VIABILITY OF A NATIONAL HEALTH INSURANCE FOR INDIA: A COMPARATIVE ANALYSIS

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MASTER OF PHILOSOPHY

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Certificate

This dissertation entitled *"Viability of a National Health Insurance for India: A Comparative Analysis"* submitted in partial fulfilment of the requirements for the award of the degree of Master of Philosophy of this university has not been submitted for any other degree of this university or any other university and is my original work.

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Abbreviations

ACCORD	Action for Community Organisation, Rehabilitation and Development
AMS	Adivasi Munnetra Sangam
AFL	American Federation of Labour
AMA	American Medical Association
CBHI	Community Based Health Insurance
CCF	Co-operative Commonwealth Federation
DPP	Democratic Progressive Party
ESI	Employee State Insurance
GDP	Gross Domestic Product
GFL	General Federation of Labour
GIC	General Insurance Company
GP	General Practitioner
HDI	Human Development Index
HMO	Health Maintenance Organisation
IMR	Infant Mortality Rate
IRDA	Insurance Regulatory and Development Authority
KHC	Kupat Holim Clalit
KMT	Kuomintang
LIC	Life Insurance Corporation
MCO	Managed Care Organisation
NSIA	National Social Insurance Agency
NGO	Non-governmental organisation
NHI	National Health Insurance
NHS	National Health Service
NIC	National Insurance Company
RCMS	Rural Co-operative Medical System
SEWA	Self-employed Women's Association
SHI	Social Health Insurance
UIC	United Insurance Company
US(A)	United States (of America)

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Introduction

Introduction

Public Health is organised action by the state to provide better health conditions and services for the population at large. It is multidisciplinary in nature where many professional disciplines are involved. It is the outcome of the basic minimum welfare and technology. It includes preventive, promotive, curative and rehabilitative aspects of health. The characteristic of public health is its collective organised system of provision that incorporates ideas of social justice and equity. No one can be denied basic services, these are to be provided irrespective of ones paying capacity. This is the principle of universality that it addresses i.e. its applicability to entire society. The State is the arbitrator of collective action. It opens up avenues and needs for community participation and collective action and does not leave responsibility to the individual. The basic needs that are included in public health are inputs like gainful employment, food security, access to water supply, sanitation, housing and health services.

Health services are among one of the many inputs required to improve health of the population. This delivery system includes finance, the infrastructure, hierarchy of providers, technology of equipment and drugs, medical education, training, and research (Qadeer, 1985). Health services are inclusive of preventive, promotive, curative and rehabilitative services. Ideally a health services system should be guided by principles of equity, universality and comprehensiveness thus ensuring that services are available, accessible and responsive to the needs of the population. The State can play a major role in fulfilling these principles through its role as the financier, regulator and/or provider of health services.

Efficiency, effectiveness and equity are the three terms that are used frequently to explain the working of health services system. One needs to understand these concepts in health services in the market vs. state debate. Efficiency would be defined as a measure of how well resources are utilised to achieve a given effectiveness of service, for e.g., the number of immunisations provided in a year as compared to an accepted number. On the other hand, profit oriented interests would view efficiency as services being rendered with the

minimum of financial inputs and guarantee of profits. Effectiveness could be defined as the extent to which the underlying problem is prevented or alleviated, the ability to deliver interventions which would improve the health status. The ultimate measure of effectiveness would be a reduction of morbidity and mortality. Equity is the ability to allocate interventions according to needs and expected health benefits. The state would deem it necessary to provide for those who are neediest in terms of ill health and poverty, irrespective of ability to pay.

Choices for financing health services have an impact on how fairly the burden of payment is distributed in a society. The choice of financing also reflects the socio-economic political environment of the state. Governments are normally involved in financing of health services because private markets for health services are unable to fulfil the principle of equity. The financing of health services was always a concern of governments but has been more in the spotlight during the past two decades. The recent changes in financing health services globally have been an outcome of economic changes and political choices. The world economic crisis of the late 1970s and 1980s which was precipitated in part by oil price increases, resulted a number of developing countries to give in to the process of economic stabilisation and structural adjustment. The first to be hit was the social sector. User fees in public provisioning, insurance systems, allowing markets to enter the health services sector have all been since introduced. The increasing cost of health services and paucity of state funds and the state's retreating role in provisioning/financing of health services has been a concern for many health planners and major approaches to financing health services have been debated. In this context we explore various approaches to financing health services.

- How is the health service system financed: Who pays and what are the costs incurred are crucial policy questions. The total cost of health services is the aggregate expenditure incurred by society for financing and provisioning of health services.
- Who provides services? Is this exclusively a state function, or is there collaboration between the state and private sector?

The major approaches to financing health services include:

I). ***Mechanisms that are used for cost recovery or revenue generation***:
General taxation is a mechanism where revenue is generated by the state through the tax system.

User charges are used in developing countries by state-run hospitals. This kind of revenue generation as suggested by World Bank has made even government facilities of health care inaccessible to all as the lower income people are unable to access such services.

Fee for service- Private health services charge fees. Such direct system of payment is regressive, as there is a large section of the population who cannot make such out of pocket payments.

Loans and Grants are ways of providing resources. Grants may come in the form of technical assistance, free drugs but they are limited. Loans are also given with the condition that repayments are made. This further increases the debt burden.

II). ***Health Insurance systems***: Health services of a preventive and curative nature occurring in any individual's life lead to financial commitments that many persons cannot meet from their own resources or those of their family. Insurance systems operate on the principle of risk sharing. The concept of insurance arises when risks and resources are pooled among a larger group of persons with different probabilities of requiring care, the security of each individual is enhanced. The larger the group the higher are the chances that funds pooled together will be sufficient to pay for the service that each member is likely to require.

Insurance systems could be voluntary or compulsory. A compulsory system would include better coverage of people with high risks and low risks but must be progressive to fulfil principle of equity. A progressive system would involve collective financing in

such a way that there is transfer of resources from the richer to the poor. Voluntary systems might lead to adverse selections. Within insurance systems, there are a number of alternative combinations, with variations of the type of cover or benefits being provided- in-patient or out-patient cover, possible exclusion of chronic conditions, coverage may or may not include preventive services and so on.

National Health Insurance (NHI) is seen as a progressive system. When health services are seen as a right for whole of the population there are several ways in which the state can ensure that there is universal coverage of health services that are comprehensive and equitable. This could be through direct provisioning of health services by the state or where the state acts as the financier, regulator of health services and allows a public/private provisioning of health services and ensures that health services are accessible to all. The State acts as the insurer for its citizens and ensures compulsory insurance to all. This kind of health financing by the State must replace funds obtained from regressive sources with revenue from more progressive ones. It abolishes unaffordable premiums and out of pocket expenses for medically necessary services. Premiums are based on income rather than health status. One of the strongest arguments for such publicly financed systems is based on considerations of equity, universality and comprehensiveness. These principles can be fulfilled when insurance systems are made to be compulsory and progressive.

Social Health Insurance (SHI) systems pay for health services through contributions to a health fund or is financed through wage taxes. The most common basis for contributions is the payroll, with contributions from both employer and employee. Social health insurance is based on employment and deductions made on income. The health fund(s) is usually independent of government but works within a tight framework of regulations. But the main disadvantage of social insurance financing lies in the problems of ensuring coverage for workers in agriculture and the informal sector. When people move from formal employment to self-employment it becomes more difficult to measure income. There is an element of inequality in the system as people are insured on the basis of organised employment and not based on citizenship. In developed countries it is at time

used synonymously to NHI where rates of organised employment is high and large sections are covered.

Private Health Insurance systems rely on purchase of premiums. It results in a highly stratified system. Private health insurance is based on risk. The premium payable depend on various factors – on the type of cover required, it will also depend on the present health status of the person, pre-existing conditions and the ability to pay. This is estimated either on the basis of proxy indicators, such as age, occupation and life habits or as a result of medical examination. But systems as this kind are regressive. The higher the risk the more the premium which becomes unaffordable for many. Therefore those in greater need will need to pay the higher premium. The poor who remain most vulnerable are left out of the system. Private health insurance rarely spreads the risk between individuals who have different likelihood of illness. It is mostly voluntary and is profit oriented and there are questions of equity, universality and comprehensiveness of services.

There are some concepts of health insurance that are an outcome of market failures under a private insurance system: The unregulated private insurance system suffers from adverse selection by consumers and risk selection by insurance companies. *Adverse selection* arises because consumers have more knowledge of their own health and their own propensity to utilise health services. These rational buyers select the health insurance plan that gives them the greatest benefits. For example, consumers who frequent hospitals will take full hospital coverage. If this insurance plan raises its premium rates then consumers who feel the need to use fewer hospital services will not purchase insurance. Therefore, adverse selection discourages risk pooling. A person will select an insurance plan that closely reflects the expected out of pocket expenses for that risk group. In order to compete the insurance plans will not voluntarily pool high and low risks together. The premium for low risk population will be lower than that of the high-risk population and thus poor, disabled, aged can rarely be part of such a system as they mostly live in morbidity and therefore are considered as 'high risk cases'. This is where *risk selection* takes place by insurance companies. Private insurance creates distortion in consumers'

demand for health services. This is termed as m*oral hazard* where the protected/insured person exploits benefits unduly to the disadvantage of others or the scheme as a whole, without having to bear the financial consequences in part or in full. This tends to increase the rate of inflation in health expenditures. These market failures occur when an insurance system is voluntary rather than compulsory (Hsiao, W.C, 1995).

Community financing as a method of raising finance at the community level was suggested by UNICEF under its Bamako initiative. Community financing is argued to have the advantage of providing participation at the community level but it is restricted to the local level. China had implemented community financing in health care by 1950s but UNICEF under the Bamako initiative suggested raising finance at the community level much later in 1987. The focus then was on implementing this kind of a system in sub-Saharan Africa and now this is being experimented in communities across countries as an alternative to health financing. The resolution invited Member States to:

- Encourage social mobilisation initiatives to promote community participation in policies on essential drugs and child health at district level:
- Ensure regular supply of essential drugs of good quality and at lowest cost, to support the implementation of PHC;
- Define and implement a PHC self-funding mechanism at district level, especially by setting up a revolving fund for essential drugs.

The resolution also sought the collaboration of UNICEF, WHO and other organisations concerned. Since then, number of countries have initiated community financing at the local level successfully by experimenting on different kinds of financing structures, coverage and benefits. India too has experimented and implemented some successful cases of community financing.

There are different ideological positions that inform the various approaches to health financing, regulation and provisioning. When seen as a *right*, there is clearly a central role for the State. The State is committed to financing and provisioning of health services to all irrespective of paying capacity and plays an important role in defying market forces. The *Marxian* ideology, for one, would view health as a right. For example, China

during the time of revolution would be the ideal example that viewed health as right. The political ideology was towards building a socialist State through mass movement and establishing a classless society. This was achieved through land reforms, giving equal opportunities to all through process of collectivisation and bringing down inequalities in society and in turn securing the health system, part of which included providing accessible, responsive health services to all. In such a case finance, provision of services, administering health services would be by the collectives and the State. Under such an approach State would be concerned with issues of equity and justice in general and the same principles get applied in making of health system and health services system. Health is viewed as an integral part of the development process.

The neo-classical school is divided over the relative merits of the market and state in achieving objectives of equity and efficiency in the allocation of health services resources and distribution of health services. These two orientations are the *paternalists* and the *liberals* (Veeranarayana, 1991). The *paternalist* ideology within a capitalist framework would see health services as a public good and hence a right. This is synonymous to the Keynesian ideology of welfare state that came about post Second World War as an outcome of capitalist crisis. Paternalists believe that health services is a public good and argue in favour of free provision of public and personal health services by the State. Public health services according to them are synonymous to preventive services that include clean water provision, sanitation, pollution control, communicable disease control programmes. Paternalists support their arguments through concepts of externalities, joint consumption and the irrationality of the concept of consumer sovereignty. Apart from market inefficiency in health services, paternalists consider state intervention in health services necessary to reduce income inequalities in the access to health services. From an investment viewpoint, State could perform different roles and intervene in various ways to make health services accessible to all. The State could finance and provide health services as in U.K. Market is allowed to play a minimal role in provisioning and financing though the State takes the greater responsibility. On the other hand, the State could take up the role of the financier, administrator and regulator and leave the provisioning of health services to the private. This is seen in the Canadian health services

system. Canada's incremental journey to national health insurance led to the view that health care was a public good, or even a human right. The larger role is by the State that ensures that health services are accessible and available to all.

As consumption, health services are seen as any other commodity where role of the market is greater than that of the state. This coincides with the *liberal* viewpoint where markets are given the autonomy in every sector to fulfil the process of demand and supply. This laissez faire policy calls for minimising state intervention. This view therefore sees health services in no significant way different from other economic goods and services. The liberals are not opposed to state intervention in public health services but they argue that personal health services should be left to the market because individuals are rational buyers. The United States system of health services is an example of this viewpoint. Financing of health services is private and out of pocket, provisioning is strictly private and the system is regulated and administered by privately run organisations called 'managed-care organisations'.

How a country conceptualises its health services system has to be largely understood within the broader framework of the socio-political context. Within each of these viewpoints of right, investment and consumption which have been portrayed as existing in isolation, no state is likely to take a simplistic view but broadly these ideologies need to be understood.

Research Question

What methods are available for financing health services? For this purpose we will review the health insurance systems of some developed and developing countries. In addition the Canadian model of national health insurance (NHI) will be examined in detail. Based on an analysis of the review we wish to examine the viability of a NHI scheme for India.

Hypothesis

The NHI is a viable model for India

Rationale

The State's retreating role in provisioning and financing of health services has been a major concern debated by public health experts in the last decade (1990s onwards). The core issue of concern during this period has been on financing health services. This concern has been an outcome of the cuts made on social sector spending by the state. Investments on the so-called 'soft' social sector have been considered 'unproductive'. The liberal view of increasing privatisation and introduction of market principles in all sectors, including the social sector, has been seen as the solution to all ills. For health services financing, tapping households for payments, introduction of user fees in public hospitals and devising mechanisms for risk sharing through private insurance schemes have been introduced in a big way. The assumption that has been made is that people are willing to pay for health services and therefore the market model is efficient. However, available evidence suggests that with increased privatisation of health services and introduction of market principles in public provisioning, more number of people are unable to access health services. Physical, economic and social access is integrally related to burden of health care. This burden depends on the nature and duration of illness, individual or family income, position of individual or family in society, availability of health services, external sources of financing like health insurance or employer support, and the loss of income of the people during periods of ill-health. Health services in the present context are definitely not guided by principles of universality and equity.

History of health services in India goes back to British India where the concern was more for armed forces and the British civilian population. The Bhore committee was the first insight in to the dimensions needed for a comprehensive health system in India. This was the time when the world was debating in favour of a welfarist state based on the Keynesian ideology. Independent India was driven by this viewpoint. The logic of early planners to have a nationalised system of health services was motivated largely as a means of containing cost and regulating care. It was well recognised that everyone had the right to access health services irrespective of one's paying capacity. The 'insurance function' of sheltering people from having to incur costs was sought to be provided by

state intervention by either providing free services or at a reasonable and affordable costs. By 1970s all the commitment towards providing comprehensive, universal and equitable health services had waned. This was a result of the fiscal crunch that countries all over the world began to feel as a result of the oil shock. There was reduction in public spending and markets were allowed to enter welfare services. In India, organisation and utilisation of health services differs across states and in general is provided by the private, public or voluntary organisations, the greater part is provided by the private. With the health sector reforms in 1990s, market has been allowed to enter health services in a bigger way. This has resulted in an increase and mushrooming of private health services everywhere and in turn there has been a further increase in out of pocket expenses that has put the burden of costs not only on the poor but also on the middle class. Utilisation of health services shows inequities across states and income groups that are directly related to availability and accessibility of health services. Over three-quarters of health expenditure is private. This inability of government to identify financial resources in order to lessen the burden of health services costs has made health services financing an important policy concern. The recent budget (2003-2004) does talk about a rural health insurance initiative but it needs to be seen how far it will be realised.

In this context it is essential to study the viability of a National Health Insurance model. One has to obviously keep in mind the organisation and structure of health services in India. This model has not been seriously examined under the belief that it would be beyond the means of a poor and large developing country. Issues like what kind of coverage of services would such a system provide, can such an operation of a NHI system perform the function of a watchdog for the health services system and hence take into account the principles that should guide the health service system, are important to consider.

Objective of the study

1) To examine the evolution, changes and working of various health financing systems with a focus on health insurance in selected countries.

2) To understand the emergence and working of the Canadian model of National Health Insurance.
3) To examine the viability of a NHI model in the Indian context through a comparative analysis given the present political and socio-economic scenario and existing systems of health financing and health services.

Research Design

The study is essentially based on a review of studies of health insurance schemes in developed and developing countries. A few countries have been chosen with varied socio-economic and political milieus in order to enrich the analysis. These will include among developed countries: United States of America (USA), Germany, United Kingdom, France, Chile, Israel, South Korea, Taiwan and among the middle income and developing countries: China, Thailand, Brazil. These countries have been categorised into developing and developed according to their ranking in Human Development Report (HDR), 2001. A specific focus on Canada is undertaken in order to get an insight into the emergence of NHI, its philosophical basis, and the administration of the system.

Framework of analysis

To examine the country experiences, the analytical framework will attempt to use five concepts to understand the development of insurance systems:

Class: According to Marx, Class is defined as a relationship between two categories of people who need each other, in which one category dominates and economically exploits the other. This definition refers to the major economic relationship in a modern industrial society. Class status has additional correlations like common ideology, availability of resources, family links, access to government and other networks of associates and extent of accumulated wealth. Class consciousness is the psychological factor that helps to identify one's position in the economic production process. An alternative to the concept of class includes occupational categorisation. For example, the concept of profession in the instance of physicians plays a major role in the explanation of a physician's behaviour. The concept of profession is a unifying factor for physicians across various categories.

Interest groups: This is different from class. These are groups of people with shared interests who negotiate with the power structure. Their main mode of action is not to engage in a struggle but to obtain satisfaction of their needs from an existing system through lobbying or advocacy. The professional groups and business interests play a role and influence in shaping social reform as organised groups.

Social Movements: This can be defined as collective challenges by people with common purposes and solidarity in sustained interactions with the elite, opponents and authorities. There can be variation in such movements. It could extend from marches to something like the civil rights movement as in the USA. Collective action is strengthened by five factors: division in the opposition, an organisational direction, incentives to participants and availability and mobilisation of resources.

The State: State is defined as "a body of people occupying a definite territory and organised under a government, especially a sovereign government". A State can hold certain ideological positions: could be liberal or market oriented, paternalist or welfare oriented or could be socialist. Governmental programmes, in sectors such as health, may address the needs of the entire population, of a certain interest group or a certain class.

Political parties: There is much variety among countries in the role and structure of party systems. At one extreme, there is a single party system with a two way channel- to transmit views of citizens to the party and to inform citizens of their role in fulfilling government policies. At the other end, there would be great number of parties centred on specific issues. Some countries have two, three or even a multi-party system (Jaheil, 1998).

The experiences of the countries are described and analysed with variations in development, working and changes in their health insurance systems. The process of analysis will take a historical approach and through the above concepts will seek to understand the rise of a particular kind of financing system, be it a private, social or a national health insurance system.

The *comparative framework* of analysis deals with the following issues:

- The political system of the countries that gives a conducive environment to debate in favour of a NHI system.
- The mechanisms of financing involved, organisation of health services, provisioning of health services (public vs. private) and the working of the health insurance system.
- Coverage of health services.
- Regulating private health services.
- Concepts of equity, universality, comprehensiveness.
- Pressure of reforms (privatisation and its implications on equity).

The study will include the following chapters apart from the Introduction:
Chapter I and II give a review of country experiences. Chapter I is *Financing of Health Services: Some Country Experiences* and Chapter II focuses on Canada and is titled *National Health Insurance: The Canadian model.* The third chapter gives *An Overview of Health Financing in India.* The discussion chapter on *Viability of a National Health Insurance for India* examines the possibility of a NHI in India.

Chapter I
Financing of Health Services: Some Country Experiences

Financing of Health Services: Some Country Experiences

This chapter deals with experiences in health financing with a focus on insurance systems in various countries around the world. The objective of reviewing these experiences is to understand the development and working of different types of health insurance systems within their social, economic and political contexts and to capture the variations across countries. It is important to note the dominant ideologies that determine and influence the introduction and development of a policy. Therefore, the analysis of these country experiences attempts to take a historical approach by addressing the following questions: Why does a country take up a particular type of health insurance and how do these systems evolve and change through time? The first section deals with why the role of state is important in the process of financing, regulating and providing health services. The second section briefly discusses the history of health insurance and the final section is on country experiences.

Role of the State in Health Services

The evolution of the 'positive state' can be examined through three historical periods. The period of mercantilism saw the emergence of the modern nation state from 16th century to the latter part of 18th century. The early 19th century was the time of industrial revolution in much of Western Europe and saw the emergence of laissez faire policy by the state. During the last period the state intervened more frequently and directly in the lives of people and on a much broader scale and in a more effective way. This was the emergence of the positive state (Leichter 1979).

Industrialisation produced serious public health problems with inadequate living and working conditions that resulted in epidemics. Health status demonstrated a clear class distinction, where the average age of an industrial worker was one half the age of an upper class citizen. During the course of nineteenth century it became clear that state had to take an active role in minimising human misery. It was clear that private charities, existing poor laws and other voluntary efforts were not enough and were only addressing the symptoms and not the problem, it was also only piecemeal (Rosen, 1958). A more

receptive environment to state involvement existed in countries like Germany, Austria and Russia where paternalism had persisted over laissez-faire policies. However, even in England, France and US where laissez faire had its strongest advocates, the doctrine was losing support in favour of a more active and positive concept of state. Industrial legislations, universal primary education and social insurance systems were some of the changes that occurred in the latter half of 19th century. These were efforts taken by the state to ensure health of the working population for a productive economy and also to check the rise of worker agitation and demands.

State participation in the regulation and/or provision of medical care has a long tradition. The earliest and most consistent form of involvement has been the licensing of medical practitioners. As early as 1500 BC, the Indian kings required all medical graduates to demonstrate their professional competence before royal assent to practice was granted. State responsibility in provisioning of medical care as opposed to regulation had its origins during the 16th century. Publicly financed medical care was limited to the impoverished while the rest of the society had to access medical care from individual private physicians. It was not until the advent of industrialisation that health care became the concern of the State (Leichter 1979).

Following the Second World War, the Keynesian understanding of the welfare state became prominent. It was an answer to the failure of capitalism. It emphasised the state's role and duty towards its population within a capitalist economy. On the whole, countries almost all over the world had realised the importance of intervening as bigger actors in the sectors of health, education, housing, employment to enhance well being of the population.

The state is therefore seen as an institution of social justice. Its functions can be all encompassing to bring in equitable distribution of resources. Similarly, when it comes to health services system, ideally a state can make the system universal, comprehensive and equitable by taking up the role of financier, regulator and provider.

History of Health Insurance

The practice of pooling resources to ensure protection against the risks of ill-health grew as a result of labour movements. In medieval Europe, craftsmen formed societies or guilds that, in turn, created funds to help members in times of distress due to sickness. Each member contributed to the fund on a regular basis. With industrialisation there were broader and more varied arrangements to deal with ill-health. The threat of falling sick and the subsequent loss of income by an individual worker were seen as a risk to be shared. From the late 18th and early 19th century groups of workers and small farmers in the same industry or location formed sickness funds as mutual benefit societies to serve this purpose. These early mutual benefit societies collected contributions to provide benefits for needy members and not to gain profits for commercial enterprise or to acquire resources for investment. The basic principles of these mutual benefit societies were solidarity, the involvement of members in their administration and distribution of benefits to the changing needs of the members. Guilds initially started providing cash benefits and asked doctors to certify sickness. Some guilds then began to contract with providers on a regular basis. New initiatives came from employers and some became compulsory schemes. Contributions related to earnings rather than to individual risk became firmly established in some countries (Ron et al, 1990).

The shift from poor law relief to the concept of social insurance was a significant one. As socio-economic insecurity advanced during industrialisation, the increasing voice of the urban working class and the middle class began organising and demanding for better working conditions and health care services. Early public health preventive measures did create the difference in living and working conditions. Wage increase also ensured food security but insecurities associated with loss of wages owing to job-related injury, illness, unemployment and old age was still prevalent.

The first comprehensive social security programme was developed in Germany during 1880s. Under the powerful hand of Chancellor Otto von Bismarck, laws in 1882, 1884 and 1889 established compulsory sickness, accident, old age and disability insurance

programmes. Prussia[1] had a long-standing tradition of being a paternalistic state. Bismarck enjoyed sufficient authority in the Prussian-German State to push through social legislation and his dominant concern was to woo the workers away from socialism and to preserve the country's authoritarian monarchy. Workers in defined industries earning less than a specified amount were compulsorily affiliated to sickness fund, the fund was financed through compulsory contributions of workers and their employers.

