the target number of population and also in insuring the poor people i.e. the below poverty line people. Along with it the claim was made by less than 1% people only [13]. After a year of its introduction some changes were brought in this policy. The subsidy amount was increased and it was only confined to poor people. After this change some positive result were observed but this scheme was not successful. The reasons for its failure are:

a) There were no efforts made to propagate it and for fulfilling the aim many officers pay premium through false identity.

b) It was not possible for the poor people to pay the full premium at one time.

c) Lots of paper work required.

d) Difficult to find out the eligible family.

e) Problem occurs when insurance company refuses for the renewal of contract. Further research is needed for this scheme and it's still in the testing state. As a financial supporting scheme it is attractive to the poor, but it is unable to

cover large group of people. For this scheme to get successful both the state as well as local government should come together.

IV. HEALTH INSURANCE THROUGH NGOs NGOs are the nongovernmental organization which specifically works for the week sections of the society it includes the rural people, women, children, handicaps without any profit intensions. Some of these NGOs are working for the health upliftment of poor people they are providing community based insurance to these people for getting good quality and affordable healthcare [14]. The necessity for involving NGO's in the health insurance sector of India is due to many reasons.

First of all it is already discussed that government contribution in health sector is very less as a result people are devoid of getting cheaper health services, on the other hand a large expenditure is made by private sector which is not easy to afford due to the high spending or out of pocket payment. Secondly, the quality of services provided in the public sector is not up to the standard. Thirdly, the insurance system is not so popular among poor people, the majority of people are not aware of the schemes. So involving NGO's it will be great help to rural poor people as well as government. NGOs contribute 5% of health care to the Indian population. They constitute a predominant part of the private health finance contributed by the voluntary and charitable organization of India.

They are the reliable source of health services for poor Indians. SEWA is one of the NGO based health insurance services [15] in Ahmadabad, Gujarat started in the year 1992. It was for the poor people which include the self-employed women and their husbands with the age limit ranging from 19-58 years. They have to pay Rs 20 per year for premium and they can also get membership through fixed deposit [16]. It includes the cases of delivery, pre-existing disease, chronic diseases which have occur recently, HIV/AIDS and its complications, disease from abuse of drugs and alcohol. Previously, SEWA's health insurance was managed together by SEWA and the United India Insurance Company. As per GIC (Government Insurance Company) the scheme covers only allopathic, inpatient care (it does not include gynaecological illnesses, delivery care, and occupational illnesses).

SEWA gets full control of the medical insurance component in 1994. Further in the next year it has enlarged it services and covers diseases from, occupational causes, obstetric and gynaecological problems and also homoeopathic or alternative medicines. To save itself from calamity in 2001, SEWA stop running the scheme alone and started purchasing it from the National Insurance Company (NIC) although it does not change its policy features. To attract people for becoming lifelong members through fixed deposit so the interest of these deposits can be used to pay the premium, special package is given to these life term members like one-time payment of Rs 300 for delivery and post-partum care, dentures Rs 600 payment for one time and hearing aids payment of Rs 1000 for once. SEWA also provides coverage for the first hospitalization related to HIV/AIDS. One of the main goals of SEWA is to support the AIDS/HIV patient by providing an affordable treatment in which there is outpatient cover and charges for first hospitalization [17]. Although SEWA is having so many beneficial features but along with it its having limitation for hospitalization as for each chronic disease hospitalization it will only refund once, in spite of how many years the insured stays with the scheme. Other schemes for poor and rural which are under the control of NGOs are listed below:

a. KKVS Madurai, Tamil Nadu started in year 2000 includes the insurance fees of Rs 150/ for a family and covers up toRs 10,000 per family each year.

b. ACCORD Nilgiris, Tamil Nadu started in 1991 for Adivasis at the premium of Rs 20 per year and gives benefits of hospitalization cover up to Rs 1500/ per year.