Shortly after its introduction, several nations followed the German example. Austria and Czechoslovakia established programmes for injury insurance in 1887, sickness insurance in 1888 and old-age disability insurance in 1906; Denmark developed a similar set of programmes by 1896; Italy between 1898 and 1919; and Great Britain between 1897 and 1911. By the second decade of the twentieth century, most advanced nations in the world had relatively comprehensive social insurance programmes. The major exception was the United States (US). US set up old age, disability and survivor's insurance programme in 1935 almost half a century after the German law and several years after laws in nations such as Spain (1919), Uruguay (1919), Brazil (1924), and Chile (1924). The US adopted a partial social health insurance programme only in 1965 (Ron et al, 1990).

The original German law did not specify that the fund should pay the doctor for each specific service given to the patient i.e. on a fee for service basis. Most funds initially chose the capitation method, whereby doctors were paid a monthly sum for each insured person registered on their lists. The capitation method of paying physicians provided the insured person with a regular source of medical care rather than the ad hoc system of billing for each item of service provided. This was therefore the first mechanism at the level of the general practitioner to promote continuity of care. A different form of payment was later introduced first in Norway and then in France. The insured person paid the doctor directly and then major part of the expenditure was refunded by the social insurance administration. United Kingdom, Denmark and the Netherlands still pay general practitioners a monthly sum according to the number of insured persons on their

[1] A former kingdom in north-central Europe including present-day northern Germany and northern Poland, developed as the chief military power of the Continent, leading the North German Confederation from 1867-71, when the German empire was established.

lists. But most of the other countries follow the fee for service or refunding the patients for most of the fee (Leichter, 1979). These methods of payment are 'indirect' methods where provision of services is separate from the funds as opposed to 'direct' method where provision of services and facilities is operated by the fund or the scheme itself.

Insurance in developing countries has been generally less known. It is only in the last 30-40 years that risk coverage availability and participation has increased dramatically. Different health insurance programmes have been introduced but none at present have a universal health insurance system. There are systems of different health insurance programmes and coverage of population is mostly limited.

Developed Countries

The United States of America: Domination of the Private Health Insurance model

The growth of the United States (US) health financing system has to be understood in the context of the parties in power, the formations of corporations, labour, and the medical profession and health industry. The United States has a two-party system- the Democrats and the conservative Republicans.

Following the end of civil war in 1865, large industrial and financial corporations developed within a period of 30 years. This was the period when the conservative Republicans were in power. The period was characterised by reduced role of government, difficulties for labour, large scale economic corporate restructuring with trusts and mergers, socio-economic inequalities and increased debts. Industrial entrepreneurs during industrial revolution were able to employ workers at low wages and long working hours, as there was an excess supply of workers due to large immigration from Europe and China. These industrial corporations did not recognise labour unions and repressed strikes violently. Though workers made repeated attempts to organise locally and nationally, they were weak in organisational direction and had limited resources. *American Federation of Labour (AFL)* was founded in 1886 but was to be as free as possible from any political ideology (Jaheil, 1998). Therefore, there was no scope to form a labour

party. Attempts by other labour organisations to form political coalitions or to organise locally were unsuccessful.

The curative model of health care got promoted only in the 1920s-30s when public health lost its priority. The *American Medical Association* (AMA) that had formed in 1856 was reorganised in 1901 by the elite in the profession who favoured scientific medicine.

The first attempt to pass a *national health insurance* came between 1912-1920. It received support from the Progressive Party, organised medicine and some government employees but was opposed by a significant part of the labour movement that was suspicious at that moment of any governmental intervention. The division of labour, therefore, weakened the first attempt towards a national health insurance programme based on the German model and further effort was suspended when a conservative leadership came to power in the American Medical Association (Jaheil, 1998).

During the Great Depression, the liberal party of Roosevelt came into power with strong pro labour policies and legislation. Labour became closely allied to the Democratic Party but it never dominated the Democratic Party. Some companies at this point had begun to practice certain welfare measures like provision of health care benefits through employer. By 1935 the nation achieved some measure of recovery, but businessmen and bankers were turning more and more against Roosevelt's *New Deal*[2] program. They feared his experiments, as he had allowed deficits in the budget, and they disliked the concessions that he gave to labour. As a response to it Roosevelt launched a new program of reform: social security, heavier taxes on the wealthy, new controls over banks and public utilities, and an enormous work relief program for the unemployed. Collective action initiated by

[2] The New Deal legislation passed during Franklin D. Roosevelt's first two presidencies included several laws favourable to labour. The Wagner Act passed in 1935, marked the end of the federal government's laissez faire attitude in industrial relations. The right of workers to organise was explicitly reaffirmed and employer interference was explicitly forbidden. The Fair Labour Standard Bill provided for a minimum wage and maximum work hours. The Work Progress Administration provided unemployed workers with governmentally financed jobs. The Social Security Act provided federal specifications to states for unemployment pension, old age pensions and grants to states for the aged, blind, disabled.

labour movements was supported by Roosevelt but was met with severe protests from business interest groups.

Meanwhile, the status of the physicians was gradually increasing and they turned out to be self-employed professionals. The *Flexner report* increased costs, duration and prestige of medical education. It helped to select students from higher socio-economic background. Organised medicine led by AMA also took steps to enhance the social status of physicians.

The cost of medical care was a problem for many and the depression period only aggravated the cost problem. The problem was also for physicians who found it difficult to fill their hospital beds and collect fees from patients. A local initiative in private health insurance organised by teachers in Texas in 1929 was seized upon as a way to meet the costs by spreading them over majority of the population that still had a regular income. Thus was born the *Blue Cross* for hospital insurance in 1929 and *Blue Shield* for physician insurance in 1939 (Jaheil, 1998). The physicians allowed this third party to intervene on the condition that they would be not-for-profit. The physician's autonomy in practising and billing was respected and physicians were members of insurance company boards. Thus, the first kind of private insurance was selective as it was built around people who had regular income.

The 1935 Social Security Act was the most important antecedent of the Medicare and Medicaid bill. It targeted a social insurance system that was to follow three decades later. The social security board that spoke of social insurance for the aged, unemployed, the disabled, the widowed and their children also suggested on initiating discussion on a National Health Insurance. But this met with a powerful opposition from the American Medical Association and private health insurers. This was because any kind of government intervention seemed as a threat to their autonomy. The *Wagner-Murray-Dingell national health insurance bill* was introduced in the Congress several times and was the first to state a compulsory National Health Insurance (Brown, 1984).

By the end of World War II labour movement gained considerable momentum. But the *Taft-Hartley Law* passed by the Conservative Party, which was vetoed by President Truman of the Liberal Party, prevented labour unions from the right to strikes and boycotts. This was the consequence of the onset of the Cold War. The nation was moving towards an anti-left ideology that gained strength through time. The national labour unions at that time: AFL and Committee of Industrial Workers that was formed by unions of workers who had been neglected by the AFL complied with the new law.

In 1949, President Truman presented a 21-point program in the Congress, proposing the expansion of Social Security, a full-employment program, a permanent Fair Employment Practices Act, and public housing and slum clearance. The program, Truman wrote, "symbolises for me my assumption of the office of President in my own right." It became known as the *Fair Deal* but the Republicans blocked most of the programmes. Truman included in the bill a *comprehensive NHI* with coverage of all medical, dental, hospital and nursing services, to be financed by payroll tax, included contributors, their dependants and subsidised the poor and was to be administered by the federal agency. The bill reflected the views of the labour movement, the public opinion polls. But the Republican's and AMA's strong protest and lobbying campaign defeated the bill (Source: Internet). The fear of a 'socialist' America meant that they stood to lose a lot. As a response to the regular introduction of bills calling for a NHI, the AMA expanded its Blue Cross hospital insurance plans and the Blue Shield plans for covering physician fees. As a result of the spread of private health insurance to workers in unionised industries, reduced the labour movement's political support for a NHI.

The 1960s saw the emergence of two federal legislation for targeted public health insurance- *Medicare* (for elderly) and *Medicaid* (for poor) signed by the then Democrat leader, President Johnson. This was initially opposed by physicians but after giving them the assurance that they would be able to charge their usual fees they accepted. The continuous opposition and campaigns by AMA against universal insurance schemes finally gave way to some respite for the elderly and the poor. This basic welfare approach was considered much more favourable to the opposition. Although Medicare met with

resistance, the opposition was assured that they would be able to charge their usual and reasonable fee and more importantly it became a source of income for many physicians. Medicaid on the other hand was not considered profitable and not many doctors were willing to see Medicaid patients, the chief complaint being that the reimbursement was inadequate. But being poor is not the only criterion that allows a person to enrol as eligible for Medicaid. Most people become eligible by meeting a federally defined criterion (i.e., advanced age, blindness, disability, or membership in a single-parent family with dependent children) (Brown, 1984).

Following the victory of Medicare in 1967, organised labour united in 1972-74 to pass a *national health insurance* programme. But the groups of hospitals, insurance companies, physicians and business opposed it yet again (Brown, 1984).

Private insurance companies had entered the private health insurance field during WW II and within a short time entered the health market. This was stimulated in part by the increase in employers' health plans and in part by state legislation that allowed them to use risk rating rather than community rating[3]. Justification of for-profit business in health care was becoming an emerging ideology, leading various types of businesses-pharmaceutical and medical device industries, laboratories, for-profit insurance, and hospital associated business that were helped by permissive government policies. The emerging ideology was that society could be improved through expansion of technology.

Organised medicine was initially opposed to group practice but increasing number of physicians made competition among individual practitioners harder. Thus came the *Health Maintenance organisation* (HMO) in the 1970s. This approach combined risk pooling with delivery of clinical services in an organisation known as pre-paid group practice plan. The HMOs rendered clinical services to a defined population. By 1980s competition among physician was more intense. There was a marked increase in volume of care in the 1970s and the new federal HMO legislation attracted for-profit *Managed*

[3] Charging everyone in the insured pool the same premium is known as Community Rating. It does not require the insurer to calculate the risk status of different enrollees.

Care Organisations (MCOs). Managed Care has been defined as health care services under the administrative control of large, private organisations, with capitated financing (that means that an employer- private or public- or a public agency prepays the MCO a negotiated sum of money per covered person per unit of time, typically a month) (Waitzkin and Iriart, 2001). Copayments are made by the insured persons and at present most insured persons are covered by an MCO. Physicians joined MCOs in large numbers as they gave them a competitive advantage. MCOs were brought about to manage increasing costs of health care. It also refers to the care provided by insurance plans that offer a free choice of physician but manage care by monitoring claims and denying or reducing payment for those deemed unjustified. The great majority of managed-care plans are of this type. In the absence of some limit on total expenditures, how can one be sure it would save money in a system so driven by expansive entrepreneurial forces? In the present profit-oriented medical insurance market, all insurers try to keep their prices as high as possible while still staying competitive and as a result the prices of all competitors still continue to rise, even though none would be far out of line with the others. The consumer has to compare the prices and quality of insurance products and then select and enrol. Not only have most managed-care plans failed to slow cost inflation, but their intrusive surveillance and control methods have also increased discontent among physicians and patients (Relman, 1993).

The ideological divide of the Democrats and the Republicans has prevented broader reforms. The Reagan government allowed major cuts for the two programmes- Medicare and Medicaid- and allowed for profit MCOs to enter these public health insurance programmes. In some geographic areas, these organisations have dismantled their programmes after three or four years and made extensive short term profits from capitated patients (those for whom the payer has made per-person, per-time period payments to the MCO). This rapid entry and exit from public markets has left patients and their public insurance programmes vulnerable (Waitzkin, 2001). Medicaid suffered a greater setback because reimbursements for the programme were lower than private market rates. It was difficult for individuals covered under this to locate health providers who will render services.

The recent attempt towards a *national health insurance* came in the form of Clinton proposal under the leadership of President Clinton, then leader of the Democratic Party in 1993. In essence, it called for the formation of a National Health Board that would oversee the activities of the states within a budget designed to bring health care costs into line with general inflation by 1999. The states would be required to set up purchasing co-operatives that would enrol all residents within a given area and purchase insurance on their behalf from at least three competing groups of providers. Large corporations could form their own alliances. The health plans would have to offer the same comprehensive package of services at a price below an established ceiling. Each enrolee would then choose from among the approved plans and would be permitted to change plans once a year (Angell, M., 1993).

One indication of how this defeat has changed public discourse on health care is that in the 1996 presidential election, for the first time since World War II, the Democratic candidate did not advocate universal health insurance coverage. The defeat was brought about in the Congress and the opposition was again from the private interest groups: the medical profession, the MCOs and the pharmaceuticals. By eliminating government as a credible source of solutions to problems in health care, the defeat of the Clinton proposal for reform sparked an ongoing experiment with private health care markets (Blumenthal, 1999). Efforts to resolve the issue of health costs and access in the Congress have always looked for solutions within the market model. The goals of universal access and comprehensive health care reform have largely faded from view.

Health care financing has been dominated by the private health insurance industry but one of the most frequently discussed feature of the health care system is the incomplete coverage of millions and 43.4 million uninsured people i.e. 16.1 percent of the population (Iglehart, J., 1999). Most of the uninsured are unemployed, self-employed or in transition from job to job or work for the minority of employers that do not provide insurance. Private health insurance plans are generally divided into large employer group plans and small group or individual plans. While large employers pay majority of premium costs

the employee share has been rising. But difficulties are mostly shared by the small group and individual plans. New entrants have to undergo medical underwriting[4]. Large proportion of these employees remain uninsured. Small employers can seldom buy coverage and firms with employees having chronic health problems are often unable to obtain coverage at all. If an employee develops a costly illness, the group may face a premium increase of 200 to 300 percent in a single year. Many health insurers also blacklist occupations with increased risk of health problems (Bodenheimer, 1990). Private health insurance might have gained popularity among large employers where unions are present but it is by no means a universal system. It has not and still does not meet the needs of the poorly paid, non-unionised working population or their families, the very poor and unable to work, the blind, the disabled.

Conclusion

Each time a national health insurance has been suggested, it has met with a counter response from the private interest groups. Passage of NHI on several occasions has failed and each time has been brought up in the Congress by the Democrats: 1912 to 1920 when labour was opposed to it; 1935, when the Wagner bill was defeated; 1949, when Truman's proposal was defeated; 1972-74, when labour could not muster the strength and in 1992-94 as there was no united response to it. The triumph of the West in the Cold War and the continued success of the U.S. economy have fostered an uncritical acceptance of market mechanisms throughout the world as the optimal way to allocate goods and services of all types. This ideology gained strength over time and any policy demanding greater state intervention has been viewed as a socialist intervention. The outcome of private health insurance as seen can be attributed to the weak organisation of labour that has been weak, disorganised and discontinuous. The strong lobbying against a compulsory health insurance for all has been a result of the voice of the interest groups like the medical profession, the private insurers, the big corporations, the pharmaceuticals, and the medical device industries. They all have now entered the health market in a big way. These dominant players have emphasised more on curative services,

[4] Underwriting is a systematic technique for evaluating, selecting, classifying and rating risks. Out here the term risk refers to the object of insurance i.e. the person.

ignoring the importance of preventive services in health services. Services have been specialist oriented and hence not comprehensive. Health is viewed as consumption rather than a public good. These groups have worked together as a class and at the same time taken care of their interests. The targeted public insurance programmes have suffered a setback due to heavy reliance on the market. The political history of United States clearly shows the ideological divide among the Democrats and Republicans throughout. On the whole the dominant ideology of the State has been favourable towards laissez-faire policy, where the market has been allowed to dominate and state intervention has been kept minimal. The financing system has not been able to bring about universal coverage. This has led to increasing concerns of equity, as the poor and lower income groups of population are left without or inadequate coverage.

The German model: Social Health Insurance (SHI)

As mentioned earlier, Prussia had been a paternalist state. Statutory sickness funds evolved from relief funds that existed in the 17th century for craftsmen, factory workers, journey men and community relief funds for people who were not covered otherwise.

Germany too went through the process of industrialisation. Though it began somewhat later than other European countries, it proceeded rapidly. The growth of cities, oppressive working conditions, low wages were features of industrialisation in Germany too. The new working class faced considerable social and economic insecurity. Traditional protective mechanisms such as paternal landlord, guild societies were unavailable and inadequate. The logical source of assistance for the worker was the state itself. But, the overall effort of the state was limited by the dominance of the laissez-faire thinking at that time. Some industrial employers in 1850s offered health insurance. In 1856, Krupp industry, one of the largest industry in Germany introduced compulsory health insurance for its employees with the company paying one-half of the premium. But, these were scattered instances and were not enough to meet the needs of the German working class. By the early 1860s, German socialist movement had become prominent. German socialism, whose birth is generally associated with the ideas of Lassalle, had a profound

impact on social policies for the rest of German history, with the exception during the Nazi period. The support for *social democrats* grew rapidly between 1871 and 1890 were followers of Marx, Engels and Lassalle came together. The conservative regime of Chancellor Bismarck began taking the socialists more seriously. Bismarck saw them as a threat and issued the anti-socialist law but this did not help much to affect the popularity of the socialists. Bismarck recognised that some positive measures were necessary to win support of the politically powerful working class. By 1881, social reform package was announced which referred to the Accident Insurance Bill and proposals of health, disability and old-age insurance. State action of a positive nature was needed to convince the working class of the good intentions of the regime to secure their support. The *Sickness Insurance Bill* was the least controversial and not considered radical. Prior to 1883, numerous such compulsory insurance systems existed for various occupational groups, example- for mine workers. As early as 1623, the Prussian government had begun setting doctors' fees. In 1876, the government enacted a health insurance law that sought to regulate the existing private insurance funds. So the 1883 law of sickness insurance was not seen as a radical policy departure for the German State. Administration was to be decentralised, using possible public and private institutions. The programme would be privately and not publicly financed. The bill when implemented compulsorily insured only the poorest of the industrial wage earners and required a relatively small contribution (Leichter, 1979).

The role of the medical profession, workers, employers and existing insurance carriers in developing the social insurance programme was almost nil. The reason being that imperial Germany was an authoritarian system in which public policy was largely a product of imperial and bureaucratic design. Medical profession and employers did not see it as a threat to economic interests. Medical profession was also too disorganised and employees did not see it as making 'unnecessary demands' on them. For the medical profession a compulsory health insurance meant a new source of income.

From compulsory participation by all factory wage earners, the sickness insurance gradually extended coverage to workers in commercial enterprises, to farm workers. It

did not cover self-employed persons, dependants or those earning above the income limit. Financing was by joint employee and employer contribution and the state made no contribution but it was regulated by the state. Under the original law there were four benefits: medical cash, maternity and funeral. Dependants were to receive income maintenance during periods of illness. When hospitalisation was necessary, patient was entitled to free complete medical care and accommodations. Administration was through existing organisations. Thus, of the 6 types of sickness funds recognised in 1883, four were based on existing organisations: building trade, miners, guild and industrial sickness funds. Where no organisations existed industrial, local or district funds were established by municipality for one or more trades. The other was a rural sickness fund, which required local authorities to insure any eligible person not covered by other insurance funds. Administrative authority was given to these insurance funds. Its operation was simple. A worker was automatically insured upon getting employed in an industry or occupation where insurance was compulsory. Employer paid entire premium directly to the sickness fund for each insured worker and deducted the workers share from his wages. When ill the worker went for treatment to a physician contracted by the particular fund. If illness lasted longer than three days, worker was eligible for cash benefit.

Following World War I, the German monarchy dissolved in 1919 and *Weimar Republic* was established. The social democratic party was one of the largest political parties. They became committed to extend social services as a political right. Meanwhile, the medical profession was uniting in a big way, the German doctors association was founded in 1900 for the protection of their economic interests. Conflicts between the government, insurance companies and the doctors were present. The primary issues of contention were: the doctors favoured an increase in fees and fee for each service performed; the doctor wanted the insured patient to choose any physician he wished while the fund wanted to limit the choice of doctors; the medical profession also wanted to limit the expansion of the public insurance in order to maximise their private practice, whereas funds favoured expansion of the system. There were ideological and class differences between the doctors and the insurance funds. Between 1903 and 1911 doctors fought with both government and insurance funds over issues of free choice and fees. The law

included a provision that wherever possible, members of sickness societies should be provided with a choice of at least two doctors. The number of sickness funds increased through the years. The sickness insurance programme developed into an ambitious and encompassing system. There was enlarging of the insurable population and expanding benefits was unmistakable. During the great depression period more than half of the existing funds was dissolved. Certain cost-sharing measures were introduced during this time were patients had to pay 10 percent of all medical fees. By 1932 other occupational groups were brought under compulsory sickness insurance: agricultural workers, transportation workers, salaried employees in offices and industrial enterprises. The benefits for dependants had also increased by 1925 (Leichter, 1979). Between 1860s and 1920s, labour controlled two-thirds and business controlled one-third of the seats on the board of individual sickness funds. During the mid-1920s to 1933, each side had an equal representation.

Health care went through change under *Nazis* to serve the political aims of the regime. Nazis were determined to eliminate Social Democratic Party influence on health care policies. Nazis banned the Social Democratic Party in 1933 and most of its leaders were sent to the concentration camps. They instituted administrative reorganisation of the sickness insurance system. A single person was appointed to exercise power that was formerly held by worker dominated committee and the medical profession was assigned the role of promoting racial purity. The German doctor was the political apparatus of the state. Although Nazi health care policy had long term health care implications during the post second world war period, the system of health insurance survived and continued to provide the foundation of the German health care policy.

After the Second World War, Germany was governed by four allied control councils- US, Britain, France and the Soviet Union. But conflicts between Soviets on one hand and the US, British and French on the other hand led to the dissolution of the council. Germany divided in to two: East Germany (German Democratic Republic) that was under communist rule and West Germany (Federal Republic of Germany). The Social

Democratic Party was recreated and had to ally with the Communist Party in East Germany. They regained status after Germany's unification.

The unification of Germany in October 1990 under the leadership of *Christian Democratic Party* was a major turn in the German political scenario. Reunification was the main agenda of the conservative, pro-American party. East Germany had kept a state-run delivery system until the West German model was adapted in 1989. The imposition of West German structures on East Germany did not happen easily. Resistance came from the Social Democrats who proposed a uniform social insurance as opposed to separation of social insurance in to different types. The West German health insurance at that time was criticised for being inequitable because of its liberal structure. But the same structures were implemented in East Germany within a short span of time. The Christian Democratic Party attempted to make major cuts in social programmes like cutting sick pay and pensions, reducing unemployment benefits, postponing an increase of payments to workers with children, and making it easier for small businesses to fire workers (Isaacsson, 1996). This met with a strong protest from the labour unions and was abandoned by the rulers. The new Chancellor of Germany at the moment comes from the Social Democratic Party. Social Democrats would like to return to state run provisioning and community health centres but the Christian Democrats believe that health insurance should cover just core services and personal services paid out of pocket or through private insurance. This has been strongly rejected by the Social Democrats who intend to redraw the boundaries between providers, payers and Ministry of Health (Altenstetter, C., 2003).

The working of the Health insurance system

At present, health services in Germany continue to be funded through compulsory contributions to sickness funds. These are non-profit organisations, operating either over a particular geographical area or for particular occupational groups. Although autonomous, the system is tightly regulated by the state governments. Money is reallocated between funds to take account of differences in the incomes and risk profile of their members. Care is provided by self-employed physicians and a mixture of

government and private hospitals. Coverage extends to almost all of the population. Competition has been introduced as people are allowed to choose the insurance societies. Today, less than 0.5 percent of all people living in Germany do not have any health insurance (Barnighausen and Sauerborn, 2002). 92 percent are insured by the sickness funds while the rest are covered by private health insurance or are wealthy to pay out of pocket (Altenstetter, C., 2003).

Patients can choose services from any appropriate provider. Around one-third of hospitals are publicly owned, 35 percent of beds are provided by non-profit making and voluntary organisations and 15 percent by profit making hospitals (Normand and Weber, 1994).

Physicians are paid fees for service, based on a points system for units of work done. Very few work as salaried employees. The total funding for physician services is agreed, and then divided up on the basis of the number of treatments given by each physician. This type of fee for service system has cost containment built in. Physicians cannot compete on the basis of price as the fees for services provided are negotiated and legally binding. This prevents physicians from exploiting and monopolising. Physicians who belong to relevant associations are party to contracts and are reimbursed by health funds for services provided. Hospitals are paid on the basis of daily charges covering reasonable costs. They must provide information to prove that their costs are reasonable. Contracts between hospitals, physicians and health funds are generally reached through negotiation between the associations representing the three parties. The contracts that specify pay for providers are signed with associations and not individual providers (Normand and Weber, 1994). After 1997, the competence of the self-governance to negotiate provider reimbursement was partially restored. Contributions to the health funds are paid by employers and employees who are both represented on the board of the funds. Since the mid-1970s, cost containment policy has been a recurrent agenda. Reformers have favoured emphasis on primary and secondary prevention and early detection of disease but this has been voiced timidly. In 2000, Germany adopted a diagnosis-related group based hospital reimbursement system to be fully operational by 2007 (Altenstetter, C. 2003).

Conclusion

In spite of all the political turmoil, German health insurance has survived one hundred and twenty years. From a historical perspective, in terms of health insurance, the most important development has been the change from a limited, class-based insurance system to a virtually universal system. A single payer system of financing was never a real option nor was a system like United Kingdom's National Health Service (NHS). Given the historical mix of public, non-profit and specialised facilities, service delivery was based on pluralism. The State, however, retains important functions as supervisor, enabler, facilitator and monitor. National standards have to be maintained though implementation is reserved for regional governments. The system is under constant challenge by physicians. Though strictly regulated by state it has given concessions to doctors by allowing free choice of doctors for patients. The presence of Social Democratic Party has been instrumental in bringing about welfare measures for the working class in terms of health insurance and other benefits. Labour movements in Germany, leaving the Nazi regime, have been strong.

United Kingdom and France: A Brief Review

Health services in ***United Kingdom*** were financed by private fees, charities and public hospitals since a long time. Britain has seen changes in the history through Poor Law reforms, public health measures during industrialisation, the shift to curative services and finally the emergence of the *National Health Service* (NHS). The birth of the NHS was an outcome of the larger social political process to humanise capitalism post war (Doyal, L., 1979). The Beveridge[5] plan for a tax based national health service as a public good offered a basic alternative to the Bismarck design of national insurance to provide access as an individual right. The large tax based financing system that funds health services is

[5] Sir William Beveridge, a civil servant was asked to plan social reconstruction after the war. He had served as a social worker and had witnessed the many contradictory and partial programmes for unemployment, child support, public health services and housing run by different departments. He decided that the only approach was to address them all at once, in ways that would create partnerships between the individual and the state. The Beveridge report, *Social Insurance and Allied Services* called for comprehensive health care as part of a post-war master plan promoting education, employment, housing and social security.

free at the point of service. At the level of primary care everyone can choose a physician or general practitioner (GP) and referrals, if needed, are made at this point. The British system has always had a private sector. This was a result of compromises made by the state in order to maintain private interests. The NHS has sought to limit and control costs within a fixed national budget. The period of the conservative Thatcher government saw some changes within the NHS. The government had joined international policy movement of competition as a way to challenge the 'inefficient' public services in education, municipal services and health care. People seeking health services were seen as consumers. The government aimed to provide greater rewards to providers by inducing competition. But it was soon realised that the competitive structures as in US had deep flaws and was undermining the principles of universality. Market failures were soon evident as health costs rose. The present labour government has raised the tax for increasing funds for NHS. The increase has been the largest ever in history. The new plan also aims to bring the GPs to the centre of the NHS. They will be organised according to geographical units called primary care trusts and will be combined with community health services with a public health agenda. There is an attempt to build an integrated health service system by linking community services to specialist care. At the same time the present Blair government is trying to push in private partners in the form of large corporations. It is yet to be seen how these changes are implemented but on the whole till date government control over the NHS has been the primary concern so as to ensure universal health services (Light, D.W., 2003).

The health service system of ***France*** combines universal coverage with a public-private mix of hospital and ambulatory care. The French politicians defend their health system as an ideal combination of solidarity and liberalism i.e. lying between the British nationalised health service and the US competitive system. The French health insurance evolved from 19th century mutual aid societies to a post Second World War system of local democratic management by trade unions and employer representatives. It is controlled by the French State. Although the National Health Insurance Act was passed in 1924 it was only in 1974 that another law proclaimed that it should be universal and it was in 2000 that universality was achieved. The health insurance system is an integral

part of the French social security system characterised by pensions, family allowance, workplace accident coverage and health insurance. The health insurance consists of different plans for different occupational groups that operate within a common statutory framework. There are three main health insurance funds: for salaried workers, for farmers and agricultural workers and for the independent professionals. There are 11 smaller funds for workers in specific occupations. The fund for salaried workers covers 84 percent of legal residents in France. It includes beneficiaries from 7 of the smaller funds. The funds are non-profit, quasi-public organisations supervised by the government. The other two funds covers 12 percent of the population and the rest get covered by the remaining 4 smaller funds.

By 2000, France covered the remaining one percent of its population that was uninsured and offered supplementary coverage to 8 percent of its population below an income level. The health service system is dominated by individual-based, fee for services private practice for ambulatory or out-patient care and public hospitals for acute institutional care. The patients are free to choose and be reimbursed under the health insurance system. There are no gatekeepers to regulate access to specialists and hospitals. The French indemnity model allows for direct payment by patients to physicians that are reimbursed by the health insurance funds. For in-patient hospital services there are budgetary allocations. There are also supplementary private insurance provided (Rodwin, V.G., 2003). Despite the achievement of universal coverage under NHI, there are striking disparities in distribution of health resources. There is a non-integrated approach to health services, neglect of preventive public health services and the undue focus on specialised care.

European countries provide coverage of health services under social health insurance systems with universal coverage or provisioning and financing of health services is directly undertaken by the State. Whatever models of insurance have been adopted in the rest of the world have tried to follow the European experiences in one way or the other. The social democratic political economies of Europe- Austria, Sweden, Denmark, Norway, Finland- provide 100 per cent public medical care coverage. Among other

countries, United Kingdom, Ireland, Italy, Switzerland, Portugal and Greece have 100 percent medical care coverage for its people (Navarro, 2001). But with the European Union market, substantial deregulation has stripped regulatory bodies of their power to protect consumers and poses interesting challenges for national regulators particularly if the market is to expand in the future.

The Chilean Experience

In the majority of *Latin American* countries welfare programmes were built on social insurance principles. Social insurance was never universal but was arranged through insurance funds for specific groups of workers. Initially the insurance funds focused on funeral costs, old-age pensions and industrial injury compensation but later the range of benefits was expanded to cover unemployment, preventive and curative medicine. In Latin America the percentage of population covered by social insurance rose from 21.1 % in 1960 to 40.4% in 1980. Social insurance provision and coverage expanded in the post-war years with more developed countries such as *Argentina* and *Chile* reaching welfare provisions that were comparable to European countries. In contrast to the US, most countries have organised social security systems that include health care benefits for employed workers in large private or public enterprises. There are also public sector institutions for those unemployed and for workers not covered under the social security system. The Latin American experience brings about a distinct shift in their health insurance systems in recent times as a result of global and internal politics (Barrientos and Lloyd-Sherlock, 2000).

With the exportation of managed care by the US as part of adjustment policies and health care reforms in the 1980s the focus has shifted from state run insurance programmes to private insurance. The social security funds in these countries were seen as an important source for profit by the US. Privatisation of government health insurance systems has permitted capital expansion for MCOs and investment funds. Managed care organisations have encountered less organised resistance in countries like Argentina, Chile and Colombia where prior dictatorships or authoritarian government exist. They have

felicitated the privatisation of public services. On the other hand countries like Ecuador and Brazil have resisted the introduction of managed care. Physicians and public health activists have organised themselves to resist changes (Waitzkin, 2001).

Chile has a long history of organised health services dating back to 1920s with the establishment of several social security funds providing curative health services for blue-collar workers. In 1938, the government passed the Preventive Medicine Law providing early detection of communicable diseases and establishing government agencies providing preventive services. Hospitals that were originally supported by private organisations, mainly Catholic Church, gradually became semi-governmental institutions. By 1970, Chile was providing health services through, the National Health Service (SNS) that was established in 1952; government health insurance plan (SERMANA) and the private health care system. The SNS provided free preventive and curative services to 65 percent of the population consisting of blue-collar workers and indigents. SERMANA provided health coverage through payroll contribution for white-collar workers and their dependants. This covered 20 percent of the population. The private health care system covered 10 percent of the population and the armed forces had their own health care system that covered 4.5 percent of the population. The organisation of health services under the *Christian Democratic government of Frei* in 1970 was a mixed system based on worker status. The *Allende government* accelerated the process towards socialised medicine. The long term goal was to create a unified health system with progressive financial participation by the State (Jimenez de la Jara and Bossert, 1995).

The trend towards a completely state financed health system was reversed in 1973 by the new *military government under Pinochet.* After a long and intensive struggle between neo-classical economists, military authorities and the Chilean Medical Association, legislation supporting a mixed system of health financing was finally enacted (Viveros-Long, 1986). By 1980 the Pinochet government permitted the diversion of government health care and social security funds to privatised managed care institutions, which then could be bought by multinational insurance companies. Health insurance at present is provided by FONASA (Fondo Nacional de Salud) and the ISAPRE (Institutos de Salud

Previsional). FONASA is the social insurance system and provides insurance to unemployed, low-income workers and higher income workers. The insurance system is stratified in to four groups. Category A and B provide coverage to low-income workers, middle income and unemployed. Category C and D members are from the higher income group. The latter group has the option to use private health providers and have to make copayments of 10-15 percent while category A and B have access to public health facilities providing primary, secondary and tertiary care. ISAPRE's is a group of managed care organisations and its members are selected by their ability to pay. This inequality in health insurance systems has led to segmentation in financing and provisioning (Barrientos and Lloyd-Sherlock, 2000). Co-payments required under managed care plans have introduced barriers to access. The membership is restricted to high income groups and to those with low health risks. Private health expenditures as a proportion of GDP has increased from 0.38% in 1985 to 1.77 % in 1996 while public health spending remained stagnated at 2.4 % (Waitzkin and Iriart, 2001). Laws have permitted the introduction of private management companies. The social security funds that should pay for health care services do not have resources to pay.

The new *democratic government* that followed in 1991 could not bring any change to the severely underfunded health sector passed on by the military government. The Aylwin government did not propose radical reorganisation of the Pinochet reforms. The new government wanted to pump significant resources in to primary care and expand the national budget for health by 50 percent. The proposed reforms in primary care funding mechanisms were debated in the parliament and their implementation was delayed till the second democratic administration. The legislative process and health providers' strike had delayed this reform and have eliminated modifications that were suggested for ISPARE system i.e. protection for retired workers and a single basic benefits package. The health professionals' strike resulted in shifting of national priorities back to hospital care and reduction in investment budget. The efforts of the democratic governments have been thwarted which show some of the difficulties in incremental change in the face of newly created interests (Jimenez de la Jara and Bossert, 1995). The poorest population has no access to health services as priority is given to those who can pay and there has

also been a decreasing access to preventive programmes. Epidemics like cholera, typhus, dengue have recurred. But all these changes have met with resistance from the common people. In 2002, for the first time, unemployed people and the middle class gathered in streets for the same goals. Coalitions of workers union and medical associations too have moved to develop alternative proposals. Health workers and common people are attempting to reorganise the management of public health and social security institutions.

Conclusion

Chilean health services had tried to meet the needs of the population under the Christian Democratic Party under Frei. Frei's introduction of SERMANA was to give public aid in medical care to white collar workers and at the same time preserved their status separate from blue collar workers and the indigent who were being provided by the SNS. This class based services system was challenged by the Allende government that attempted to unify the system by redistributing social and economic benefits and making the system progressive. Pinochet's military government put emphasis on increasing the influence of free market choice and hence bringing in the private health care sector. The major thrust of the financial policies has been to provide incentives for the private sector investments. This process received acceleration from United States that exported its managed care systems to Chile in order to make profits. On the whole, Chile has seen a dramatic decrease in State health expenditures that had accelerated in the early 1970s. Both the present insurance systems are stratified and modifications initiated by the present government to increase the public funding have been thwarted by interest groups. It is interesting to note the ideological changes of the State that were brought in by various political parties in power.

Health Insurance in East Asia: South Korea and Taiwan

East Asia is often represented by the following countries- Korea, Singapore, Taiwan, Japan and Hong Kong which share a common Confucian[6] heritage as well as a historical

[6] The teachings of Confucius emphasizing love for humanity; high value given to learning and to devotion to family (including ancestors); peace; justice; influenced the traditional culture of China.

experience of rapid economic growth during post World War II. The west has always been interested in the success of their economies (Son, 2002).

East Asian governments have been relatively low spenders on social welfare. The State in these countries is to varying degrees a regulator that enforces welfare programmes without providing direct finance unlike European welfare states where the State finances and at times provides health services. The State takes up the role of directing a process of economic development with growth objectives. State sponsored welfare systems have developed gradually over time. Public expenditure in social welfare programmes has increased within the last two decades. Taiwan's level of public expenditure was already higher than the other East Asian countries, it rose sharply from 1989-1992.

South Korea: Domination of Social Health Insurance

It was not until the end of the Second World War in 1945, that Korea was finally liberated from Japanese colonial rule.

Welfare system in *South Korea* was, by and large, brought into effect by the *Military government* in 1961. The first social welfare programme introduced was Industrial Accident Insurance in 1963 along with a pilot programme for health insurance. Social Health Insurance for health care in Korea was first applied to employees of large corporations in 1977. It then extended to public employees and private teachers through contributions. The self-employed, farmers and others without employers fell outside this. The question of the inclusion of these people in the health insurance schemes was never considered seriously until public concern over health care became a political issue in the late 1980s. By 1987, government was paying half the contributions for those previously not covered and the health insurance scheme became a National Health Insurance programme which covered the entire population in conjunction with the Health Assistance Programme which is a non-contributory programme for the poor.

The welfare initiative of the military government of 1961 was a calculated move to gain political legitimacy. The political strategy of legitimisation was however, mainly based on economic performance. President Park, the military leader launched the first five-year Economic Plan. Throughout his term, economic growth was put forward as the overriding common good. North Korea, with its communist ideology was seen as a threat and it was important to mobilise resources. The Park government set favourable conditions for Korean business to grow by giving special concessions to business and industries. Health insurance programme was seen as a way to mobilise capital as well as to contribute to social security, both of which were important to justify the authoritarian regime. President Chun Doo-Hwan, came in power through a military coup. There was continuity between the two military regimes in terms of ideology. President Chun followed a similar strategy of gaining political legitimisation and that was by claiming that the government would build a 'welfare state'. Social welfare and especially health insurance happened to be in the forefront of the political manifesto. Debates centred around increasing coverage. While the Chun government was reluctant to pay the bill for people who could not contribute to the insurance, the competitive presidential election in 1987 forced the governing party candidate, Rho Tae-woo, to take up the responsibility. Through the health care reform of 1987, State began to partially play the role of provider and financier of health care (Kwon. H, 1998).

The outcome of the gradual increase in coverage was a fragmented system of health insurance. The NHI was unable to equitably distribute the funds. Separate health insurance funds existed for different occupational groups. For example, public employees who had better health were all pooled into one fund while farmers who needed more health care facilities had a separate fund. Logically, the expected medical costs would be higher for the farmers' group than the public employees'. Redistribution of funds across risks was not taking place and the whole concept of a health insurance started being questioned as it raised the issue of social solidarity through pooling of risks. The opposition parties formed a coalition to pass an amendment to the NHI law stating that all insurance funds should merge into a single National Health Fund. The bill was vetoed by President Rho, who feared that he would lose support from the middle class if he

accepted the amendment. Even in the era of democracy, which followed this period, the political party in power did not seem to have the intention of carrying on with the change (Kwon. H, 1998). Following the economic crisis, health care reforms saw the merger of all health insurance societies into a single insurer as of July 2000. An alternative choice would have been to allow consumers' choice of insurance societies as in Germany but the new *democratic government* and the strong support of rural population emphasised social solidarity and favoured the single payer system (Kwon. S, 2002).

Before the recent health care financing reforms, the NHI system consisted of over 300 non-profit insurance societies. There was no freedom of consumer choice of insurance societies, the insured were assigned to insurance societies based on employment (industrial workers) and residential area (self-employed). For industrial workers, the employer and the employee equally share the social insurance contribution. For the self-employed, government provides a subsidy for the contribution. In response to the economic crisis, the government expanded the insurance programme and subsidised insurance contribution of the unemployed.

However, the national health insurance in Korea has limited benefit coverage despite its universal coverage. In addition to the co-payment for insured medical services, the patient pays a substantial amount of out-of-pocket expenses for services due to the stringent benefit coverage. 39.3 percent out of pocket expenses are still made for inpatient and 61.1 percent out of pocket expenses are made for outpatient care (Kwon. S, 2002). On the other side of this has been the attempt to introduce private health insurance. There is strong criticism that the focus should be on strengthening the National Insurance system rather than introducing the market in health care. Physician fees are strictly regulated by fixing amounts for services provided. Providers have responded by increasing the volume of services because more the services provided more the income. They also increase their charges for uninsured services, as these are not regulated. Another reform that was brought about was the government implementation of separating drug prescribing from drug dispensing. Without the separation, the physicians prescribed and dispensed more drugs that resulted in overuse of drugs. Health care delivery is

mostly through for-profit providers and hospitals. Public delivery system has a limited role to play.

Table 1: Public and Private Share of National Health Expenditure in South Korea

	Govt.	SHI	**Public Total**	Household	Private Insurance	Others	**Private Total**
1989	8.67	23.34	32.01	57.33	5.38	5.29	67.99
1998	11.79	34.44	46.23	41.60	6.96	5.22	53.77

Source: Internet (Kang, S. National Health Expenditure in Korea, School of Public Health, Seoul National University, 2000, cited in slide show by Kwon, S, Health Care Reform in Korea: Politics and Vested Interest.)

Conclusion

State intervention in health care came rather late. Interest behind health insurance had to do with political legitimacy and the opposition had initially not strongly voiced in favour of welfare issues. Priorities were mostly associated with broad development strategies and there was greater reliance on private enterprises. Health insurance for a long period of time posed questions of equity and universality till there was a merger of funds and universal coverage. The new single payer is still a social health insurance system but the centralised insurer now looks similar to a tax based financing system with subsidies provided for those who cannot afford to contribute. Income inequalities have increased with the economic crisis that has increased the burden of health care on the poor. Organised labour has played a relatively small role in the introduction and extension of national health insurance in the Republic of Korea. Labour unions became active only in the late eighties and were in most cases organised in the large corporations already covered by the social insurance scheme since its inception. Furthermore, labour unions have been more interested in the basic terms of employment such as wages and working conditions rather than in employment benefits and health insurance. Liberalisation has increased voices for more market mechanisms in health care financing in Korea. There are many private health insurance advocates in South Korea represented by the interest groups of health providers and employers. With the introduction of private insurance system, some fear that the government might get reluctant to expand their benefit coverage of the NHI. There have been labour movements against letting private health insurers enter in a big way. It is interesting to note that while most of the developed world

is welcoming market mechanisms in health care, Korea is trying to regulate and bring together the NHI system and is unwilling to give way to the private easily. But efforts to strengthen the system and curb private interests has to be taken and worked out by the State as SHI accounts for less than 50 percent of the national health expenditure and there is a limited coverage of benefits. But the positive is that the SHI contributions have increased over the past decade thus reducing out of pocket expenses.

Taiwan: Social Health Insurance

The *Kuomintang* (KMT) government of the Republic of China fled to Taiwan after being defeated by the Communists led by Mao in 1949. Taiwan's political isolation in the international communities due to China's instigation forced the KMT to consolidate Taiwan's security via economic growth. The Labour Insurance programme was introduced in Taiwan as the first social insurance scheme in 1950 and was introduced by the KMT to enhance its political legitimacy. There has been a radical imbalance in welfare allocations between various groups covered, favouring those who are deemed important to the stability of the government, such as military personnel and civil servants. National resources have been mostly utilised for capital accumulation. Social insurance system that was taken up in the post-war period was selective rather than universal (Ku, Yeun-wen, 1998). After the Labour Insurance programme, the Government Employees' Insurance and Retired Government Employees' Insurance programmes were introduced in 1958 and 1965 respectively. Till 1991, 74.9 percent of total welfare expenditure by the government was spent on military servicemen, government employees, teachers, veterans and retired MPs. State was seen as protecting the interests of the elite, although, until the lifting of martial law in 1987, there was little criticism (Kwon, H, 1998).

In 1980s, Taiwan experienced series of political changes towards democratisation in which state power was no longer monopolised by the KMT and a formal opposition party, namely the *Democratic Progressive Party* (DPP) founded in 1986 competed with KMT. The radical increase in social movements that called for welfare needs damaged the legitimacy of KMT. The social movements directly emphasised on welfare needs of

women, labourers, farmers, the handicapped and the homeless. Repressing these movements meant risking a backlash from subordinate groups and the DPP. Fearing protests, big industries also started creating better working conditions but business anger also reached its peak by 1989 as they suffered heavy losses due to increasing labour movements. The KMT announced in 1987, that the government would implement a National Health Insurance programme by year 2000. But the increasing social movements forced the government to realise it by 1995 (Ku, Yeun-wen, 1998).

Organisation and Administration of Health Insurance

The Department of Health of the Central government was directly responsible for policy making and supervision of NHI. Another agency, the Central Bureau for National Health Insurance (CBNHI) under the Department of Health was made responsible for working of the system. The CBNHI located six local branches to collect premiums. The premiums are based on earnings-related contribution scheme. The insured are divided into six levels according to their incomes and they pay varied amounts of premium, though the benefits received are the same for all. Contribution is shared by the government, employers and insured according to different categories. Government contributions are made particularly for people with low incomes, farmers, fishermen, and those with no fixed employers. By 2001, 96 percent of the population was covered under the NHI (Huang et al, 2001). The institutions of care have been also reorganised and are mostly private providers. Taiwan has been divided into seventeen medical care regions for the development of both medical manpower and facilities. Hospitals are classified according to their functions. 90.75 percent of total medical agencies have contracted with NHI to provide health care to patients. A health insurance card is allotted to each insured person who can gain access to any contracted medical institution or provider. The price fixing of services provided by health care providers has met with repeated disputes between the government and the providers. A conflict of interest between the medical professionals and pharmacists is present. Traditionally the doctors used to dispense medicines but under government regulation the insured can get medicines only from pharmacists. Though all basic curative services are covered by the NHI some out of pocket expenses are also made (Ku, Yeun-wen, 1998).

Taiwanese health care system has undergone substantial changes since the implementation of NHI. In 1990, Taiwan's social health insurance system, including labour insurance, government employees' insurance and farmer's insurance, covered approximately 50 percent of the total population. The health care sector was opened to foreign competition between 1987 and 1994 when private health insurance market was allowed to enter. Private health insurance is mostly purchased by people who can afford the premiums. In recent surveys, more than 70 percent of all Taiwanese viewed the NHI positively (Huang et al, 2001).

Conclusion

Though called NHI, the health insurance in Taiwan is not universal and is in the lines of a social health insurance model. Inequalities in the system still exist. There are around one million people outside the coverage and these are the unemployed, residents in remote regions, homeless and abandoned people and some employees who do not get insured by their employers (Ku, Yeun-wen, 1998). What started as a class based insurance system has gradually spread across to other income categories.

While health care reforms in most parts of the world has increased the role of the market, the East Asian experience shows otherwise. Their emphasis has been to increase public expenditures and bring in more state regulation over the past decade. Although they are facing challenges from interest groups to let the market forces in, the State has been successful in resisting the entry of the market to a large extent.

Israel: National Health Insurance

Israel is a small nation with a population of 6 million. The roots of institutional structure of the State can be linked to the period of independence in 1948. Several political parties sought to maximise their influence and control over the community and its resources to shape the future of the State. The provision of health care services was seen as an essential channel for gaining such influence. It was then that the tradition of politically

linked sick funds began. Israel is a welfare state where the government is responsible for assuring a minimum income and basic education, as well as housing, health and social services. Israel's expenditures for social services comprise 23% of the GDP. Israel's National Health Insurance Law was put into effect in January 1995 (Gross and Anson, 2002).

Israel's largest sick fund, Kupat Holim Clalit (KHC) was founded in 1920 by the General Federation of Labour (GFL) that was a leading trade union of the time. GFL was politically linked to the *Labour Party* representing Israel's work force and has been a pivotal player in the nation-building process. GFL's sick fund was characterised by a nation-wide network of comprehensive and egalitarian services. The Revisionist Party founded its own trade union and sick fund, Leumit, in 1933. The Liberal Party founded a sick fund in 1936. Another sick fund was established in 1940s by the physician organisations seeking to ease unemployment among physicians who immigrated from Germany during Nazi rule. Health care is provided by the four not-for profit sick funds. Traditionally, KHC has dominated the sick fund and own more than thousand primary care clinics. Through its ties with the GFL and the Labour Party, it had strong influence on the national health policy and decision making. However, during the 1980s, government coalitions were dominated by the right-wing *Likud Party* and the government financial support in KHC declined. The trigger for change in Israel has been the power contest between the two main parties-the Labour Party and the Likud Party-with the Likud attempting to impair the financial basis of the former. The liberal party sick fund and the sick fund started by physicians, were much stable and had no links with the labour unions. By early 1990s the market share of KHC declined while the share of the other sick funds increased. The regulations imposed by the other three sick funds enabled them to selectively recruit young and healthy members while KHC had a relatively high proportion of poor, elderly and chronically ill (Gross and Anson, 2002).

In 1994, prior to NHI, 50 % of Israel's national health care expenditure was financed by households through both voluntary sick-fund membership fees (23%) and out of pocket payments (27%). Coverage included curative, preventive community care as well as

acute hospital care. Secondary care was provided by sick-fund speciality clinics, independent physicians or hospital outpatient clinics. Israel has one of the highest physician to population ratio in the world, 4.7 per 1000 population in 1997 (Gross and Anson, 2002). Nearly all Israeli physicians are members of the Israeli Medical Association (IMA), which operates both as a professional association and as a trade union, co-ordinating collective working agreements. Other health professionals like the nurses and technicians are also organised in strong trade unions. All these are linked to GFL, which supports and backs them. While most physicians are salaried workers in the public sector, employed by Ministry or the sick funds, they were allowed to maintain private practices prior to NHI.