c. Sewagram, Sorghum Health Scheme Wardha, Maharashtra introduced in 1978 under this scheme villager has OPD as well as IPD coverage with the payment of Rs 48 for landless family.

d. Seba Calcutta, West Bengal began in year 1982 .The members have to pay Rs 105 per annum with the hospitalization coverage of Rs 8000.

e. RAHA Jashpur, Chattisgarh started in 1974. In this scheme members are not paying in cash inspite of cash they are giving rice as insurance fees. In return they are getting free OPD and free hospital care up to Rs 1000/. The schemes which are managed by the NGOs are not only providing health insurance but are also work for the other services which are helpful in the development of the poor people. These services include providing education, make them aware of the hygiene and guide them about the family planning, and micro saving and crediting. Other goals include supporting the people who are suffering from life threatening diseases(AIDS/HIV), child development program, women support programs etc.

IV. **RECENT STUDIES ABOUT RURAL INDIA HEALTH INSURANCE**

Devadasan et al.[18] study showed that in Indian health system is mainly funded by out-of-pocket payments. It is estimated that more than 80% of population spend in health services from their personal expenses. Only 3% of the population, especially in the formal sector, is getting some type of health insurance. Community Health Insurance (CHI) schemes are started with the collaboration of some Indian Non-Governmental Organizations (NGOs) within their existing development programs. This research describes the main features of the design and functioning of a selection of 10 CHI schemes and presents a brief overview of the current landscape of CHI in India. This scheme mainly involves the poorest and most unprotected households in Indian society— scheduled tribes, scheduled castes and poor women. There are three CHI management models. In the first model local NGOs serve as both insurer and the provider. The second model shows that NGO is the insurer but it is not providing care by itself but its purchasing it from a private. In the third model, the NGO is not acting as a insurer neither its providing health care but the NGO, on behalf of a community, links with an insurer and purchases health care from a provider. Both primary and secondary cares are included in the package and most of the providers are in the private sector. Most of the schemes require external resources for financial sustainability.

They suggested that these schemes should have reasonable premium and government support so that more people can use these schemes. Dror et al. [19] studied how much Indian poor persons are ready to pay for the medical insurance. This research was carried out in India in the year 2005 with 3024 household (HH) in seven location. About two-thirds of the sample agreed to pay at least 1% about half the sample was willing to pay at least 1.35%; 30% was willing to pay about 2.0% of annual HH income as health insurance premium. Jain et al.[20] studied the acceptability of health insurance and willingness to pay for these health policies. They conducted a mixed methods study of 33 respondents located in 8 villages in southern India. Those who were interested in health insurance policies were willing to pay Rs. 1500 ($27) as the model annual insurance premium. The study suggests that the entry of community health insurance programs in rural India will require education of the consumer base, careful attention to premium rate setting, and deeper understanding of social networks that may act as financial substitutes for health insurance. Ourooj [21] present the challenges and opportunities for Indian health insurance sector.

IV. CONCLUSION

Health is declared as a Universal human right that means every person on this planet should have equal access to health. All the persons whether they are poor or rich should have the medical facilities available to them. Health Insurance can give them support in getting medical facilities at minimum cost. The poor and rural people can take the advantage of health insurance which is an expanding field today. It is important that the importance of health policies should be explained to rural people and also they should design in such a way that they find it beneficial for themselves.

Along with it the healthcare worker should also be well qualified and trained. They must have full knowledge of schemes and have the quality to explain and convinced them for health insurance. The most essential thing to be done in order to succeed the health insurance in the country is to establish well equipped hospitals along with the fine professional in rural areas as it will be easy for rural people to access the health care facilities. It is also important that the government should increase its spending on public health care sectors, so that it better healthcare facilities can be achieved. For maximum covering of rural population under insurance the premium should be low and do not create any financial burden on them. The term and conditions of the policy should be easy and simple. By following the above points it will be easy for poor and rural people to access health and lead a healthy life.

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