1992 had brought the Labour back into power. The appointed health minister supported the NHI legislation but said that it was important to severe ties between GFL and KHC so as to separate political links with the sick fund. All the other sick funds too had to severe their political links. NHI was made possible through the political struggles at the macro level of Israel's political system and micro level of labour movements. It is a compulsory insurance system. The main goals of the law were to achieve universal health insurance coverage, to promote greater equity, to define a universal benefits package and to stabilise the system financially. The main thrust was not a market reform aimed at competition but to increase regulation of sick funds in order to achieve the stated goals.

The medical profession did not oppose strongly the NHI but did oppose hospital reforms that were going to be introduced along the managed care lines in the 1990s. But there have been constant negotiations between the providers of health care and the government for increase in salaries.

Organisation and Administration of NHI

Some salient features of the NHI law are as follows:

- Every resident must register as a member with one of the four health-care organisations or sick funds.

- The health-care organisations may not bar applicants on any ground, including age or state of health.
- Residents, who had been insured with one of these organisations before the law came into effect, will continue to be members of that organisation and residents, who had not been insured prior to the law taking effect, are assigned to a health-care organisation by the Ministry of Health. After a period of six months they may transfer to another organisation of their choice.
- Children under 18 belong to the organisation of the parent who is receiving child benefits from the National Insurance Institute.
- Israeli citizens who have been living abroad for more than five years and have not spent more than 90 days in Israel must renew registration with a health-care organisation upon their return to Israel.
- New immigrants must register with a health-care organisation upon arrival in the country. They will be exempt from payment during their first year in Israel.
- Any person registered for at least one year with one of the health-care organisations may transfer to another organisation.
- The law accords equal status to all four health-care organisations.

The health care organisations are required to supply all the services enumerated in the standardised basket, within reasonable time and distance from the insured persons homes; they include: medical diagnosis and treatment both at clinics and at the home of the patient, preventive medicine and health education (i.e. early diagnosis of embryo abnormalities, vaccinations, counselling for pregnant women, mothers and the elderly), hospitalisation, surgery and transplant. If medical treatment is not available in Israel, treatment abroad will be covered, preventive dental care for children, first aid and transportation to a clinic or hospital, medical services at the workplace, medical treatment for drug abuse and alcoholism, medication, in accordance with a list issued by the Ministry of Health, treatment of chronic diseases, Paramedical services (i.e. physical therapy, occupational therapy, etc.).

The sources for funding include:

- Health insurance premiums paid by each resident.
- National Insurance Institute funds.
- Funds from the Ministry of Health budget.
- Consumer participation payments.

Payment of health insurance premiums is compulsory. Employees will have the premium deducted by their employer. Self-employed persons will remit them directly to the National Insurance Institute. The collection of health insurance premiums is progressive: low-income earners pay less and high-income earners pay more.

The government may augment, but not diminish medical services under the National Health Insurance Law, unless authorised to do so by the Committee on Labour and Social Affairs. The health-care organisation may offer supplementary insurance to cover medical services that are not included in the basic-services basket. The premium must be equal for all members of a given organisation, except for nursing services, for which payment according to the age of the insured may be charged.

The Ministry of Health will supervise the quality and availability of the medical services supplied by the health-care organisations, who are also required to submit quarterly financial statements which are open to public scrutiny. A public complaint office will also function in the Ministry of Health (Source: Internet).

Conclusion

Sick funds in Israel were a response to the political interests and all four were initially associated to one of the political parties or professional group. Labour party has been one of the main parties in Israel's political history and they have had a major role to play in developing the health services system. The main thrust of the NHI law was to increase state regulation of sick funds, to make coverage universal and not to allow market reforms. There was marginal role left for competition in health services. The sick funds receive funds from the National Insurance Institute and are providers of services too.

Developing Countries

China: Socialist Experience

The period of pre liberation in China was one of extreme inequalities in a society marked with high levels of poverty. The period of revolution in China, 1949-79 was of immense turmoil and radical change. History was rewritten from the bottom and the idea was that the base could be changed easily. Mao was committed to bring about change in social structure through changes in social relations of production and forces of production. Peasants in rural China were to bring about this process of reconstruction. The political ideology was instilled in to any change that was brought about, whether land reforms, education or health measures. All changes were entrenched within the political context and that was Mao's philosophy of attaining a perfect social order through collectives. China achieved success in reducing inequalities, improving its health status indicators.

Three types of health services financing exist in China: the labour insurance medical care scheme, the public service medical care scheme and the co-operative medical care scheme. By the end of 1970s, the labour insurance scheme covered all employees in state owned enterprises and most workers in collective owned ones; the public service medical care scheme was responsible for payment of medical care expenditure of the government employees and the co-operative medical scheme covered the rural population. This latter scheme appeared as a result of agricultural collectivisation that began in mid 1950s. In the late 1950s the agricultural collectives developed into people's commune and they provided a part of the public welfare fund to establish a health station i.e. a co-operative medical care clinic at the village or brigade level. The barefoot doctors provided primary health care at the village level. They were responsible for provision of primary health care for peasants at low cost and were paid by the collectives based on the workpoints they earned. The system also received financial contribution from peasants through a prepayment mechanism and the peasants obtained reimbursement for a fixed amount of health care expenses. The system involved community participation and cost sharing and

enabled access to basic health care to farmers (Xing-Yuan and Sheng-Lan, 1995). The vast majority of rural population received basic health services at low costs. Rural co-operative health insurance reached a peak in the mid-1970s when 90% of the rural population were covered. The foundation of the health services system was the three-tier network of health care (village health workers or barefoot workers, township health centres and county hospitals) and the Co-operative Medical scheme. Preventive measures to eradicate communicable diseases were taken up through organised mass campaigns.

China has undergone great economic, political and social change since 1978 with far reaching implications for the health services system. The introduction of market reforms shows a re-emergence of classes and a rise in income inequalities. The average infant mortality rate (IMR) was officially recorded at 34.7 per 1000 in 1981 and at 37 in 1992 (Bogg et al, 1996). Even more alarming is the growing difference in IMR between the poorer rural areas and the major cities. Government budget for health increased in real terms but the share of budget allocated to public health services system decreased from 1980-1995. Between 1978 and 1993, government share of total national health expenditure fell from 28 percent to 14 percent and the share of co-operative medical schemes fell from 20 percent to 2 percent (Bloom and Xingyuan, 1997). The government health budget is being increasingly used for hospital services (Liu, X. and Mills, A. 2002).

With the economic reforms, the Chinese Medical Reform in 1980s made cost recovery a primary objective. The urban population is mostly protected by generous government health insurance. A high share of the government budget is allocated to urban health care. The urban insurance programme ensures access to basic care, wide coverage and joint premium contributions by employers and employees (Liu, G. et al, 2002). But today even the urban insurance programme coverage has reduced to 50 percent as more state enterprises have declared insolvency and people find work in the private sector or in the informal urban sector. In the 1980s rural co-operative health insurance collapsed and its present coverage is less than 8% (Bogg et al, 1996). The collapse of the co-operative medical system and the weakening of the three-tier network of rural health care have

jeopardised preventive programmes. User fees have been implemented in a large scale in the absence of rural health insurance and there has been a substantial increase in out of pocket expenses. The most important characteristics of the market for health workers in recent years have been substantial pay increases and increasing mobility of health workers. There has been inequitable distribution of health facilities with high concentration of facilities in rich areas with increase in private practitioners and private pharmacies. Local governments that had been once handling preventive and curative health services do not receive enough funds. Regulatory systems have weakened.

In 1993, the government initiated a series of steps to improve access to health care in rural areas. The rural co-operative medical system (RCMS) was launched by the Ministry of Public Health to design, implement and test a number of health insurance schemes in several poor counties. By 1995, the RCMS design was implemented in 13 pilot counties. The insured population included farmers and enterprise workers. Contribution collection was carried out by village leaders on once- a- year basis. The sources of revenue are the contributions made by farmers, the village or county government and workers. The higher the income level the higher the contribution. Coverage of benefits varies and there are different levels of reimbursement for the various types of services, and for different levels of charge, from a low 20 percent (mostly for in-patient services) to a high 70 percent. The RCMS keep separate accounts for farmers and workers. This limits risk-sharing as reimbursement levels are higher for workers and low for farmers. The RCMS project has yet not provided universal coverage to rural population. It is still being experimented (Carrin et al, 1997). Many villages are establishing their own rural health insurance schemes.

Conclusion

China's approach towards providing access to health services for all has been different from the rest. Pre-market reforms, China followed a comprehensive approach towards providing universal coverage for access to health services. Firstly, it has not been focused just on curative services but preventive, promotive and curative services have been integrated within the three-tier service system. There was a strong primary health care

system at the village level with referral links. Health services in China were decentralised at the local government level. Priorities were set to deal with diseases and curative services were a component of the public health services system that was financed through the rural health insurance programme. All this was strongly linked to the political ideology of that time. The socio-economic base of the co-operative medical scheme was initially the agricultural collective. When this was transformed into household responsibility at the end of 1970s, most of the schemes collapsed. With the introduction of market reforms there has been a breakdown of insurance system. In the 1980s, the prime feature of Chinese health reforms was cost recovery. It is now dependent on fee for service revenue, mainly from drug sales. But considerable local variations exist and co-operative health insurance is seen as an important part of the solution to the growing inequities in access to basic health services.

South Asia: A focus on Thailand

Health financing systems in most South Asian countries have included limited public expenditures through general revenue and large out-of pocket payments. Financing of health services in ***Sri Lanka*** has a balanced mix of the public and the private. The working of insurance systems came up rather late in the South Asian developing countries. Most of the insurance systems till present have been targeted to certain groups and hence has never been universal. But debates in recent times have centred on having a universal insurance system that has been more pronounced in Philippines and Thailand. ***Philippines*** introduced the National Health Insurance Act in 1995 that emphasised on access to health care as a right to all citizens irrespective of paying capacity. How the NHI has been implemented is still to be seen but Philippines has a compulsory social insurance for the employed; separate medical insurance; health maintenance organisations and voluntary medical insurance for the self-employed and unemployed in select pilot areas. Approximately 42 percent of the population was covered by health insurance prior to 1995, with only 5 percent under the voluntary scheme (Giridhar, 1993).

The population of ***Thailand*** as of 1998 was 61.47 million. Divided into five regions the country is ruled under the democratic monarchy system and has relatively stable political conditions. In the past Thailand was essentially an agricultural country. However, over the past few decades it has gone through a significant shift from agricultural based economy to more industry based and export oriented. In 1997, 40 percent of the country's population lived in urban areas. Thailand faced economic crisis in 1997 and experienced negative economic growth, inflation and increase in international debts. This crisis had major social implications for unemployment, underemployment and contraction in household income. Income distribution has continued to be inequitable. Although Thailand has made substantial economic progress it still has 10 million poor people (Sawanpanyalert, 2002).

Thai parliament first passed a Social Security Law in 1954 though universal social security programmes remained unimplemented. About one-fourth of total health care spending is made through public channels i.e. through Ministry of Public Health (MOH), other ministries, state enterprises and local governments. The other three-fourth is spent through private channels like out of pocket expenses. 95 percent of the public financing is used for curative services.

Health insurance in Thailand can be classified in to welfare, compulsory, voluntary health insurance. Only about three-fourths of the Thais are insured or covered under one or more insurance or welfare schemes. The other 25 percent remain uninsured. There are welfare schemes, social health insurance for workers, private health insurance for employees in private sector, school health insurance scheme, health insurance covering government employees and voluntary rural health insurance system. The salient features of all these programmes are given in the table.

Table 2: Summary of various existing health insurance in Thailand

Name of Scheme	Population Covered	Nature of funding	Services Covered
Welfare scheme (Public Assistance Programme)	Lower income group (covers 17 % population), elderly, handicapped, war veterans, priests (covers 11.8 % of population)	General taxation	Free medical care in public hospitals
School Health Insurance	Primary children under 12 years (covers 14 percent of population)	General taxation	Preventive, Promotive and curative services
Workmen Compensation Fund	Working class in formal sector (covers 7.3 % population)	Contributions made by employers only	Medical care in private or public hospitals
Government employees programme	Civil servants, state enterprise workers and dependants (covers 13.1 % population)	General taxation	Out-patient services from public and private hospitals and in-patient services from public hospitals
Private health insurance	Covers mostly employees in private organised sector (covers 6 percent of population)	Employee/ Employer contribution	Hospitalisation Insurance
Voluntary Health Insurance	Farmers/ workers/ in informal sector (covers 9.1 percent of population)	General tax and contribution from household	Out patient care for illness and injuries, inpatient care and maternal and child health services

Source: Compiled from: Sawanpanyalert, P. (2002).

Out of all these schemes, the most recent initiative has been that of voluntary rural health insurance. Voluntary health insurance is the health card project for farmers and workers in informal sector. This voluntary pre paid rural health insurance scheme was initiated by Ministry of Public Health (MOPH) in Thailand in 1983. At the time of its inception in 1983, it was developed to complement the activities of primary health care on mother and child health. The low price pre paid health card was an experiment to raise funds at the village level for the mother and child health development fund. This was expanded to one sub-district in each province in 1985. The principle was gradually shifted from community financing to a mix between voluntary health insurance and public subsidy. The card price is 1000 baht and the national government gives an annual matching fund of equal amount from tax revenue. A household contributes half of the price and the other half is subsidised by general tax revenue. From the revenue from each card sale, 2.5

percent of 1000 baht is deducted and transferred to the central fund to pay for cross-boundary services and high cost services in different provinces. There is no limit to utilisation of services. The beneficiaries can only go to health care providers under the MOPH. The first contact is either the health centre or the community hospital; patients then follow a referral line for higher levels of care. According to a study of health card user patterns, clearly demonstrates that health card purchase is influenced by proportion of employed persons to total family members, and presence of illness. As it is voluntary system there are adverse selections and the sustainability of the system is being questioned (Supakankunti, S, 2000).

The amount of government contribution to each insurance/welfare scheme varies considerably. For example, the level of government subsidy per head for assistance programme for poor is 350 baht, while government pays more than 2000 baht per head for government and state enterprise workers. This shows that there are problems of equity in access to health care. There are inequities in modes of payments and kinds of benefits provided. The Thai health services system is geared towards curative services and recent health reforms have pushed the system towards technology and specialist oriented growth. Thai people are still not universally covered by health insurance schemes. This came up after a group of social activists and health reformists lobbied the government to set up an ad hoc office to finish the drafting of health reform act. In the 2001 election, reform of health care system was on the political agenda of various parties. The newly formed Thai Rak Thai party that was elected in 2001 defeated the democrats and is more economic growth oriented party. They are working on a universal health insurance policy, providing universal coverage with an essential health package and a nominal user fee charge (Sawanpanyalert, 2002).

Brazil: an overview of the health financing structure

Brazil's state of health service system dates back to 1923, when a landmark law was passed to create a social security system for urban workers employed in the private sector. Universality and equity of health services did not become constitutional rights in Brazil until 1988. Before this the Brazilian government had created a model of social

insurance based on compulsory contributions by employers and employees. This left millions of agricultural and informal sector workers out of the insurance system. Since 1920s social insurance provided health services to its beneficiaries through the private health sector. Changes were brought about in the health service system after introducing the principles of universality and equity in late 1980s. The constitution Article called for a Unified Health System. Private sector was to play a complementary role. The new constitution established new revenue sources for social security through mandatory contributions tied to the gross revenues and net profits of companies (Elias, P.E.M, 2003). Presently health services financing depends on national budget i.e. general funds from federal, state and municipal budgets (37.24%), private insurance (8.92%) and out of pocket expenditures (53.84%) (Medici, A.C., 2002). But the health service system has two distinct divisions. Brazil has been unable to bring the private sector to reach out to majority of the population that caters to a limited population and offers highly individualised services while the health services provided through public institutions is left for the poor people to access and is dependant on government budget. The majority still accesses government run health services. One major change during the last two decade has been in sharing of funds between the federal and the municipal. The municipalities share was increased by double as emphasis is being given to disease prevention and health promotion strategies. The move towards universality and equity of health services in Brazil is still an on-going process. The implementation has been gradual and there is still a lot to be achieved to make the fragmented system equitable. One positive thing is that Brazil has been able to resist US driven managed care organisations. It is not only the people who have protested against it but the medical profession has opposed it vehemently.

Summary of the experiences

The role of political parties, labour movements and interest groups in development of health financing especially through insurance is very important to understand. This can be seen to a certain extent in the review of country experiences given above. In the United States model the ideological divide between the two parties is clear. It has always been the Democratic Party that has tried to bring about a change or raised the issue of

universal access in most cases. Germany has been a paternalist state from the beginning so it was not difficult for them to gradually expand their insurance system to a universal system. The social democratic party took major steps to push for a sickness insurance. In the case of East Asia the beginnings of a welfarist objective began as a cover up to mask the overriding priority of economic growth related activities. But as the democrats began to voice their opposition against the selectivity of the insurance systems, steps were taken towards making coverage universal.

In most countries, a transformation in ideologies can be noted post Second World War. This was the time when number of countries gained independence from their colonisers and a feeling of nationalism had developed. Leaders had the vision to work towards a positive state. A move towards welfarism and paternalism had also arisen in developed and capitalist countries as a response to market failure. The break from this ideology is again seen with the entry of market reforms in the 1980s. As in most cases economic reforms have brought about changes in the health financing systems. While some states have tried to resist these changes, the ones with a liberal view have gone ahead with it while some have been forced to accept the reforms.

Social movements have had an impact on the development of health insurance systems. It started with the labour and working class movements having links with a labour and democratic party. In the United States the labour movements have been weak and have not been allowed to have strong political affiliations. In some other cases these movements have also brought in the middle class to demand for accessible health services. These have acted as pressure groups for the political parties to make changes in policies. On the other hand, professional groups like the medical profession and other interest groups like pharmaceuticals, technology industries have resisted moves towards state regulation. In all capitalist countries even with strict state regulations, concessions have been given to these groups. With the market reforms these groups have developed stronger voices as any kind of privatisation works in their interest.

Health Insurance systems have mostly focused on curative services and that too medical care. A comprehensive coverage has included hospitalisation and out-patient services. In terms of public health, the focus has been very narrow because curative services are not linked to primary health services. Primary health care and preventive services have not been a priority and therefore are not integrated within the health services system. They are mostly handed down to local authorities. Israel shows handling of preventive and curative services by the sick funds. China during its pre-reform period had tried to integrate preventive, promotive, curative health services in to a system. It was made a component of the health system. Where private financing systems have taken over as in Chile and USA and where market reforms are dominating health services system as in Thailand and China, preventive services have been further neglected and focus has shifted to hospital based specialised services. Private insurance systems here have created a two-tier health services system. The upper class who are insured through private plans are reluctant to pay higher taxes to fund similar health services for the less affluent and the poor.

The *tables* in the following pages summarise the socio-political and economic influences on health insurance systems and then give a comparison between the different insurance models discussed in the country experiences with regard to financing, organisation, administration, provisioning and coverage of services.

Table 3: Development of Insurance system within the socio-political context

i. *United States of America*

Period	Type of ruling government	Political/Social/ Economic Events	Development of Health Insurance Systems
1865-1899	Conservative	End of civil war and rapid industrial expansion	Health services is provided by private individual practitioners
1901-1919	Moderate	Reorganisation of AMA; WW I and Russian revolution	Workman's compensation 1912- Effort for NHI supported by progressive party but opposed by some part of labour and AMA.
1920-1933	Conservative	Industrial expansion and crash of 1929	
1933-1945	Liberals or Democrats	Depression; WW II, Pro labour laws were brought about, Wagner law	Public health services were expanded 1935- Second proposal for a NHI supported by the labour movement but opposed by AMA and business interests.
1946-1960	Moderates	Cold War, Taft Hartley law passed	Growth of private health insurance
1961-1980	Democrats	Oil price crisis, inflation	Medicare/Medicaid, medical price controls and beginnings of HMO 1972- Another proposal for a NHI by labour but opposed by AMA, hospitals, insurance, physicians and business
1981-92	Conservative		Growth of private health insurance and introduction of for-profit managed care organisations
1993-1999	Democrats		Clinton proposal for a NHI supported by labour movement but opposed by the conservatives, pharmaceuticals, MCOs and AMA.

Source: *Compiled from Jaheil, Rene. I. (1998), Angell, M. (1993), Brown, E.R. (1984), Relman, A.S. (1993).*

ii. *Germany*

Period	Type of ruling government	Political/Social/ Economic Events	Development of Health Insurance Systems
17th –18th century Prussia	Paternalist state		Relief funds existed for some group of workers
1850s-1880s	Authoritarian Monarchy	Industrialisation Rise of socialist movement, Social democrats gain popularity, demands for health insurance by workers movements Anti-socialist law issued by government	Large corporations start with compulsory health insurance. Regulation of private insurance funds and Sickness Insurance Bill issued by government in 1883 to secure support of working class.
1900- 1918	Authoritarian Monarchy	German Doctor's Association formed who wanted patients to have free choice of doctors while public insurance were not in favour of private practice by doctors	Sickness societies provide a choice of two doctors to the insured.
1919-1932	Weimar Republic took over after WW I with the social democratic party as the largest political party.	Great Depression	Number of sick funds increased and other occupational groups also insured. Benefits extended to dependants. Number of sickness funds dissolved and some cost-sharing measures were introduced.
1933 till WW II	Nazis	Nazis ban Social Democratic Party	Sickness Insurance funds and medical profession used as political apparatus to conduct experiments on racial purity.
1940s- 1989	East Germany under Communist rule West Germany received support from USA, France and Britain.		Health services under control of State Sickness insurance funds continued functioning as before Nazi regime and increased with time to cover more occupational groups.

Germany *(Continued)*:			
Period	**Type of ruling government**	**Political/Social/ Economic Events**	**Development of Health Insurance Systems**
1990-1999	Christian Democratic Party (Conservative)	Unification of Germany	Social Democratic Party proposes a uniform social insurance system but the federal government imposes the same social health insurance system to East Germany

Source: *Compiled from Barnighausen, T. and R. Sauerborn (2002), Leichter, Howard M. (1979), Altenstetter (2003).*

iii. ***Chile***

Period	Type of ruling government	Political/Social/ Economic Events	Development of Health Insurance Systems
Pre 1980s	Christian Democratic Party		Social Insurance systems financed through payroll contribution for white collar workers, Presence of national health service system and private health care system
	Socialist government		Attempt to unify and centralise health services system
1973-1990	Military government	Class based organisation of health services gains prominence as the poor go to public institutions and the upper class access private institutions.	Introduction of ISAPRE i.e. private health insurance system through managed care organisations.
1991-present	Democratic government	In recent times, 2002, there have been resistance movements by unemployed, and even the middle class against the unequal access to health services	Modifications initiated by the government to increase public funding of primary care and to introduce single benefit package by ISPARE was thwarted by health professionals

Source: *Compiled from Iriart, C, H. Waitzkin et al (2002), Waitzkin, H and C. Iriart (2001), Jimenez de la Jara, J and T. J. Bossert (1995).*

iv. ***South Korea***

Period	Type of ruling government	Political/Social/ Economic Events	Development of Health Insurance Systems
1960-1990s	Military Government	Concessions to business and interest groups Economic growth was the overriding concern and health insurance funds were seen as a way to mobilise capital Opposition Democratic Party seeks merger of all funds but bill is vetoed by the President because of fear of losing middle class vote bank.	Industrial Accident Insurance in 1963 SHI introduced for large corporations SHI for public employees and teachers Separate funds for different occupational groups.
2000-present	Democratic Party	Economic crisis	Merger of all 373 health insurance societies funds Government Subsidies provided for self-employed, low income group and unemployed to make system universal.

Source: *Compiled from Kwon, Huck-ju (1998), Kwon, Soonman (2002), Son, A.H.K (2002).*

v. ***Taiwan***

Period	Type of ruling government	Political/Social/ Economic Events	Development of Health Insurance Systems
1950-1986	Kuomintang (KMT) government	The Kuomintang government flees from China and tries to establish political legitimacy in Taiwan. Focus on economic growth	Labour Insurance Programme SHI programme is selective and is introduced for government employees, civil servants and military personnel
1987-present	KMT	The opposition party i.e. Democratic People's Party becomes stronger and there is a radical increase in social movements by workers who demand for welfare services.	Government forced to introduce NHI in1995

Source: *Compiled from Kwon, Huck-ju (1998), Yeun-wen Ku (1998).*

vi. *Israel*

Period	Type of ruling government	Political/Social/ Economic Events	Development of Health Insurance Systems
1920s-1930s			General Federation of Labour (GFL), a trade union established a sick fund, KHC in 1920 Two other sick funds founded by another trade union in 1933 and another sick fund was established in 1936 by the Liberal Likud Party
1940s- 1970s	Labour party	Strengthening of link between labour party, GFL and KHC.	Another sick fund introduced by physician organisation. KHC dominated the sick funds and expanded its provisioning so as to increase coverage.
1977-1991	Government coalition dominated by right winged Likud Party came to power in 1977	Financial support to KHC decreases which was an attempt to break the link between the labour party, GFL and KHC.	The other sick funds recruit healthy members through their selective memebership and KHC loses memberships and has larger membership of poor and chronically ill. Physicians were salaried but allowed to maintain private practice.
1992 - present	Labour Party	Health Minister opposes GFL and KHC link as it is felt that political links to sick funds are coming in the way of providing benefits to the population.	NHI legislation is prepared and introduced in 1995. Other three sick funds oppose as they would lose autonomy due to state regulation but later accept.

Source: Compiled from Geva-May, Iris and Allan Maslove (2000), Gross, R. and Ofra Anson (2001)

vii. *China*

Period	Type of ruling government	Political/Social/ Economic Events	Development of Health Insurance Systems
1950-1978	Socialist Government (Communist Party)	Land Reforms with focus on rural china Formation of communes and collectives	Health services are handled at the local level. Priorities set to target diseases. Community rural health insurance set up and administered through a Co-operative Medical System Urban health insurance also provided through SHI system.
Post 1978	Liberal Party	Introduction of market reforms	Complete breakdown of rural health insurance system and urban health insurance system.

Source: *Compiled from Bogg, L., Dong Hengjin et al (1996), Carrin, Guy, Aviva Ron et al (1997), Liu, G., Zhao, Z et al (2002), Bloom, G. and Xingyuan, G (1997).*

Table 4: Comparative Table on Variations in Financing, Administration and Coverage of Health Services

Country	Dominant Financing System	Administration & Organisation of System	Provisioning	Coverage of Population & Benefits for insured
United States	Voluntary private health insurance funded by employee/employer contribution or individual contribution (34.6 percent of total funds) Medicaid/Medicare that are public insurance systems (both constitute 29 percent of total funds). Medicaid gets some federal subsidies based on percapita income in State.	No centralised administration, policies made at many levels of State, local and national governments. Medicare policy is made at Federal level.	Private provisioning of health services and is administered through for-profit Managed Care Organisations	83.9 percent of population insured, the rest are uninsured Benefits include hospitalisation , out patient services, prescription drugs are covered
Germany	Compulsory Social Health Insurance funded by employee/employer contribution State governments give subsidies to hospitals for infrastructure. Government subsidies cover unemployed, disabled and pensioners.	1000 autonomous non-profit sickness funds negotiate with physician association for payments to providers Strictly regulated by the State and is diffused through national, state and local levels.	Public and private mix of providers Providers are reimbursed by the health funds	92 percent of the total population are insured through SHI and government subsidies, rest are insured privately. Benefits include in-patient, out-patient, diagnostic facilities.
France	Compulsory Social Health Insurance that provides 75.5 % of total funds. Supplementary private insurance covers 12.4 % funds and 11.1 % are out of pocket expenditures.	3 health funds based on occupational groups and 11 smaller funds. All work as non-profit, quasi-public organisations under state control.	Public-private mix of health services. Patients make direct out of pocket payment for private services and get reimbursed by health funds.	All legal residents are covered through the social health insurance and supplementary coverage provided by the state.
Canada	Financed through general taxation. Provinces are the single payers. Federal government provides financial support and financed through a progressive tax system.	Interlocking 10 provincial and 2 territorial health insurance schemes. Linked through adherence to national principles. Most health services under control of provinces	Mostly private providers Fee for service reimbursement by provincial government	Universal coverage Hospital insurance i.e. inpatient, out-patient and medical insurance i.e. physician fees

Country	Dominant Financing System	Administration & Organisation of System	Provisioning	Coverage of Population & Benefits for insured
Israel	Compulsory health insurance through health insurance premiums by each resident; parallel tax payment by employer and self-employed persons; National Insurance Institute funds and funds from Ministry of Health budget. Premium collection is progressive.	Operates through four autonomous not-for profit sick funds Regulated by state government and administered through National Insurance Institute.	Public and Private mix of providers	Universal coverage Standard basket of benefits includes preventive medicine, health education and in-patient and out-patient services.
Chile	Social Health Insurance (SHI) Private Health Insurance (PHI)	SHI is administered through FONASA PHI is administered and operated through ISAPRE MCOs	Public and private mix of providers	61.8 percent covered through FONASA and 23.1 percent through ISAPRE Benefits include hospital services and limited out-patient services
South Korea	Social Insurance through employer/employee contribution Government subsidises for unemployed, self–employed	Recently 373 health insurance funds merged in to a single insurer. Strictly State regulated.	Mostly private providers	Universal coverage but benefits are limited for out-patient services. Medical and surgical services, hospitalisation, drugs are provided. Out of pocket expenses are high.
Taiwan	Social Health Insurance through employer/employee and State contribution Government subsidises for people with lower income	Administered through Central Bureau of National Health Insurance (CBNHI) State regulated	Mostly private providers	96 percent of population covered under insurance Benefits include basic curative services, some out of pocket expenses have to be made.
Thailand	Private health insurance by employers Voluntary community health insurance for farmers and informal sector Government subsidies and provisioning for lower income group, handicapped, school children, and government employees.	Private Health Insurance is administered through private for-profit companies Community health insurance is government organised and administered at the local level	Public and private provisioning	75 percent of population covered All types of insurance provide benefit for a range curative services

Country	Dominant Financing System	Administration & Organisation of System	Provisioning	Coverage of Population & Benefits for insured
China	1950s-1978- Labour Insurance, Public Service medical care and Co-operative Medical Care Scheme. The three insurance systems are financed by enterprise welfare fund, government budget and collective welfare fund respectively.	1950s to 1978 -Urban Insurance systems were strictly administered, regulated by State and administered. Rural health insurance was administered and financed through collectives	Provisioning before 1978 was by State	Urban population was universally covered and 90 percent of rural population was covered by end of 1970s
	Post 1978- the three insurance systems and out of pocket payments.		Presently there is a mixture of public private providers	Labour Insurance covers 17.8 % of the population, Public Service Medical Care covers 2.4 % of the population and Co-operative Medical care covers 7 percent of the population. The rest pay out-of-pocket.

Source: *Compiled from - Barnighausen, T. and R. Sauerborn (2002), Gross, R. and Ofra Anson (2001), Iglehart, John K. (1999), Iglehart, John K. (2000), Kalisch, David. W, Tetsuya Aman et al (1998), Kwon, Soonman (2002), Rodwin, V.G (2003), www.mfa.gov.il/mfa/go.asp, Xing-Yuan, G and Sheng-Lan, T. (1995), Yeun-wen Ku (1998).*

Table 5: Some Important Features of Countries Around the World

	HDI Rank	Total Population (in millions) 1999	Urban po (% of total	Life Expectancy F	Life Expectancy M	IMR (1999)	Under 5 MR -1999	MMR	Health Expenditure Public (as % of GDP)	Health Expenditure Private (as % of GDP)	Health Expenditure per capita (in US $)	Physicians (per 10000 population)	Economic Activity (Employment by economic activity) (percentage)-1994-1997 Agriculture F	Agriculture M	Industry F	Industry M	Services F	Services M	Unemployment (in thousands 1999)
North America																			
United States	6	280.4	77	79.7	73.9	7	8	8	5.8	7.3	4180	279	1	4	13	34	85	63	5,878.90
Canada	3	30.5	77	81.4	75.9	6	6		6.3	2.8	2391	229	2	5	12	32	86	63	1,188.90
Europe																			
United Kingdom	14	59.3	89.4	80	75	6	6	7	5.9	1.1	1532	164	1	3	13	38	86	59	1,779.10
France	13	59	75.4	82.3	74.5	5	5	10	7.3	2.3	2102	303							2,924.10
Germany	17	82	87.3	80.6	74.3	5	5	8	7.9	2.6	2488	350	3	3	19	46	79	49	3,428
Spain	21	39.9	77.4	81.9	74.8	6	6	6	5.4	1.6	1202	424	6	10	14	39	80	52	2,604.90
Sweden	4	8.9	83.3	82.1	77	3	4	5	6.7	1.3	1707	311	1	4	12	39	87	57	240.8
Latin America																			
Chile	39	15	85.4	78.5	72.5	11	12	20	2.7	3.1	511	110	4	19	14	34	81	47	
Costa Rica	41	3.9	47.6	79.2	74.5	13	14	29	5.2	1.5	509	141							
Argentina	34	36.6	89.6	77	69.9	19	22	38	4.9	5.4	1291	268							
Brazil	69	168.2	80.7	71.8	63.9	34	40	160	2.9	3.7	453	127							
East Asia																			
Korea, republic	27	46.4	81.1	78.4	70.9	5	5	20	2.3	2.8	720	136	13	10	21	38	66	52	1,353
Japan	9	126.8	78.6	84.1	77.3	4	4	8	5.9	1.6	1844	193	6	5	24	39	69	55	3,171.50
China (Taiwan)	87	1264.8	31.6	72.5	68.3	33	41	55				162							
South Asia																			
India	115	992.7	28.1	63.3	62.4	70	98	410	1.3*	4.2		48							
Thailand	66	62	21.2	72.9	67	26	30	44	1.9	4.1	349	24	51	49	17	22	32	28	
Sri Lanka	81	18.7	23.3	75	69.3	17	19	60	1.4	1.7	95	37	40	33	24	22	34	31	
Phillipines	70	74.2	57.7	71.1	67	31	42	170	1.7	2	136	123	28	48	13	19	59	33	
Middle East																			
Israel	22	5.9	91.1	80.4	76.6	6	6	5	6	3.6	1730	385	1	3	14	38	84	58	

HDI Rank
1-48: High Human Development
49-126: Medium Human Development
127-162: Low Human Development

IMR- Infant Mortality Rate
MMR-Maternal mortality Rate
*National Health Policy, 2002

Source: Human Development Report, 2001, UNDP

Chapter II
National Health Insurance: The Canadian Model

National Health Insurance: The Canadian Model

Canada's National Health Insurance is almost 40 years old. As a comparative study, it would be interesting to study the health insurance system of Canada and how it has been able to sustain it despite internal pressures and external forces. The State developed a paternalist ideology after World War II when health was viewed as a right, irrespective of paying capacity. All Canadian citizens are insured for medical care, therefore ensuring 100 percent coverage for its population. The State takes the responsibility of being the single payer of health insurance. These salient features make the Canadian health insurance system an interesting country case study that needs to be understood in greater extent in order to provide lessons for other countries.

This chapter focuses on the evolution and working of the National Health Insurance in Canada in phases. It starts by explaining the structure of government and how the system works. The next section examines how the interplay between political forces, labour movements, interest groups led to the emergence of public health insurance in Canada. The third section goes on to the development and changes in the health insurance system till the present. The last section examines the working of the NHI.

Structure of the government in Canada

Canada's population of 30.5 million is mostly concentrated in urban areas. Canada is a federation of ten provinces and two territories, with power and resources divided between the national (federal) government in Ottawa and the provincial governments. The federal state was formally created in 1867 when the British North America Act (BNA Act) was passed by the British parliament. Canada has a parliamentary system of government. At both the federal and provincial levels, the people elect a legislature. Party with majority of elected members forms the government. Leader of the government is First Minister (called Prime Minister at the national level and Premier at provincial level). Ministers who comprise the cabinet are elected member of the legislature and the cabinet determines the government policies. The Queen is the nominal head of the government,

at the federal level she is represented by the governor-general and at the provincial level the Lieutenant Governor (Soderstrom, 1978).

Section 92 of the British North America (BNA) Act stipulates that each provincial legislature 'may exclusively make laws in relation to the establishment, maintenance and management of hospitals, asylums, charities for the province.' The BNA Act has not prevented the federal government from being involved. Federal government has offered to share its revenue with those provinces willing to establish certain health and other programmes that meet federal standards (Soderstrom, 1978). Canadian federalism is by nature more decentralised than its neighbour, the United States. Many policy areas including health policy are considered to be under provincial responsibility and the provincial governments play an influential role in intergovernmental relations.

Emergence of public health insurance in Canada

State financing of health care came relatively late in Canada as compared to most capitalist countries. Hospital insurance came in 1958 and medical insurance a decade later. Hospital Insurance includes in-patient and out-patient services while medical care insurance includes physician services and services by other health professionals.

The idea of health insurance grew out of the efforts of industrial workers to combat illness and work related injury and deal with associated losses of income. Unions and friendly societies either set up insurance funds for their members themselves or did so through some arrangement with employers. Many employers who saw difficulty in recruiting labour and maintaining them saw health insurance as a way of increasing efficiency of labour and others saw political benefits in health insurance because of their realisation that 'distress breeds a dangerous temper' (Swartz, 1993). But these arrangements had severe limitations because of their ad hoc nature and inadequate coverage of services.

The presence of a social democratic third party in Canada spurred Universal Health Insurance to national prominence as a viable alternative in the health reform debate and focused powerful political pressure that led to the passage of legislation.

During the 1940s the presence of a social democratic third party helped rouse the governments interest in health reform. The *Co-operative Commonwealth Federation* (CCF) was formed in 1932 in response to the failure of major parties to respond to the Great depression and protest movements that rose from agrarian society and industrial workers. It was a federation of the independent labour representatives in the House of Commons, progressive farm and labour organisations in Western Canada and elements of the socialist left. There was a rising interest in the post Second World War social order that was heightened by the release of the Marsh report[7]. The CCFs social reform platform, which included universal health insurance, captured attention of Canadians. The party gathered momentum in both federal and provincial politics and by 1944 won a majority of the popular vote in British Columbia, became the official opposition in Ontario and defeated the liberals and took office in Saskatchewan in an election dominated by the health reform issue. By this time 75 percent Canadians supported the idea of a national health plan. The 1945 election resulted in a narrow win by the liberal party and they were under an increasing pressure to act. The health insurance proposal suggested by the liberals took into consideration the interest of the medical profession and business concerns. The liberal government realised that they were straining relations with these two interest groups and to reassure them and to regain their confidence unemployment insurance and family allowances were enacted as programme of reform. Many provinces, beginning with the CCF government in Saskatchewan, experimented with various types of hospital insurance but found it difficult to finance such programmes without assistance from the federal government. By 1955 the conservative government in

[7] This was a crucial report, which detailed the need for comprehensive and universal social programs. Dr. Leonard Marsh wrote the report. The report is considered by many to be the most important single report in the history of the development of the Canadian welfare state. Marsh suggested that the country should establish a "social minimum," a standard aimed at protecting the disadvantaged through policies such as social insurance and children's allowances. The study did not attract much attention from policymakers at first, but by 1966, most of Marsh's recommendations had become law. His work served as the blueprint for the modern Canadian social security system.

Ontario, under pressure from CCF opposition and its allies in the labour movement, refused to take it up alone and insisted on federal cost sharing guarantees before initiating a hospital insurance plan (Maioni, 1997). The Hospital and Diagnostic Services Act was introduced in 1958. The legislation empowered the federal government to share the costs of acute hospital care and diagnostic services with any province establishing an insurance programme for which all residents were eligible.

The federal conservative government was not eager to reopen the health reform issue again. Instead, the CCF government in Saskatchewan again provided the initiative. A medical insurance programme that combined private fee for service delivery with public administration and financing was introduced in 1961 despite vehement opposition to 'socialised medicine' from CCFs political opponents. The Saskatchewan doctors went on strike in July 1962 but this contributed to a loss of prestige for the medical lobby and propelled medical insurance on to the national political agenda. Public hearings revealed the extent of polarisation between groups across the political spectrum: from labour and farm groups who advocated complete public control of health services to the medical lobby, insurance and business interests who recommended voluntary medical insurance and a means tested public programme for the medically indigent to purchase medical insurance. The New Democratic Party formed in 1961 by alliance of CCF with the Canadian labour movement emphasised the public demand for action on medical insurance. The liberal government introduced the Medicare Act in 1966. The federal government offered to split the costs of physicians' services with any province adopting a plan that was universal, comprehensive, portable from province to province, and financed through a publicly administered non profit fund. This drew opposition from doctors and insurance companies. Liberals emphasised that the reason for doing so was efficiency (Swartz, 1993).

Table 6: The table indicates when the various provincial plans started and **evolution of public financing of hospital and medical services:**

Province	*Hospital Insurance*	*Medical Care Insurance*
Newfoundland	July1, 1958	April 1, 1969
Prince Edward Island	October 1, 1959	December 1, 1970
Nova Scotia	Jan 1, 1959	April 1, 1969
New Brunswick	July 1, 1959	Jan 1, 1971
Quebec	Jan 1, 1961	November 1, 1970
Ontario	Jan 1, 1959	October 1, 1969
Manitoba	July 1, 1958	April 1, 1969
Saskatchewan	July 1, 1958	July 1, 1968
Alberta	July 1, 1958	July 1, 1969
British Columbia	July 1, 1958	July 1, 1968
Yukon	July 1, 1960	April 1, 1972
Northwest Territories	April 1, 1960	April 1, 1971
Federal Programme	July 1, 1958 [a]	July 1, 1968 [b]

Source: Soderstrom, 1978

a. The Hospital Insurance and Diagnostic Services Act was proclaimed in April 1957

b. The Medical Care Act was proclaimed in December 1966.

After a struggle lasting over 50 years, the Canadian working class had achieved a real victory. By 1971, all Canadians were guaranteed access to essential medical services, regardless of employment, income or health. The NHI is called Medicare in Canada.

Working of the NHI

Organisation and Provisioning of Health Services

The Medical Profession

Despite the large role played by the state in the early development of Canada, the health system was overwhelmingly a creation of private interest and initiative. The original medical practitioners were petit-bourgeois independent commodity producers selling their services on a fee-per-service basis at the prevailing price. These medical practitioners were a heterogeneous lot, ranging from physicians, to midwives with years of experience to patent medicine peddlers. What the physicians sought was a licensing monopoly from the state that would at one and the same time remove competing practitioners from the market as well as enable them to control the supply of physicians. In 1865 the Parker Act culminated a 75 year struggle and realised both of these objectives for physicians (Hatcher et al, 1989). In gaining its monopoly the medical profession acquired full control over the definition of disease, as well as how, when and where to

treat it. This becomes particularly important when the development of the hospital is considered. Hospitals in Canada, as elsewhere, were initially founded by church orders and/or charitable organisations as places for sick poor to die. With the development of medical science in the last quarter of the 19th century, however, hospitals were transformed into places for the treatment and cure of those who could afford these services. The subsequent growth can be understood as a process in which the dominant classes in particular locations, including socially prominent physicians, pooled some of their resources to build a private non profit organisation. Government sponsored hospital insurance, relative to a system of private insurance, meant that the state could, through budgeting policies tying hospital revenue to a set number of beds, exercise a crude control over the overall size and hence the cost of the hospital sector. Medical Insurance was of course introduced upon physicians remaining self-employed with income derived fees for service. It implied that the provincial medical associations had to bargain for the fees that would be paid for specific services, which necessarily gave the state more control over costs than under private insurance.

Universal medical insurance began with a serious maldistribution of doctors. They were concentrated where patients had money or private insurance coverage through their employers. Since 1971 these differentials between over and under-doctored areas have been decreasing. Many more doctors have been attracted by health insurance fees to provinces and areas previously under-doctored (Hatcher, 1989). Generally surgical specialists earn more than general or family practitioners, while the highest incomes go to support specialists in areas such as pathology, radiology or anaesthesia. This is a function both of market forces and of medical politics in the negotiations between the medical associations and the government health insurance plans in each province. Specialists and sub-specialists tend to be concentrated in cities and towns where problems are referred by general practitioners for consultation. General practitioners control access to specialists, other health providers, diagnostic testing and drug prescriptions and are the system's gatekeepers (Woodward et al, 2002). A common fee schedule province wide and to a lesser extent, similar fee schedules between provinces use market forces to redistribute physicians from over-doctored to under-doctored areas. The zero price feature of

Canadian medical insurance, with universal coverage and virtually no out of pocket payment to a doctor, means that a blue collar worker or a poor farmer in an industrial area is just as good a source of income as a wealthy suburbanite (Hatcher, 1989).

The first Canadian medical schools were modelled on the Scottish Medical Schools in Edinburgh. All the sixteen Canadian medical schools are public, university based institutions and are heavily subsidised by the federal and provincial governments. Post graduate medical speciality training is supervised by a single body, The Royal College of Physicians. This ensures quality of speciality training and enables provincial governments to control relative proportions of generalists and specialists. (Hatcher et al, 1989).

The physician population ratio is about 229 physicians per 10000 (HDR, 1999). Between 25 % and 30 % of Canadian doctors are essentially hospital based, although not government employees, and nearly all the rest are in office based private practice. The major component of primary health care in Canada is provided in the community by general practitioners and tertiary care is provided by specialists in hospital settings. This is unlike the case in the United States where primary health care is provided by specialists (Shah, 1998).

Hospitals

The Canadian hospital system evolved from a collection of separate units of various kinds developed by local communities to meet perceived needs and care. Public authorities established province wide hospital systems for tuberculosis and for mental illness, and for a time operated province wide clinical laboratory services and provided free supplies of immunising agents for the use of doctors in private practice. The dominant hospital 'system' in Canada is made up of over 1,200 non-federal hospitals. Most of the hospitals in Canada are called public hospitals and governed by community boards and funded by a single party payer – the provincial government.

Public Health service in Canada followed the narrow understanding that originated from England[8]. At the end of the First World War, the province of New Brunswick was the first to establish a Department of Health headed by a cabinet minister. Other provinces followed suit. The provinces passed Public Health Laws modelled in principle after the landmark English Public Health Act of 1875. Some Industrial provinces developed occupational health and safety programmes. Local public health departments were set up across the county in the 1950s. Immunisation and other maternal and child health programmes have long been a key element in of local health departments. The local government was therefore handed down preventive and promotive services and was not integrally linked with the curative services. The functions of public health units include: communicable disease control, maternal and child health, health promotion, dental health and environmental health.

Coverage of services

Under the Constitution, the provinces are responsible for organising medical care and health services. The ten provincial plans are not identical, but have many common features because they must meet certain *federal standards* in order to qualify for federal cost sharing.

Discussions on financing methods in Canada have focused on two questions. Firstly, how do provincial governments finance their expenditures for health services? They levy taxes and receive some federal cost-sharing payments, which will be discussed later. The relative importance of these two sources varies among provincial programmes. Secondly, how are the actual providers of services financed? The two schemes of insurance under NHI are: Hospital Insurance and the Medical Insurance

[8] Public health services include preventive, promotive, curative and rehabilitative aspects of health service. With the beginnings of bacteriology, the definition of public health became synonymous to preventive and promotive services like clean water supply, sanitation and control of communicable diseases. It was passed on to local government and was not integrated to the overall health services. The inception of NHS in UK also passed on preventive services to local government while taking in itself curative services.

Hospital Insurance

Hospitals and hospital care in Canada had previously been financed by municipal governments, religious groups, voluntary insurance programmes and patient payments. Later the Hospital insurance and Diagnostic services Act induced all provinces to adopt universal hospital insurance by 1961. Federal standards for hospital insurance (1978) stated that:

Insured services must be available to all residents upon uniform terms and conditions. All residents are eligible for coverage. The requirement avoids various problems that arise with private insurance plans. It meant that someone cannot be denied benefits because of his/her age or past health record, or because s/he has become unemployed or retired or poor. Nine categories of in-patient services provided by general and allied special hospitals must be insured benefits. Additional in-patient and many out-patient services are covered in all provinces. There are no specific disease exclusions as found in private insurance plans (Soderstrom, 1978). Coverage to all residents is automatic and compulsory, except in Alberta where people may formally opt out of the plan. In Ontario coverage is compulsory for people working for firms employing 15 or more persons. Coverage is voluntary for everyone else. The number of non-participants is very small in both provinces. Residents who move from one province to another typically will not be covered by the plan in the new provinces until they have lived for two complete calendar months; in the meantime they are covered by the plan in the province from which they moved. Newly arrived immigrants are immediately eligible in all provinces except British Columbia a two-month waiting period.

Table 7: In-patient and out-patient services generally provide the following services across provinces

In-patient Services	*Out-patient Services*
- Accommodation and meals at the standard or public ward level	- All diagnostic services
- Necessary nursing services	- All out-patient services provided by provincial cancer clinics and dietetic counselling services
- Laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability	- Physiotherapy services rendered in approved non-hospital facilities
- Drugs and related preparations as provided in an agreement when administered in the hospital	
- Use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies	
- Routine surgical supplies	
- Use of radiotherapy facilities where available	
- Use of physiotherapy facilities where available	

Source: Soderstrom, 1978; Woodward, 2002

The provincial hospital insurance plans typically do not finance the cost of TB or mental hospitals, homes for the aged or other institutions providing custodial care. The cost of treating many work-related illnesses or injuries is financed by provincial workmen's compensation plans.

Medical Care Insurance

Fee for service reimbursement is the dominant method of physician payment, both for office and hospital practice, except for interns and residents who are paid salaries.

The cost of most physician services and some services rendered by other health professionals are financed by the provincial medical care insurance plans. Public funds pay for 95 % of all physician services. Each provincial plan had to meet the federal standards of comprehensive coverage, universality, public administration and portability of benefits. Physicians initially could actually opt out. For example in Manitoba, a physician must notify that he intends to opt out, and he must inform his insured patients,

before treating them that he intends to bill them directly. Insured patients could then bill the commission. If the physician charged more than the prevailing Medicare fee from the Commission, they would have to pay the difference themselves. In 1974, 97 % of Manitoba physicians did not opt out (Shah, 1998).

Development and Changes in the NHI system: The Federal-Province cost-sharing and Reforms

In general, funds flow from the Canadian people in the form of taxes, the ultimate source of financing for the health services system. The largest single payer in Canada is the state and the actual disbursement of the funds is centralised in the respective provincial health ministries. Prior to April 1977, the amount the federal government paid for hospital and medical services depended directly on the cost of provincial plans. Thus, as the cost of the plans increased, the federal payments increased at the corresponding rate. Therefore federal shared 50 percent of the costs. Following the economic crisis that affected the world in late 1970s and early 1980s, concern regarding the above inflation increases in health services expenditures got reflected in number of government planning reports. Rising expenditures stressed the need for less expensive forms of health services delivery. Their goal was not necessarily to cut costs, but rather to contain their rate of increase. They were influenced by a strong body of expert opinion calling for improving the efficiency and containing the costs of the health care system through such measures as shifting from inpatient to outpatient care, reducing the number of hospital beds, and promoting paramedical workers and community health centres. In 1977, federal cash payments under the old arrangements were replaced by two revenue sources for the provinces. First, the federal government continued to make direct cash payments, but they were much less than the payments that would have been made under the old arrangements. Second, the federal government's personal and corporate tax rates were lowered, enabling the provinces to raise their tax rates. In addition to these two revenue sources, the federal government had started a new programme, the Extended Health Care Services Programme, under which it made a separate direct payment to each province. These payments were made to help provinces finance nursing homes and other residential care, home care and ambulatory care health services (Soderstrom, 1978).

Canada faced several potential confrontations, one between the federal and provincial governments and a second between the provinces and providers. The federal government proposed reducing its contributions and at the same time it favoured elimination of user charges.

A health services review that was undertaken in 1979 reported that health care in Canada ranked among the best in the world, but warned that extra-billing by doctors and user fees levied by hospitals were creating a two-tiered system that threatened the accessibility of care. In response to these concerns, Parliament passed the ***Canada Health Act (CHA)*** in 1984 to discourage hospital user charges and extra-billing by physicians. The Act provides for an automatic dollar-for-dollar penalty if any province permits such charges for insured health services.

The five ***principles*** of the CHA are the cornerstone of the Canadian health care system. The Act ensured that all residents of Canada had access to medically necessary hospital and physician services based on need, not on ability to pay.

The five criteria of the CHA are:

Public administration: the administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority;

Comprehensiveness: all medically necessary services provided by hospitals and doctors must be insured;

Universality: all insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions;

Portability: coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country; and

Accessibility: reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

The CHA also contained provisions that banned extra-billing and user charges: *no extra-billing* by medical practitioners or dentists for insured health services under the terms of the health care insurance plan of the province or territory; *no user charges* for insured

health services by hospitals or other providers under the terms of the health care insurance plan of the province or territory.

Pressure of reforms

Health reforms to privatise health services have been a pressure even in Canada as it has been around the world in the past two decades. There have been cuts in federal and provincial spending but largely Canada is still maintaining its universal health insurance system. Physicians were not happy with this trend toward deprivatisation of their practice, and have increasingly advocated privatisation as a way of eliminating government regulation.

The federal government began to reduce its contribution to the provincial health insurance plans more than 20 years ago, but the reductions became larger in the 1990s. The federal share of payments amounted to 44.6 percent of the total health expenditure of $14.1 billion Canadian by the provincial plans in fiscal year 1980. A decade later, the provincial plans spent a total of $39.2 billion Canadian for health care, only 36.7 percent of which was contributed by the national government. Of the $34 billion spent on institutional care in 1994, more than 3/4ths (79%) was for general and allied special hospitals. On average the per diem cost in acute care hospitals has been usually higher than that in chronic or long-term hospitals. In 1992, the 61,650 doctors in Canada billed an average of $ 188,000 each. More than 90% of doctors in private practice are paid on a fee for service reimbursement basis. In 1996 the expenditure for professional services by physicians, dentists and other specialists amounted to about $17.5 billion (23.2% of total spending). Physician services alone constituted approximately 62 % of total professional services, amounting to $ 10.9 billion. Expenditures on drugs were the third largest category of health expenditures comprising 14.4 % of total health expenditures (Shah, 1998).

Table 8: Percentage Distribution of Health Expenditures by Category of Expenditure, 1996

Hospitals	34.2%
Physicians	14.4%
Drugs	14.4%
'Other' expenditures (e.g. home care, transportation, assistive devices	10.7%
'Others' institutions (residential care for special needs groups, e.g. the elderly, disabled, mentally ill etc.	10.0%
'Other' professionals	8.8%
Public health	5.0%
Capital expenditures	2.5%

Source: *National Health Expenditures, 1996, cited in Shah, C.P. (1998), "Public Health and Preventive Medicine in Canada", University of Toronto Press*

In 1997, the provincial plans spent approximately $54 billion Canadian with the federal providing an estimated 23 percent of the total through a combination of cash payments and tax allowances that enabled the provinces to impose certain levies on their residents for the purpose of funding health care. Whereas early budget cuts were implemented to check rising medical expenditures in Canada, the later reductions were enacted to reverse a broad pattern of deficit spending in the 1970s and 1980s under both Conservative and Liberal governments. To stem the deficit spending, the Liberal government took a number of steps. One of the most important was the bundling of federal payments to the provinces for health care, higher education, social assistance and other social programmes. With this consolidation, through a vehicle called the ***Canada Health and Social Transfer (CHST)***, the provinces had the flexibility to set their own priorities. The CHST is the largest federal transfer to provinces and territories, providing them with cash payments and tax transfers and was introduced in 1996. The 2000 budget authorised an additional expenditure of $2.5 billion Canadian through CHST payments, which the provinces could use at their discretion over the next four years for higher education, health care and social programmes. The provincial premiers were seeking much more than the amount for health care alone. The new federal funds were in addition to the current annual federal contribution of $15.5 billion for health care, education and social programmes (Iglehart, 2000).

Table 9: Percentage Distribution of Health Expenditures by Sector of Finance, Canada, 1996

Provincial expenditures*	64.4%
Federal direct	3.5%
Municipal expenditures	1.0%
Workers' compensation	0.8%
Total state expenditure	**69.7**
Private expenditures	30.1%
Other	0.2%

* includes federal funding from Canada health and social transfers

Source: *National Health Expenditures, 1996, cited in Shah, C.P. (1998), "Public Health and Preventive Medicine in Canada", University of Toronto Press*

The budget cutting in Canada clearly took its greatest toll on the capacity of the provinces to deliver health care services. The policy of restricting supply has been the predominant feature of the Canadian approach to controlling health costs. Key features were a reduction in the number of students enrolled in Canada's 16 medical schools, tight restrictions on the purchase of expensive medical equipment through a centralised approval process, and the closing or merger of many hospitals. Between 1993 and 1997 the number of admissions to nursing schools dropped from 12,621 to 5,063, according to Canadian Nursing Association. 1750 physicians are going in to active practice every year. The acquisition of expensive medical equipment has also been held in check by the requirement that the provincial government approve the purchase of any expensive equipment. Hospitals were also major targets of the provincial cost-cutting campaigns. Through a variety of mechanisms, the provinces closed or merged hospitals and reduced the number of available acute care beds. In 1999, there were 877 acute care hospitals with a total of 1,22,006 beds as compared to 1128 hospitals with 1,75,376 acute care beds in 1991. Although an overall reduction of inpatient capacity made sense because of the rapid growth of ambulatory surgery and other out patient services, the provinces took few steps to strengthen other essential components of care (Iglehart, 2000).

The following are the health care reforms initiated:

- Reduction in Acute care Hospital length of stay and the size of hospital infrastructure
- Expansion of nursing homes and other chronic care facilities

- Increasing availability and integration of care in the community
- Placing greater emphasis on evidence of effectiveness and if possible, efficiency of diagnostic tests, drugs and procedures where the Canadian Co-ordinating Office for Health technology Assessment was created to provide advice and evidence on health technology. This non-profit organisation collects analyses and disseminates information on the effectiveness, cost of technology and its impact on health.
- Some services were cut from public programmes and deemed as 'not medically necessary'. This move allowed physicians to offer these services through the private sector. Although the CHA imposes a financial penalty on provinces delisting 'medically necessary' services, this term has never been defined. Thus it is hard to decide whether delisting specific medical services represents a violation of the principles of the CHA.
- Reform of drug pricing and volume of drugs dispensed through provincial drug plans. Provincial drug plans generally cover the elderly, the poor and catastrophic drug costs. Several provinces shifted costs to beneficiaries by introducing drug-plan deductibles.
- Changes in governance and devolution of responsibility to regions or local communities (Woodward et al, 2002).

Regulating private health services

Each claim submitted by a physician is assessed by the provincial Medicare agency to make sure that the claim is for an insured service and beneficiary. The assessment procedures are generally negotiated along with the fee schedule. The accumulated claims submitted by each physician are also reviewed periodically. To check for fraudulent billing practices, a sample of patients are contacted to see if they actually received the services claimed. Practice profiles are constructed and shows the frequency with which a practitioner performs each insured act.

The medical profession in Canada had achieved autonomy prior to the introduction of universal medical insurance. Since then, most provinces have enacted legislation to

ensure greater public control of the professions. The earliest and most significant of these changes occurred in the provinces of Quebec and Ontario

The professional code of Quebec enacted in 1973, places the regulation of all professions under one Act. A total of 38 professions, 22 of them in the health care field, are included. Each recognised profession is governed by a professional order. The order is charged with the traditional functions of a licensing agency. It determines the qualifications necessary to enter practice, including setting the length of training, examines candidates credentials, maintains a register of members of the profession, defines scope of practice, regulates specialists' certificates, collaborates with educational institutions and handles disciplinary matters within the profession. The code also establishes two overall supervisory and regulatory bodies to ensure that each order properly carries out its duty to protect the public. Ontario's Regulated Health Professions Act was passed in 1991 replacing the Health Disciplines Act of 1974. Only five of the professions-medicine, chiropractic, optometry, dentistry and psychology- are licensed to diagnose and the title 'doctor' is limited to these professions. Other professionals are licensed only to 'assess' and not 'diagnose' (Shah, 1998).

Conclusion

The Canadian health care system was an outcome of the working class movements articulated through the CCF that put pressure on the federal. Resistance from business interests and medical association were there, more so because private practice already existed and any regulation meant curbing of their interests. National co-ordination was essential to minimise regional differences in social security benefits between provinces. But concessions were given, fee-for service reimbursement was allowed rather than making them salaried. The rise of private professionals has been a process of dominant classes being able to open private practice in localities where people could afford to pay for their services. Market forces were allowed to fix costs for services though regulated to some extent. Canada too follows a similar structure of health services as seen in most countries i.e. separating medical care from other health services but its important to note

that although preventive services are taken care by the local government, there is enough importance given to general physicians who act as gatekeepers. Specialist training is highly regulated and technology is not allowed to take an upper hand unlike the United States where specialised services and technology receive greater accent and status. This helps in controlling rise in costs. The NHI takes care of in-patient and out-patient care. Other federal government health related functions include health protection, disease prevention and health promotion.

One significant difference between the health care system in the US and in Canada other than the Canadian health services system being universal and equitable is the administrative cost. In the U.S. which has voluntary private medical and hospital insurance systems, 12.5% of spending goes on administrative costs, whereas Canadian administrative costs are less than 3% (Shah, 1998). Moreover there are savings in Canadian hospital administrative costs because there is no need to price and itemise every service on the patient's bill. Furthermore, there are savings in the more rational distribution of high technology such as MRI scanners, which hospitals in US acquire due to competitive reasons and then frequently under utilise. The Canadian single payer system-the provincial government- pays for hospital and physician services covering 69 percent of the total cost of health care in Canada. The provincial governments are directly responsible for the overall allocation and co-ordination of resources to the health services sector. This avoids the fragmentation of decision making and wasteful competition for resources that can occur when independent non-profit or fee for service providers seek financing from a variety of private and public sources. Although Canadians are faced with their own set of health system challenges, the single payer financing system, together with universal coverage, comprehensive and equitable services has proven more effective than the market system of health in controlling overall health expenditures.

At the level of political parties, the liberals have faced three consecutive victories. The liberals are the moderates, with the Conservative to the right and the Democratic Party to the left. The Democratic Party's predecessor was CCF that had a major role to play in the legacy of social policies in Canada, especially health insurance but presently it is a weak

party and its role is limited in the period of liberalisation. The Liberal Party, however, wants political victories that would cement its popularity with voters. Recent discussions with federal and provincial ministers have focused on the development of a universal outpatient pharmaceutical benefit and a national home health care programme, but concrete proposals supported by both levels of government have remained elusive. As prescription drugs are not covered outside the hospital, a number of provinces have already introduced universal 'pharmacare' plans. The plans have varying co-payments, with seniors and social assistance recipients paying lowest out of pocket expenses (Kraker, 2002).

Many federal and provincial politicians have concluded that an integrated system of primary care must be developed and welded with other community based and specialty services. Many family physicians believe that more integrated delivery systems could reduce the demands placed on emergency rooms and provide broader coverage. Pilot primary care projects sponsored by Ontario Medical association and the province of Ontario are experimenting with capitation and reformed fee-for-service payment modes. The focus has also shifted to strengthen community and home-based care. The shift away from hospital based care is motivated in part by fiscal constraints and the belief that home care meets the need of patients more effectively.

Few elected officeholders believe that salvation lies in lifting ban on private insurance as a means of increasing access to hospital and physicians' services for people who can afford such coverage. The reason Canada imposed the ban in the first place was to prevent private firms from insuring only low risk patients. This still enjoys strong support from the public and elected officials. Most physicians in Canada remain remarkably supportive of the public principles on which it is based and are skeptical that they would be better off with a private market based model. Even the CMA has debated the idea of supporting privatisation of the health care system, but every time it has decided to maintain its support of a publicly funded system.

Chapter III
An Overview of Health Financing in India

An Overview of Health Financing in India

Introduction

This chapter gives in brief the history and the present state of health financing in India. The following section recounts the history of health insurance and then discusses the existing health insurance systems in India. It goes on to explain how financing has its implications on health services distribution and utilisation.

India has a population of over a billion now. The Census (2001) counts population of India to about 1025.25 million. 28 percent of its population lives in the urban areas whereas rest of the 72 percent lives in the rural areas. The political entity is divided into 35 states and union territories that are further divided into districts. There are 593 districts, 5564 *Tehsils/Taluks*, 5161 towns and around 6.4 lakh villages (Census, 2001). About 30 percent of the population are below the poverty line with a higher percentage in the rural areas. About 400 million people are employed in the economy. 60 per cent of India's workforce is self-employed, many of whom remain very poor. Nearly 30 per cent are casual workers (i.e. they work only when they are able to get jobs and remain unpaid for the rest of the days). Only about 10 per cent are regular employees, of which two-fifths are employed by the public sector. More than 90 per cent of the labour force is employed in the "unorganised sector", i.e. sectors which is not provided with the social security and other benefits of employment in the "organised sector." In the rural areas, agricultural workers form the bulk of the unorganised sector. The annual report of Labour Ministry puts the open or chronic unemployment figure at 18.7 million at the end of 1995.

India has shown considerable improvements in its health status indicators since the beginning of 20th century. Average life expectancy has increased from 20 years in the beginning of 20^{th} century to 62.8 at the end of the century. In spite of all the developments, the health scenario of India is grim compared to other developing countries who have been at par with India at the time of independence. Although it is

well acknowledged that the health status of a population is influenced by socio-economic factors, health services is an important input. Here the availability of resources to fund health services becomes critical. This health financing relates to the availability and accessibility of health services in rural and urban areas, which in turn has its impact on health services utilisation.

A Brief History

India never went through the period of sanitary reform that swept through most of Europe in the 19th and early 20th century. Colonial health policy was a policy of segregation. The concern was to protect the army and the European civil population from diseases and ill-health. There was absence of uniform general public health services. The work of sanitary commissioners was restricted to the cantonments. No investments were made for the general population. By 1909-10, the army showed a death rate of 5 per thousand while the general population showed mortality rates of 30 per 1000 (Qadeer, 2001). With the advent of provincial governments after the Government of India Act of 1919 some medical care network evolved. By 1941, 2,150 hospitals and 5,291 dispensaries had come into place. 74 percent of these were in the rural areas (one unit per 45, 966 rural population and one unit per 16, 913 population) and only 7.6 percent of all institutions were in the private sector (Duggal and Antia, 1993).

After Independence, India too adopted the welfare state approach that was dominant at the moment all over the world. In the constitutional division of responsibilities, the subject of health has been allocated to states. It is the state governments that have the major responsibility for health sector allocations. India's leaders at independence envisaged a national health system in which the state would play a leading role in determining priorities and financing and would provide services to the population. The emphasis of the *Health Planning and Development Committee's Report of 1944* (popularly known as the Bhore Committee report) on state's role was explicit. Bhore's report was the first insight into the dimensions needed for a comprehensive health services system in India. It was a plan equivalent to Britain's National Health Service. The committee recommended health services based on the needs of the people, the

majority who were deprived and poor. The thrust was to invest in preventive and curative care along with improving overall living conditions. It also recommended the need to invest in pharmaceutical sector in order to develop indigenous capabilities and reduce excessive reliance on multinational companies (Baru, 2002). It was recommended that 12 percent of GDP needed to be invested in health. India was therefore one of the few developing countries that adopted a health policy that integrated the principles of universality and equity. The Bhore Report was to be the blue print but in practice there was selective implementation.

When the Bhore Committee set out to examine the state of the health sector it had only one estimate of private household expenditure. This was a study done in Singur area and showed that in 1944 private household expenditure was Rs. 2.50 per capita which was 6.9 times of state health expenditure. The government was therefore spending 36 paisa per capita and the total health expenditure worked out to Rs. 2.86 per capita (4 per cent of GDP) (Duggal and Amin, 1989).

Table 10: Planwise Public Sector Outlays on Health (Rs Crore)

	Total Plan Investment Outlay	Health	Family Welfare	Sub Total	Water and sanitation
1st Plan	1960	65.2	0.1	65.3	11.0
(1951-56)	(100%)	(3.3%)	-	(3.3%)	(0.6%)
2nd Plan	4672	140.8	5.0	145.8	74
(1956-61)	(100%)	(3 %)	(0.1%)	(3.1%)	(1.6%)
3rd Plan	8576.5	225.9	24.9	250.8	105.7
(1961-66)	(100%)	(2.6%)	(0.3%)	(2.9%)	(1.2%)
Annual Plan	6625.4	140.2	70.4	210.6	102.7
(1966-69)	(100%)	(2.1%)	(1.1%)	(3.2%)	(1.6%)
4th Plan	15778.8	335.5	278	613.5	458.9
(1969-74)	(100%)	(2.1%)	(1.8%)	(3.9%)	(2.9%)
5th Plan	39426.2	760.8	491.8	1252.6	1091.61
(1974-79)	(100%)	(1.9%)	(1.2%)	(3.2%)	(2.8%)
6th Plan	109291.7	2025.2	1387	3412.2	3996.9
(1980-85)	(100%)	(1.8%)	(1.3%)	(3.1%)	(3.6%)
7th Plan	218729.6	3688.6	3120.8	6809.4	7093.1
(1985-90)	(100%)	(1.7%)	(1.4%)	(3.1%)	(3.2%)
Annual Plan	137033.5	2253.8	1805.5	4059.3	
(1990-92)	(100%)	(1.64%)	(1.32)	(2.96%)	
8th Plan	434100	7582.2	6500	14082.2	
1992-97	(100%)	(1.75%)	(1.5)	(3.25%)	

Source: GOI, 1996, 1999 cited in Antia, Dutta et al (2000), Health and Medical Care: A People's movement, FRCH, Mumbai

Table 11: Budget Allocation in past two years (in Rs. Crore)

Budget Head	BE 2002-03	RE 2002-03	BE 2003-04
Department of Health- Total	2427.14	2325	2469.09
Public Health* – Total	836.31	765.07	839.21
National Anti-Malaria programme	60.23	55.96	52.63
Kala Azar control programme	20	4	37
TB control programme	110	92	108
Leprosy control programme	72.5	72.5	71.5
National AIDS control programme	198	215	205
Family welfare services	3307.27	2742.59	3164.91

BE: Budget Estimate, RE: Revised Estimate

Source: *Notes on Demands for Grants, 2003-04, Union Budget of India cited in Sankar, D and V. Kathuria (2003), "Health Sector in 2003-2004 Budget" in EPW, Vol.38, No.15.*

*Public health definition has been limited to preventive services like protecting water supply, promotion of environmental sanitation, prevention of communicable diseases, maternal and child health. It does not take in to account medical care.

The budget allocation as a percentage of total expenditure to Department of Health and Family Welfare is 1.69% in the year 2003-2004. Department of Indian System of Medicine and homeopathy has been allotted another 0.04%. The increase from 1.61% in the year 2002-03 to the present 1.69% is due to the increased allocation in the family welfare programme (Sankar and Kathuria, 2003).

Health financing in India

Health financing is mainly a state subject with central outlays for family planning, national disease control programme. There are three types of financing systems: the State (includes centre and state government spending), the private and financing through insurance systems. The table in the following page summarises financing of health services in India.

Table 12: Summary of Health Services Financing in India

	Provision by	Provided through	Beneficiaries	Financing
A	***Financing through Government Administration***			
1	Central, State, Union Territory and Local Governments	Public Hospitals, District health centres, CHCs, PHCs	All people but mostly poor and weaker sections	Tax, non-tax receipts, foreign aid, user fees
2	Public Enterprises and Autonomous Institutions (fully or partially funded by government)	Hospitals owned by them, reimbursement for treatment obtained from private providers	Restricted to their employees	Profits, grants from governments
B	***Financing through Insurance Mechanisms (Intermediary involved)***			
1	ESIS (ESI corporation as the intermediary)	ESIS hospitals and dispensaries	Restricted to workers registered under ESI Act	Employee, employer and government contributions
2	CGHS (central government administered)	CGHS dispensaries, public hospitals and some private hospitals	Restricted to central government employees	Employees contribution and central government revenues
3	Mediclaim Policy (General Insurance Corporation as the intermediary)	Public, private, corporate hospitals/ physician and consultants	Individuals who purchase premiums or group insurance for employees provided by private employers	Premiums from insurers (household, corporations, Institutions)
4	Community based health insurance systems (Voluntary organisations as intermediaries)	Charitable hospitals, government/private hospitals	Community people who are part of the insurance programme	Contributions/ premiums from community members, donations.
C	***Private Financing***			
1	Private hospitals	Owned hospitals by individuals/groups of individuals	Open to all	Fees for services (directly from households)
2	Private dispensaries	Owned hospitals by individuals/ groups of individuals	Open to all	Fees for services (directly from households)
3	Physicians consultants	Owned consultancy clinics and private hospitals	Open to all	Fees for services (directly from households)
4	Charitable Hospitals/ NGO run hospitals	Hospitals owned by individuals/trusts/philanthropists	Open to all	Donations/fees for services on no-profit basis
5	Private corporations (Joint Stock companies)	Hospitals owned by them and reimbursements	Restricted to their employees	Profits, tax concessions, grants from government and fees
6	Private corporate hospitals	Owned hospitals	Open to all (but accessed by people who can afford)	Fees for services (directly from households)
7	Native doctors such as vaid, hakim, tantrics, naturopaths and so on	Owned clinics	Open to all	Fees for the services (household)
8	Pharmaceutical companies/surgical and opthalmological equipment manufacturing companies etc.	Medical stores, dispensing chemists/ hospitals (private and public)	Open to all	Fees for services

Source: Garg, 1998; Dave, 1993

State financing of variety of health services includes health services like disease control programmes, ante natal care, curative health services through government hospitals, dispensaries, primary health centres (PHCs), development of medical education, family welfare programs to control fertility. State governments are the source of 70% of the government health expenditure. Central government budget almost entirely finances the direct cost of the family welfare programme, it co-finances with the state variety of disease control programme. Health services financing in terms of infrastructure, personnel etc. are the responsibility of the state. Further, state also contributes to social insurance schemes for low salaried workers in organised sector, central government employees and provides health services for employees of certain state owned enterprises like defense, railways, and most of the public sector employees. The expenses are financed by the centre, individual states and by municipal and other local bodies through direct, indirect taxes, user fees, social insurance premiums and some assistance from international agencies. States on their own raise only a third of the total tax and non-tax revenues collected in the country. The average cost recovery by user fees for medical, preventive services and family welfare services is about 5 percent of government health expenditures. States therefore, depend on shared taxes from central government revenue and central government's specific and general purpose grants and loans. The major source of states own tax revenue is from sales tax (approximately 60 percent) and rest of it comes from land revenues, from stamps and registration, state excise, from taxes on vehicle, passenger goods, etc. (Garg, 1998).

Sources of ***private financing of health care*** includes finances from direct household or out-of-pocket expenses and donations from charitable sources. These out of pocket expenditures come from direct incomes of the household and are used for paying doctor's fee, hospitalization bill or for buying drugs at hospitals or pharmacies. Sanyal (1996) shows that a significant proportion of household expenditure (approximately 20 per cent) is used for indirect expenses like travel costs, food, stay, bribes that are not directly used for payment for the services. There are number of hospitals set up by voluntary organisations. These are financed through donations and fees for services on a no-profit basis.

The results of a NCAER (National Council of Applied Economic Research) survey indicates that the average household spends 5 percent of their income on curative health services and this percentage is higher for the rural household as compared to urban household (Sundar. R, 1995). The established per capita spending on health service was around Rs320 per year in mid 1990s with the major input from private households (75 percent). State governments contribute 15.2 percent, the central government 5.2 percent, third-party insurance and employers 3.3 percent, and municipal government and foreign donors about 1.3, according to a 1995 World Bank study. Of these proportions, 58.7 percent goes toward primary health care (curative, preventive, and promotive) and 38.8 percent is spent on secondary and tertiary inpatient care. The rest goes for non-service costs.

Table 13: Per capita spending on Health Care

Source	Rs per capita 1990-91	Percentage of total
Central government	16.5	5.2
State government	48.6	15.2
Municipal govt.	1.5	0.5
External donors	2.5	0.8
Third Party insurance and employer payment	10.5	3.3
Private household	240	75
Total	319.6	100

Source: Berman (1995)

There are no sound estimates to show the composition of household expenditure between medical care, preventive services and family welfare. The best estimates available from World Bank (1995) show that most of the expenditure by the households goes towards curative services. Even for primary care (which is supposedly free in widespread government facilities) 82 percent of the expenditures come from the households. Berman (1997) estimates that 65 percent of the out-of-pocket expenditure in rural areas and 61 percent in the urban areas goes toward non-hospital treatment. Of these the major share is spent on private non-hospital treatment, as the corresponding figures for out-of-pocket spending for private non-hospital treatment in rural and urban areas are 56 percent and 52 percent respectively.

Health expenditure as a percentage of GDP was 6 percent in 1990. 4.7 percent of this is accounted for private sector and out of 4.7 percent, 4.5 comprises of out of pocket expenditure. The 0.2% comprises of contribution from private employers and employees (Ellis et al, 2000). The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent (GOI, 2002). The states have been facing fiscal stringency since the mid-1980s. The onset of economic reforms at the Centre in 1991 further aggravated the situation and contributed to the deterioration in state finances (Seeta Prabhu and Selvaraju, 2001). The current annual per capita public expenditure in health is no more than Rs. 200 (GOI, 2002). Even though rural areas account for 73 percent of the population only 33 percent of government health resources have gone to the rural areas. In terms of per capita allocations, urban population received more than 5 times what the rural population received (Garg, 1998). Out of the total curative spending, nearly 75 percent is spent on secondary and tertiary sector hospitals that are primarily located in urban areas (Sankar and Kathuria, 2003)

If public-private expenditure are considered together then India spends relatively higher than other developing countries but despite this, India is far from realising the 'Health for All' goal because of inequalities in the system. This was to be realised by 2000 as stated in the National Health Policy of 1983. This goal was reiterated in the Eighth Five-Year Plan.

Table 14: Total Expenditure on health as percentage of GDP

	1995	1996	1997	1998	1999	2000
Total expenditure on health as % of GDP	5	5.2	5.3	5	5.1	4.9
Private expenditure on health as percentage of total expenditure on health	83.8	84.4	84.3	81.6	82.1	82.2
General government expenditure on health as % of total expenditure on health	16.2	15.6	15.7	18.4	17.9	17.8

Source: The World Health Report, 2002

The third source of financing is through ***insurance mechanisms*** where there is an intermediary that pools in risks and resources. Risks and resources are shared across the insured population so as to reduce the burden of costs. We will look at this type of financing mechanism in further detail.

History of Health Insurance in India

It has been stated by many scholars that some kind of communal insurance was practiced by Aryan tribes of India nearly 3000 years ago. The first life insurance company in India was started in Calcutta in 1818 under the caption of 'Oriental' by Europeans to afford protection to the widows and orphans. It first insured the European lives only. Bombay started the Bombay Mutual Life Assurance Society in 1871. This insured Indian lives too (Sharma, 1967).

As in other countries, social insurance was originally designed to help the industrial worker as a measure of income maintenance. The statutory regulation and protection of Indian labour began mainly after First World War. The labour laws that existed before this were found unsatisfactory and incomplete in several respects. The important laws came in the wake of peace established after 1918 and the formation of International Labour Organisation. The Indian Workmen's Compensation Act of 1923, The Indian Mines Act of 1923, the Indian Boilers Act of 1923, Indian Children (Pledging of Labour) Act of 1933 and Payment of Wages Act of 1936 were some of the important laws. The Workmen's Compensation Act is generally regarded in India as the first social insurance measure to be introduced in the country. The Act placed the liability of compensating the worker in respect of industrial accidents and diseases on the employer alone. The second contingency against which provision was made during this period was maternity. But this was passed by certain state legislatures only, Bombay Presidency was the first to pass a Maternity Benefit Act in 1929 and Central Provinces adopted the measure in 1930.

In addition to these, efforts were made to frame and introduce a health insurance scheme for industrial workers during this period. Though the first sickness insurance law in the world that announced the advent of social insurance was passed in 1883, the social

insurance movement in India began nearly half a century later. This was in the year 1928 when the Indian Legislative Assembly considered the question of the ratification of the two draft conventions and one recommendation relating to sickness insurance, which was passed by the International Labour Conference at its tenth session in 1927. Some state governments appointed committees to see the possibility of laying down a health insurance policy. But most states were unable to suggest any workable scheme and said that financial constraints were there. The Royal Commission on Labour of 1931, saw in to the problem and stated that "none of these arguments diminish the need of the worker for provision during sickness". It was recommended that few employers should agree to make experiments in the granting of sickness benefits. They suggested that a workable scheme of health insurance be introduced in single establishments wherever medical facilities could be made available by state governments provided employers and workers were willing to contribute. But there was a lack of will from the state governments and they only laid emphasis on financial constraints. In 1938, the Cawnpore Labour Enquiry Committee appointed to examine and report on the conditions of life and work of labourers employed in the Cawnpore factories. It recommended that it was desirable to examine a regular scheme of sickness insurance for industrial workers. They realised that organisation and expansion of medical arrangements will also be necessary. The report added that state should contribute to the scheme. Nothing was done in this regard till the outbreak of World War II.

During the inter-war period, attention was paid to unemployment insurance for industrial workers. The Bombay Strike Enquiry Committee which was appointed on October, 1928, to study the causes of the strike that had taken place in Bombay at that time and find out basis of settlement, considered the question of unemployment resulting from the adoption of efficiency schemes and examined how far it could be relieved by means of an unemployment insurance scheme. But the Royal Commission of Labour saw it as a difficult task because of the large labour turnover and migratory character of Indian labour (Agarwala, 1962).

By 1941 it was clear that workers were anxious to have a sickness insurance in place as early as possible and were prepared to contribute. State governments also started feeling the pressure to have a health insurance. The Beveridge Report of UK in 1942, Wagner-Murray Dingell Bill of US in 1943 and the Marsh Report of Canada influenced the Government of India towards taking active measures of welfare and social security. The debate on social insurance again commenced from the year 1943 when Professor B.P. Adarkar was appointed to frame a scheme of health insurance for the industrial workers India. During the course of his report, Professor Adarkar examined the working of the Indian Workmen's Compensation Act and Maternity Benefits Acts and made a strong case for merging them in a unified and integrated system of health, maternity and employment injuries insurance scheme. This scheme covered only factory labour: textile, engineering and all mineral and metals. The Adarkar Plan was based on four assumptions:

i) The adoption of scheme of unemployment insurance and the creation of new employment in the post-war period, through a drive for national planning and development; ii) the establishment of a scheme of old-age pensions, so that old age burdens may not be palmed off on health insurance; iii) the adoption and enforcement of certain premedical measures such as regulation of wages, rigorous enforcement of factory laws, housing, nutrition, education in health and improvement of environmental hygiene and iv) a national health drive (Agarwala, 1962).

The scheme was to be made compulsory if it was to be of any value to the working class and also had to be contributory. The administration had to be simple, clear and straightforward and must be financially sound and economical in its working. Workers were classified as permanent, temporary and casual. The employer was to contribute same amount for all three categories and the contribution by the State was said to be modest unlike the Beveridge plan, which asked for equal contribution from the State. The fund was to give cash benefit as well as medical benefit.

Adarkar plan of health insurance formed the basis of the Employees State Insurance Act of 1948. The government of India introduced the Workmen's state insurance Bill that was referred to a select committee in 1947. A new bill was drafted thereafter called Employees State Insurance Bill, accepting most of the recommendations of the select committee. This Bill was passed as the ESI Act of 1948.

Existing Health Insurance Systems in India

Health Insurance in India presently can be divided broadly in to:

- State run social insurance schemes for formal sector employees (Compulsory)
- Public enterprise health insurance programme (quasi-private): Mediclaim policy of General Insurance Company and other specialised Insurance schemes (Individual/voluntary scheme)
- Employer-managed health schemes/insurance in the public / private /corporate sector organisations (Compulsory)
- Community/Co-operative financing health financing scheme (Voluntary)

State run social health insurance schemes:

Employee State Insurance Scheme (ESIS)

The ESIS was established in 1948 and is managed by the Employees State Insurance Corporation. It was based on Adarkar's Plan of Health Insurance. It has been a compulsory social security benefit for workers in the formal sector and their dependants and has been the first kind of social insurance system in India. It is a wholly government owned and run organisation.

It is at present applicable to-

- all factories engaged in a manufacturing process with the aid of power and
- employing ten or more persons and factories that run without the aid of power and employing twenty or more persons such as shops, hotels, restaurants, cinemas, motor transport undertakings and newspaper establishments.

Therefore it is applicable to seven classes of establishments including factories (Subrahmanya, 1998). A recent Supreme Court judgement has held that a worker covered under the Employees State Insurance Act would be entitled to the benefits from the date of his employment and not from the date of registration after contribution by the employer as was before (The Hindu, January 2003).

Coverage and Financing

Prior to January 1997, employees who had basic salaries of less than Rs. 3000 were covered. Presently employees earning basic salaries up to Rs. 6, 500 are covered under the scheme. As of 1997-98, ESIS covers 8.4 million employees with 18 percent women. It covers total of 35.3 million beneficiaries. Region wise coverage shows larger coverage in industrialised states like Maharashtra, Tamil Nadu, West Bengal, Karnataka and Gujarat and relatively poor coverage in Jammu and Kashmir, Himachal, Assam and Meghalaya. The scheme is financed by employers who contribute 4.75 percent of the wages payable to the covered employees, by employees who contribute a minimum of 1.75 percent of their wages and state governments contribute a minimum of 12.5 percent of the total expenditure on medical care in their respective states.

Benefits

ESIS provides four major types of benefit- medical, sickness, maternity and work injury. It provides both the cash and medical benefits. The cash benefits mainly compensate for the wages lost due to medical reasons. Sickness benefit, rehabilitation allowance, maternity benefit, dependants' benefit, funeral expenses and disablement benefit are provided under cash benefits. The sickness benefit is not payable for the first two days and is ordinarily limited to 91 days. Persons suffering from chronic diseases like TB, Cancer are entitled to extended sickness benefit at a higher rate for a period up to 309 days. Medical benefits include outpatient care, hospitalisation or specialist treatment.

Table 15: Level of Coverage under ESIS: 1998

No. of Centres	640
No. of Employees	8,361,900
No. of Insured Women	1,524,100
Total Beneficiaries	35,290,350
No. of Employers covered	212,931
Local, Inspection and Cash Offices	1162
ESI dispensaries, Hospitals and Annexes	1620
No. of ESI Beds	23,692
Insurance Medical Officers	6,059
Insurance Medical Practitioners	2,885

Source: Annual Report: ESIS 1997-98

Provider payments

Out patient services are provided through ESI dispensaries or the panel system. Specialist treatment from outside is allowed if cases are referred by the ESI doctors. Inpatient treatment is provided by ESI hospitals. The providers at ESI facilities are paid salaries. The panel doctors or Insurance Medical Practitioners (IMP) are paid on a capitation basis at Rs. 5 per insured patient per month and are otherwise allowed to carry out their private practice. Medical benefits have comprised of nearly 70 percent of total benefits provided under the scheme (Ellis et al, 2000).

Limitations of ESIS

ESIS has not been implemented in Arunachal Pradesh, Manipur, Mizoram, Nagaland, Sikkim, Tripura and in Andaman and Nicobar Islands, Lakshwadeep, Dadra and Nagar Haveli, Daman and Diu. Medical Services provided are not uniformly spread and there have been complaints about low quality drugs and long waiting periods. The shortfalls are attributed to the inability of the state governments to make necessary arrangements for providing medical care. The scheme is not applicable to the unorganised or self-employed labour (Subrahmanya, 1998).

There have been suggestions on extending ESIS to the unorganised sector and at the same time employers of small scale industries want exemption from all labour laws and their federation want the labour laws to be applicable to establishments more than 50 workers. The larger question is, of course, that less than 10 per cent of the country's total

workforce is engaged in the organised sector. This kind of subsidisation of services for one section of the workforce almost amounts to creating a two-tier health care system (Gumber, 2002).

Central Government Health Scheme (CGHS)

The CGHS was introduced in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families. It also covers retirees of central government, Member of Parliaments, governors and certain autonomous, semi-autonomous and semi-government organisations.

Coverage and Benefits

It covered 4.3 million beneficiaries in 18 major cities in 1995-96. City-wise coverage shows maximum beneficiaries in Delhi followed by Mumbai. They have 241 allopathic dispensaries and 95 other dispensaries that include ayurvedic, homeopathic, unani and siddha and also polyclinic (CGHS, Annual Report, 1999). The facilities include outpatient care provided through these dispensaries. The scheme also ensures free supply of necessary medicines, diagnostic facilities, emergency treatment, antenatal and postnatal care and confinement, specialist consultations and hospitalisation facilities in public hospitals. Hospitalisation benefits are provided by some private hospitals also.

Table 16: Health Services under Central Government Health Services

	CGHS (1997)	Number
1.a	Number of Dispensaries	320
i.	Allopathy	241
ii.	Ayurveda	31
iii.	Homeopathy	34
iv	Unani, sidha, yoga	14
2.b	Number of families covered	9.46 lakhs
c.	Number of beneficiaries	42.49 lakhs

Source: Manpower Profile, India Yearbook, 2001

Financing

Most of the expenditure of the CGHS is met by funds by the Central Government. Employee premium varies from Rs. 15 to Rs. 150 per month per family according to the

income range. In 1995-96, the contributions were 15.6 percent of the expenditure and Rs. 241 per family per annum.

Provider Payments

CGHS doctors, paramedical staff and staff at dispensaries are paid salaries from central government funds. 32 percent of the total expenditure is spent on wages and salaries of the staff working for CGHS. These providers are not allowed to carry on private practice. Treatment in semi-government and certain certified private hospitals is reimbursed according to case basis and treatment provided by the government, but ceilings are attached to different kinds of treatment. The expenditure incurred by CGHS in 1995-96 was 1,475.7 million or Rs. 297 per beneficiary. 56.6 percent of this expenditure comprised mainly drug expenditure and 5 percent of the total constituted the administrative expenditure.

Shortcomings

CGHS has been criticised from the point of quality and accessibility. Significant out of pocket expenses were made for inadequate supplies of medicines and equipment and inadequate staff (Ellis et al, 2000).

Public enterprise health insurance programme:

Mediclaim Scheme of General Insurance Company (GIC)

The GIC was set up by the Government of India in 1973 to market a range of insurance services including hospitalisation cover. The Mediclaim policy was introduced in 1986. Prior to 1986, a number of private insurance companies were offering group health insurance cover to most corporate bodies. There arose a need to offer insurance services to individuals (GIC, 1995). With the formation of GIC, the private insurance companies were merged in to four of its subsidiaries: The National Insurance Corporation (Calcutta), New India Assurance Company (Bombay), Oriental Insurance Company (New Delhi) and United Insurance Company (Madras). All four companies operate nationally, although each has a regional concentration. Health accounts for a very small share of

their total business. The purpose of the merger of all insurance companies was to standardise the coverage and various medical benefits. The medical scheme marketed by GIC and four companies provided for reimbursement of hospitalisation and domiciliary treatment hospitalisation expenses i.e. expenses for treatment of such illness which would normally require hospitalisation but is being treated at home under certain compelling circumstances and as per doctors advice. Benefits are divided into six different premium categories: 5-45, 46-55, 56-65, 66-70, 71-75 and 76 plus. The insured are reimbursed for their medical claims only after the payments have been made out of pocket to the provider (Ellis et al, 2000). The GIC prescribes standard premium rates, eligibility and benefit coverage for all the four subsidiaries so that they do not compete with one another on any of these dimensions. So far, the premium revenue has managed to keep ahead of claim payments. There has been a 174 per cent increase in the beneficiaries of *Mediclaim* over the period between 1986 and 1995 (Ellis et al. 2000).

Limitations

One of the major weaknesses of Mediclaim is that it covers only hospitalisation and domiciliary expenses and does not cover out patient care. The coverage is subject to numerous exclusions and there are restrictions on eligibility. Scheme excludes people with pre-existing diseases. Maternity benefit is available with extra loading in the premium. The functioning of the system is based on for-profit principles.

Specialised Insurance Schemes like the *Jan Arogya* scheme was started by GIC in 1996 for poor people with less premium. But the scheme did not reach far and has been far below the expectations due to lack of information, guidelines and support. The scheme was meant to cover vulnerable population by covering hospitalisation expenses up to Rs. 5000 per year at a premium of Rs. 70. It also covers maternity expenses. Till 1999, it had covered four lakh people (Shariff et al, 1999).

The GIC also offers medical benefits and compensation under personal accident policies for individuals and groups. If an injury results in total disablement of the insured and thereby prevents him/her from engaging in any activity or occupation, then 100 per cent

of the sum insured will be paid. In other cases like irrevocable loss of eyesight, hearing, and different parts of limbs, different percentages of the sum insured are being paid.

Bhavishya Arogya Policy (old age medical insurance), also introduced by GIC in 1991, was designed to enable a person to plan for medical needs during old age out of savings during his/her current earning phase, as an old age security. Under this scheme medical expenses to be incurred over the balance life span after a predetermined age of retirement will be reimbursed up to the amount of sum insured. The advantage of this plan is that it assures coverage of all types of conditions from the effective date of benefits (Gumber, 2002).

The Life Insurance Corporation had introduced a special insurance programme, *Asha Deep II* in 1993 which covered medical expenses for only four diseases; cancer, paralytic stroke, renal failure and coronary heart disease. This programme was withdrawn and then again reintroduced in 1995. This programme has been limited in its scope and has not been popular (Ellis et al, 2000).

Employer-managed schemes in Public / Private / Corporate Sector Organisations

Railways, defence, police, paramilitary forces, post and telecommunications, mine and *beedi* sector maintain their own medical services.

The plantation sector employs about 1.6 million workers, and health services are regulated by the Plantation Labour Act of 1951. According to International Labour Organisation, the term plantation includes, "any agricultural undertaking regularly employing hired workers which is situated in the tropical or subtropical regions and which is mainly concerned with the cultivation or production for commercial purposes of coffee, tea, sugar-cane, rubber, bananas, cocoa, coconuts, groundnuts, cotton, tobacco, fibres, citrus, palm oil, cinchona or pineapple". It is possible to exclude from the application undertakings whose area covers not more than 5 hectares and which employs not more than 10 workers at anytime during the calendar year (Krishnamurthy, 1995).

The Act specifies minimum standards for dispensaries and hospitals. Some plantations comply with the hospital standards while others do not (Ellis et al, 2000).

Public sector industries/companies and semi-autonomous institutes like: Steel Authority of India limited (SAIL), Bharat Heavy Electricals Limited (BHEL), Oil and Natural Gas Commission (ONGC) etc., provide health services to employees through a panel of providers who are reimbursed by the organisations. Some educational institutions and universities also provide medical facilities to their employees.

Employers of private organisations (autonomous organisations, banks etc.) and public sector companies also cover their employees through i) group health insurance scheme with GIC, ii) reimbursement of actual expenses claimed by the employees for out patient care and hospitalisation, iii) fixed medical allowance, monthly or annually, irrespective of actual expenses, iv) in-house hospital facilities where companies have well equipped, self-sufficient hospital services and outpatient facilities. Group health insurance systems are compulsory for employers. Coverage includes outpatient and hospitalisation facilities. According to Ellis et al (2000), precise estimates of coverage of people under these schemes is not available but an estimate of 50 million persons would be covered wholly or partially under employer managed schemes. Certain corporate houses like the Tatas and Hinduja's have their own provisions. Apart from this, there are big corporate hospitals, like the Apollo Hospitals, which are characterised by high quality exhaustive hospital benefits but very little outpatient coverage. The delivery of health care services by such hospitals is extremely expensive. Apollo Hospital, to make the availability of its services more viable, has tied up with major insurance companies like New India Assurance and United India Insurance but the coverage is limited (Baru 1998).

A negative consequence of this rapid expansion into corporate sector hospitals is the skewing of health resources in urban areas. There is an emphasis on medical technology and state of the art hospitals which further increases costs of medical care.

Community based and Self-financing scheme: A focus on Community Based Health Insurance (CBHI)

A review of Non-governmental Organisation (NGO) involvement in provision of health services was undertaken by Ford Foundation (1994) under the *Anubhav* project. The health services among the NGOs vary from provision of maternal, child health and family planning services by Streehitkarini, Bombay, hospital services, control of communicable diseases and medical education by KEM hospital, Pune, services through own hospitals and clinics by comprehensive health and development project, Aurangabad, Child in Need Institute, West Bengal, Voluntary Health Services (VHS), Tamil Nadu, Society for Education Welfare and Action (SEWA), Gujarat and many others. Some NGOs like VHS Tamil Nadu introduced the concept of pre-payment and provide coverage not only for the sickness insurance, but covers wide range of health activities namely maintenance of family records, mother and child care, immunization, nutrition, family welfare, control of communicable diseases especially leprosy, tuberculosis, malaria, filaria and water borne diseases (Pachauri, 1994).

A study conducted by Dave (1991), in twelve voluntary organisations spread across six states in India reviewed their health financing experiences. In terms of health services, some provide community-based services, others provide hospital level care, they provide supportive role to health providers and help with training and management. Most of the community based health programmes have trained Community Health Workers who provide curative, promotive and preventive services. Most organisations generated revenue from community through user fees. Other sources of community-based and self-financing include instances like Tribhovandas Foundation providing health care through village milk cooperatives and Amul Union (the milk cooperative organisation) contributing significantly towards health services through putting a cess on milk collection. In some cases, other sources of revenue that supplemented revenue from community were the government and donor agencies. Other than user fees and fund-raising, six of the organisations had implemented prepayment/insurance schemes. Coverage is provided on the household or individual basis. It is either paid in cash or in

kind (agricultural produce) and is mostly collected during harvest time. Benefits offered varies across schemes. Members to the insurance system generally get free community health worker services, free health centre services and a subsidy towards hospital services.

Two of the experiences with CBHI programmes have been discussed below:

SEWA's (Self-Employed Women's Association) experience: SEWA is a labour union of 5,30,000 women workers engaged in the informal economy based in Ahmedabad, Gujarat. The SEWA experience of health insurance grew out of women workers facing loss of wages and heavy out of pocket expenditures in their daily lives. SEWA Bank's loan record showed that medical costs were one of the major costs borne by the poor women. In 1977, a survey of the loan defaulters showed that out of 500 women who were not repaying their loans, 20 had died and others reported inability to repay due to illness in the family. At that time SEWA began a dialogue with nationalised insurance companies and other than Life Insurance Corporation (LIC) none of the insurance companies were prepared to cover members for health risks. Doubts were expressed about poor women's ability to pay premiums as they were considered cases of 'bad risks'. In 1992, United Insurance Company (UIC) came forward and was prepared to cover only for hospitalisation for the insured women. So number of health related insurance remained uncovered. SEWA started its own maternity benefit programme. By 1995, premiums were set aside by 15,000 women from both urban and rural areas. One of the interesting outcomes of the health insurance programme was stronger links with local doctors as well as municipal hospitals, thus strengthening referral services for SEWA members. Lok Swasthya Co-operative which was a part of SEWA movement and present in two municipal hospitals ran around the clock and dispensed medicines at low cost (Vyas, J. and M. Chatterjee, 1995).

Table 17: In 1992, scheme of SEWA included:

	Type of Work	Risk Coverage	Annual Premiums	Insurer
1	Sickness (Health Insurance)	Rs 1000	Rs 15	United Insurance Company
2	Accidental death of a member (woman) including partial disablement.	Rs 10,000	Rs 3.50	United Insurance Company
3	Accidental death of a member's husband including permanent disablement	Rs 10, 000	Rs 3.50	United Insurance Company
4	Loss during riots/ floods/ fire/ theft etc. Loss of work Loss to hut, house	Rs. 2000 (max) Rs 3000 (max)	 Rs 8 Rs 8	United Insurance Company
5	Natural death Accidental death	Rs 3000 Rs 6000	Rs 15	LIC
6	Maternity	Rs 300	-	SEWA

Source: Paper presented by SEWA in 'International Conference on Health Insurance', 1995

In the earlier years of SEWA's experience with health insurance revealed the need to expand outreach particularly in rural areas and extending coverage to other family members. Another issue that came out was the expansion of preventive health related activities. SEWA members had pointed out poor, unsanitary health conditions, lack of drainage and toilets (Vyas and Chatterjee, 1995). The health insurance component was taken up by SEWA completely in 1994 from UIC. From 2001, SEWA has started purchasing medical insurance from National Insurance Company (NIC). SEWA enrols members and gives the premium amount to NIC once a year. NIC then reimburses claims on a monthly basis. At present those who pay the annual premium of Rs 85 get covered for maximum Rs 2000 per year in case of hospitalisation. A lifetime member can pay Rs. 1000, the interest of which is used as the annual premium. SEWA does not provide coverage for pre-existing disease like cancers, tuberculosis, diabetes etc. The choice of health provider is left to the discretion of the member. They are reimbursed on the submission of documents that include doctor's certificate stating the reason for hospitalisation, doctor's prescriptions and bills for medicines. An insurance committee verifies these for authenticity. Currently, 93,000 members of SEWA are insured and coverage has been extended to spouses and children.

ACCORD's (Action for Community Organisation, Rehabilitation and Development) Experience: ACCORD's experience with health insurance started with tribals in Gudalur valley of Tamil Nadu. ACCORD started working with the tribals in 1985. They started to organise tribals in to small groups. Parallel to the organising process was also a campaign on land rights. For the purpose the four major tribal groups were organised for this larger campaign called the Adivasi Munnetra Sangam (AMS). The AMS now acts as the pressure group for the Gudalur tribes. The health programme of ACCORD started in 1988. There was no access to government health services as the tribals were in far flung remote villages. It started with providing preventive services and curative services through a sub-centre by village health workers. No government doctor was willing to be posted here because it was remote. The need to have a hospital for the tribals was felt by all members. As an offshoot of ACCORD's activities, another organisation called Association for Health welfare (ASHWINI) was born. Its aim was to set up a hospital for the tribals. The Gudalur Adivasi Hospital (GAH) is a twenty-bed hospital that started functioning from 1990 was jointly funded from ACCORD's internal resources, public donations and funds.

The insurance scheme was initiated by ASHWINI in 1994. It linked up with New India Assurance Company to provide hospitalisation insurance to tribals. Under the scheme for a premium of Rs. 60 per annum for a family of five the following risks were covered:

Table 18: Benefits provided by ACCORD

Damage to hut and belongings	Rs. 1500
Death and permanent disability to head of family	Rs. 1500
All illnesses requiring hospitalisation	Rs. 1500

For the initial six years ASHWINI took the responsibility of paying premiums on behalf of the tribal members. In the meantime people's contributions were put in a fixed deposit. From the 7th year the scheme was to become self-sufficient as the interest from fixed deposit and people's contribution would be the major source of finance (Prasad, 1998). The New India Assurance Company after a period of time showed reluctance in

continuing the programme, as there was no profit margin for them. To see how the health insurance system could be sustained because there were non-payers who visited other health services, the AMS held discussions on why there were non-payments. The reasons were: people were too poor to pay premiums, the calendar time at which premium was to be paid was not very convenient, people did not see health insurance as a priority for allocating their money, the hospital was a long distance away and as they were not using the hospital, paying premiums would be unnecessary and that they preferred private practitioners.

Limitations

Community based health insurance has its pros and cons. Operating at the local level, the premium collection depends on the community. It has to be a voluntary scheme rather than compulsory as the reasons for not willing to pay premiums as listed in the ACCORD experience seem valid. Most voluntary organisations cater to the poor people and hence it becomes difficult to have a progressive system as the well off are not part of the system. In both SEWA's and ACCORD's experience, the two GIC subsidiaries were willing to reimburse just for hospitalisation but one has to keep in mind that the unorganised sector get wages on a daily basis, people are not willing to be hospitalised due to loss of wages unless absolutely necessary. But there are other experiences that have emphasised on community based programmes that is inclusive of preventive and promotive services. Out patient visits are more than in-patient visits. The GIC support was also temporary in both cases, as the insurance company did not see any profits for them. The management of insurance at the community level has to be on a no-profit basis.

Table 19: Prepayment and Insurance Mechanisms in some more Select NGO Managed Health Insurance Schemes

Features	**Sevagram**, Wardha, Maharshtra	**RAHA,** Raigarh, Orissa	**Tribhovandas Foundation**, Anand, Gujarat
Coverage provided	Household	Indivdual	Household
Annual subscription fee	A wage earner contributes 15 kg which is the base. A rich landowner gives 2.5 kg over the base. Families who do not own land pay Rs. 15 per person in cash per annum.	Rs. 5 or 2 kgs rice	Rs 10
Number of members	23 villages covered in all, total insured 15,000	75,000	Approximately 1/5 to 1/6th of all households in villages (319 villages covered)
Member entitlement	Community care: free CHW services, drugs and mobile (doctor + ANM) services Hospital: free care for illness episodes, 25 % subsidy for anticipated illness episodes, e.g., pregnancy and chronic ailments	Community care: free CHW services and drugs, free health centre services including MCH clinic. Hospital: free care after paying entrance fee up to ceiling of Rs. 1000	Community care: free services, subsidised drugs Hospital: 50 % subsidy
Non-member entitlement	Non-members not entitled to use community health services	Non-members charged for drugs, not entitled to attend MCH clinic	Non-members have same emoluments to community services as members but not hospital care
Management of fund	Voluntary health workers (VHW) responsible for membership collections, collections once a year at harvest time. Compulsory that 75 % of villages covered.	Individual health centres responsible for membership collections. Collections once a year.	VHW services responsible for membership collections. Collected once a year at times bonus payments distributed.

Source: Dave, 1991; "Insurance Premium Paid in kind" in Hindu, April 8, 2003

Table 20: Summary of the available insurance systems

Name of Scheme	Population Covered	Nature of funding	Services Covered
Employee State Insurance Scheme	Formal sector employees and their dependants with a salary of less than Rs. 6, 500. Covers around 35 million people.	Social Health Insurance system	Medical, sickness, work injury and maternity benefit
Central Government Health Scheme	Central Government employees, MPs and their families. Covers around 4.5 million people.	Social Health Insurance system	All in-patient, out-patient services.
Mediclaim Policy of GIC	Provides group insurance to private sector companies and provides voluntary health insurance to individuals. Covers 16 lakh population	Premiums by insured persons like Private Insurance system	Hospitalisation
Jan Arogya by GIC	4 lakh coverage	Premiums from indivduals	Hospitalisation up to Rs. 5000 and maternity benefits
Employer Managed Systems	Railways, Defence, Paramilitary, Mine and Beedi Sector, Plantation sector, post and telegraph employees Private / public sector and corporate sector employees	Services directly provided by employers Group health insurance like SHI/ direct provision by employers or reimbursement through panel of doctors	All in-patient and out-patient services
Bhavishya Arogya Policy	Individual/spouse aged 18-55 years for post retirement benefits up to Rs 5 lakh. Covers 1 lakh population	Voluntary premiums by individuals	Hospitalisation coverage after age of retirement
LIC Asha Deep II	Individual aged 18-50 years, covers 1.75 lakh people	Voluntary premiums by individuals	Coverage provided for four ailments, benefits vary from Rs. 50,000 to a maximum of Rs. 3 lakh

Source: Gumber, 2002

Health Services Development in India

An outcome of health financing and the way resources are allotted is the way the financing system influences the health services system development. Health services development in India can broadly be divided in three phases: the post independence period up to 1970s; the late 70s to late 1980s and from late 80s to present (Baru, 2002). The first period attempted to develop basic infrastructure and manpower although less than 5 percent of the total budget was invested in health (Qadeer, 1999). The real growth period for health services was during the 1960s but investment by the State was far from adequate. Bhore committee vision suffered a setback during 1960s and resulted in weak primary health services and more investment to secondary and tertiary levels of care. Therefore there was no integrated planning. Despite the unintegrated nature of health services development India managed to build a fairly extensive network of services, created indigenous capacity for training personnel for various levels of care and invested in research and pharmaceutical capability. But low level of investment in the public sector was one of the reasons for growth of private sector from '70s. The needs and aspirations of the growing urban and rural middle classes were reflected in the development of health services but these pressures had a marginal impact. The skewing of health services was apparent by 60s. The kind of investments that were being made was questionable. Family welfare that has been synonymous to family planning received a huge chunk of plan resource from the 4th plan. The undue importance to family planning arising from population debates and emphasis on vertical programmes also worked against the development of basic health services. The rate of expansion of infrastructure slowed down and there was a shift from building peripheral health centres and training paramedical professionals to hospitals and specialisation.

The 1970s saw a number of debates internally and globally. It witnessed the cut in social sector spending due to the oil shock. It also witnessed the Alma-Ata declaration in 1978 that argued for comprehensive primary health care. But the rhetoric of selective health care returned when it was felt that the state could not 'afford' a comprehensive health care. The underfunding in the health sector was realised by the government. Private

institutions started growing from 70s and were confined to urban areas. This secondary level of care was provided through nursing homes Number of committees was formed around this time to discuss and question structural inequalities in the health sector and the rural-urban disparity. The 1983 National health Policy stated that 'Health for All' goal would be realised by 2000.

As in other countries, the health sector reforms was brought about by the World Bank and IMF as a response to adjustment policies. These have initiated reforms at the secondary and tertiary levels of health services by stating that the state has to develop a strong primary health care. But the segregation of the three levels has increased costs and weakened the links in the service system. Introduction of user fees in public hospitals has been another major reform. Poor have been exempted from this but how does one do the means testing for exemption. The present situation shows a skewing of distribution patterns of health services with weak primary health care facilities. Increase in unregulated private provisioning has added to unequal distribution of services and problems of equity. Some of the changes recommended for health sector reforms have been: cutback on tertiary medical care in the public sector, private sector to play a prominent role in providing care, introducing cost recovery mechanisms in the public sector, implementing an essential clinical package for primary level care (Baru, 2001). Since 80s there has been a rise of corporate sector in medical care. With cuts in social spending in the late 80s and early 90s, it was realised there should be more investment in preventive services by the state. World Bank loans have been directed towards specific disease control programmes. 34 percent increase was because of AIDS control programme. In 1993-94 there was marginal increase in spending for malaria but there was decrease in spending for other communicable diseases. There were several outbreaks of epidemics across India like plague in Surat and malaria in western Rajasthan. This was attributed to decrease in state budgets. These outbreaks revealed the glaring weakness in the public health system, the lack of co-ordination between departments and lack of information regarding diagnosis and treatment (Baru, 2001).

Table 21: An overview of the present health services infrastructure:

1	**Health Services**	**Numbers**
i.	Sub-centre	1, 37, 271
ii.	Primary Health Centres (PHC)	22, 975
iii.	Community Health Centres (CHC)	2935
2.	**Hospitals and Beds by Organisation**	
i.	***Government Hospitals***	
a.	Hospitals	4808
b.	Beds	395664
ii.	***Private/Voluntary Organisations***	
a.	Hospitals	10289
b.	Beds	228155
3.	**Health Care Providers**	
i.	Doctors (Allopathy)	5,03,900
ii.	Nursing personnel	7,37,000

Source: Manpower Profile-India Yearbook, 2001 and National Health Policy, 2002

Utilisation of Health Services in India

One needs to understand utilisation patterns in relation to availability, accessibility, quality, cost and nature of ailment. These variables are crucial in determining choice and utilisation of services (Baru, 1999). Health is a state subject and given the socio-economic development in every state regional variations are bound to exist. In most states, public hospitals are the major providers of health services. Kerala, Maharashtra, Gujarat and Andhra Pradesh have a higher proportion of institutions and beds in the private sector. The bulk of the providers of private and voluntary services are clinics and dispensaries, which provide out-patient services. Use of private facilities on an average is higher for out-patient services. State wise utilisation of health services is different. The 42nd Round of the National Sample Survey provides state-wise data on morbidity and utilisation of health services. For in-patient services or hospitalisation more than 70 percent of hospitalised cases in rural areas were in public institutions in Karnataka, Madhya Pradesh, Orissa, Rajasthan and West Bengal. In Andhra Pradesh, Kerala, Maharashtra and Punjab less than 50 percent of the cases were hospitalised in public hospitals. If one examines share of hospitalised cases in the public sector the bottom 20 percent utilise public health services across all states except Andhra Pradesh, Bihar, Himachal Pradesh and Orissa. The utilisation of public hospital services among the top

20 percent in majority of the states was significant. So large number of people are still dependent on public hospitals (Baru, 1999). Utilisation of health services brings out clearly the rural-urban differences in access and costs. Rural population uses public facilities for out-patient services but alternatively use private services that include allopathy and traditional medicines. Rural people land up spending much more than their urban counterparts on health care. Most rural poor seek treatment only when their condition becomes serious. This is directly related to unavailability of public health institutions due to poor supply of medicines and the inaccessible private providers due to high costs. The burden of ill-health weighs down on them far more than the urban people.

Although India spends more than 5 percent of its GDP on health, health financing in India by the state shows a low spending and inequitable distribution of resources. The high out of pocket expenditure is a reflection of the skewed development of health services as part of the planning process. This is also having an effect on utilisation patterns and have resulted in health services becoming increasingly inaccessible in India.

Viability of a National Health Insurance for India

Viability of a National Health Insurance for India

The research question as stated in the introductory chapter is whether a National Health Insurance is a viable model for India or not. The objective of the study is to review country experiences in health insurance systems across the developed and developing world, to understand health financing in India with a focus on available health insurance systems. In doing so, I seek to evaluate the viability of a NHI for India by drawing lessons from other experiences.

Based on a review of country experiences one can infer that there is plurality in approaches to financing. The country experiences further highlight the socio-economic and political context within which health financing systems have developed. The influences of political parties and interest groups have played a dominant role in shaping of health financing systems. Where the *liberal ideology* has dominated, the development of the health financing has been influenced by market principles. As in the United States, the private insurance model dominates as a financing mechanism and hence the market gets the impetus with minimal state intervention. As against this the *paternalists* like United Kingdom, Germany, Canada, Israel and later South Korea and Taiwan, have emphasised the state's role in health services in order to ensure equity in health services within a capitalist economy. These welfarist states have viewed health services as a right and have ensured this by taking the role of financiers, strict regulators and/or providers. The market is allowed to intervene but is under constant scrutiny. The *socialist* ideology that dominated the pre-reform period in China brought up an insurance system that was a collective responsibility by and for the rural masses. The health services were regulated by local governments and financing was through collectives. The health system was an integral part of the development process. The market had a very minimal role to play.

There are different approaches to health services financing that are influenced by the ideological positions. These structures of financing relate to provisioning. When financing and provisioning is by the State it is through the *principle of taxation* as seen in the case of United Kingdom. Where the *insurance principle* comes in there is either a

mixed provisioning of public-private services or presence of solely private health services with the state playing an independent role of a financier and regulator. The state could even hand over the administrative part to non-profit sick funds and strictly regulate their functioning or to for-profit sick funds/health maintenance organisations with minimal intervention. The type of insurance systems could vary depending on nature of funding and the degree of state intervention. The various types are the private health insurance system, social health insurance system, targeted health insurance system, national health insurance system and community based health insurance systems. The review attempted to bring out the characteristics, experiences and variations in the working and administration of the health insurance systems in developed and developing countries.

A *private health insurance* system of financing is based on market principles where health services is seen as any good for consumption. The eligibility here is based on ability to pay and is voluntary. State intervention is kept to minimum and financing and provisioning is by the private. In United States the private health insurance system is managed by for-profit managed care organisations. They provide services and costs are determined by the market. Premiums are collected mostly through employer-employee contributions but individual premium payments are also made. This system is not a progressive and universal system and therefore raises questions on equity. A large section of the population remains uninsured and a large number also remain underinsured.

In the case of a *social health insurance* system, eligibility is based on employment and financing is through a progressive payroll contribution. The dominant health financing system in Germany, France, South Korea and Taiwan is through a compulsory *social health insurance* system. These countries have been able to provide good coverage because they have high rates of organised employment and the social health insurance (SHI) system works through the payroll contribution that are managed by non-profit health fund(s). Along with SHI, Germany and South Korea provide subsidies for the unemployed, disabled and self-employed, thereby providing universal coverage. Provisioning of services is largely through the private providers and the health insurance systems in these countries are regulated by the state. This system can be made universal

and equitable if there are large sections of population in organised sector and cross subsidies are made for the unemployed and poor.

A *targeted health insurance* system as the name suggests intends to insure a section of population that has common social or economic characteristics and in most cases it is the poor. A distinct example of this type is the Medicare (for elderly) and Medicaid (for poor) programmes in the United States. The financing is by the State while provisioning is by the private health system. The problems with this system include the question of membership, links to providers and the question of universality. Such a system when targeted at the poor reinforces class differences in society and may create a two-tier health service system if services for the group are not integrated well.

In the case of a *National Health Insurance* system, eligibility is based on citizenship and financing is either by the State i.e. through general taxation or through various insurance systems that are brought under one institute but ensuring that coverage is provided to all. The system is progressive. This is seen in the case of Canada and Israel. While in Canada the system is financed through general taxation, in Israel there are several sources of funding and the National Insurance Institute pools in contributions from these sources and then distributes this to the sick funds that provide services. The provisioning in Canada is largely private and in Israel the not-for profit sick funds also known as health care organisations provide services. The system is regulated by the state. This system is based on principles of universality and equity.

Community based health insurance system (CBHI) refers to contributions made by individuals, families or community groups towards health care. This approach has resulted in communities taking responsibilities for certain health care services. The health fund in this case is handled by local voluntary organisations consisting of community members. Resources are pooled in here. Such an initiative was first taken in China during the 1950s and the system worked through agriculture collectives. Thailand too has introduced a voluntary community financed health programme in the last decade. Most of the present instances of CBHI are targeted to the poor households. Such a system can be

made progressive and successful if all community members participate and can attain universality if the state plays an active role.

None of the developing countries have a comprehensive national health insurance providing universal coverage. Social health insurance programmes are present but they cover a small section of the population and that too the organised sector. Employment is a prerequisite for a social health insurance programme and in developing countries where there are large unorganised, self-employed and unemployed people it is not an easy task to develop a universal social health insurance programme. Some developing countries have initiated successful community health insurance schemes but the population covered is negligible. This is seen in Thailand and India. Thailand has various insurance systems covering three quarters of the population through public and private health services. China's almost universal health insurance has broken down with the advent of market reforms. China has three types of health insurance scheme: the labour insurance and the public service medical care for the urban population and the co-operative medical care scheme for its rural population. Prior to reforms China had covered 90 percent of its rural population through the co-operative scheme and had provided universal coverage for its urban population. Though all the three insurance systems still exist, the coverage has drastically reduced in the post reform period and out of pocket expenses have increased. India too has various insurance systems as discussed in the earlier chapter but the coverage is limited to a small percentage of the population. Almost all developing countries have a public-private mix of health services.

Based on the review of country experiences, it is of course not possible to replicate any of the experiences given the different socio-economic and political context within which the systems of financing have developed, but it is possible to draw some lessons from each of these experiences for India.

The preceding chapter on India gave an overview of the existing approaches to financing and the state of health services in India. It is well established that health services are inaccessible (socially, economically and physically) to many and most are paying dearly

out of their pockets. The out of pocket expenses is not in any ways an indicator of willingness to pay as has been justified by World Bank. Even if people are willing to pay, the question is to what extent are they willing. The vision of 'Health for all by 2000'" has also waned out. How does one realise this goal? Of course health of a population is not determined only by the presence of health services but it is inclusive of this basic right and it has been well acknowledged that it should be available to all irrespective of paying capacity. Burden of treatment includes direct and indirect costs, depends on the nature and duration of illness, income, external sources of financing like health insurance or employer support, loss of income due to illness and position of individual in society. In India this burden is greater for the rural people, the poor, the lower castes and tribes. Should two persons with the same illness receive differential treatments just because one has the ability to pay and the other does not have the resources tc seek care and treatment? The burden of treatment is different for different people so can the direct cost of treatment be taken care of by the state through the insurance mechanism? One has to take up this challenge as an ethical issue. In a time where government health expenditure has not seen an increase due to fiscal crunch and when it is getting increasingly difficult to rely on further expansion of public health services, a comprehensive and progressive insurance system as a way of financing the health services system is what comes to the mind where one can pool in risks and resources. Can the central, state and private expenditure be mediated through an appropriate institutional mechanism? We can start from the basic philosophy, the philosophy that is behind Canada's publicly-funded health insurance system and is simple: no one should go without necessary health services for lack of money or access to health facilities or providers. One realises the importance of health reforms but they have to be drastically different in direction from the recent reforms brought about by structural adjustment policies.

Existing debates towards universal health care coverage

At the level of ideas many have suggested universal health coverage. *Shivakumar* (1999) stresses on the notion of equity over the logic of efficiency and mentions the alternative of having universal health coverage through progressive tax and social insurance mechanisms. *Krishnan* (1999) wrote off the argument that is generally given against a

NHI in India that India is too vast a country to formulate a NHI. He is of the view that one has to look into the possibilities and means of working out a universal system.

Krishnan (1996) proposed hospitalisation insurance initially targeted at people below the poverty line and then expanding it to make it universal. He saw a hospitalisation plan for the poor as an income protection plan for the poor as episodes of illness put undue economic burden on the income of the poor and recommended that over a period of time it could be expanded to include all sections of the population. He gave three grounds for the case of hospitalisation insurance: Firstly, illness cannot be predicted; secondly, hospitalisation costs are lumpy and cannot be planned and thirdly, the proportions falling ill requiring hospitalisation in any large population is small and therefore permits risk-pooling. He derived the estimate of total cost for 1996 for the bottom 40 percent of the population. The number of in-patients from this section of the population was calculated to be 12.5 million from the total number of 300 million living below poverty line. The insurance coverage is for medicines, tests and fee for consultation. It is assumed that patients will get admitted to free wards in public hospitals. After calculations the insurance protection comes to Rs. 5000 per family per year for hospitalisation at a premium of Rs. 30 per person. GIC at the same time charges Rs. 70 for Rs 5000 coverage. For large group coverage the premium will be less. The total amount for the group comes to Rs. 900 crore. Krishnan suggested that the amount of Rs 900 crores should be provided by the government as part of the anti-poverty programme that could be found from unspent savings under anti-poverty programmes or by reallocation of the expenditures. For the institutional set up, he had recommended the conversion of the four GIC subsidiaries into four separate Health Insurance Corporations that should be allowed to compete among themselves and should function as not-for-profit organisations. This would be the first step towards a universal health financing scheme. Krishnan gives a very cost effective and administratively workable structure of health insurance. Though very comprehensive as it covers all aspects of administration, regulation and provisioning it lacks certain points. Firstly, it starts with a targeted approach and it is for people below poverty line. Second it covers only hospitalisation. The poor take in-patient admissions only as a last resort because getting hospitalised means losing wages. The need is also for

out-patient services for which out-of pocket expenses are made almost every other day. The responsibility of provisioning is again left to the free wards of the public hospitals, the private too has to take the responsibility but one has to make links with the private sector or else the targeted section will remain neglected.

Gumber (2002) discusses the problems and prospects of having health insurance for the informal sector and the poor in general. This has been discussed through a pilot study on feasibility of health insurance for the informal sector in both urban and rural areas. The households surveyed were divided into four categories: those insured under ESIS, those insured under Mediclaim, those insured under a community health financing scheme by SEWA and those who have no health insurance. The issues under study were: morbidity patterns, expenditure on treatment, burden of health care expenditure, users' perceptions on the delivery of health insurance services, demand for health insurance, expectations from a new health insurance scheme, willingness to pay for the scheme. He sees a strong need for health insurance in low-income families from both rural and urban areas. The per capita out-of-pocket expenditure among both ESIS and Mediclaim was seen to be lower than in SEWA and non-insured households. Even those insured under the ESIS, especially those in rural areas, showed interest in health insurance due to the distant and inefficient ESI services. The types of benefit packages expected were in-patient, out-patient, chronic and maternity services. This kind of insurance he says could be managed by a managing institution in collaboration with NGOs and *panchayats*. The study has been largely left to the needs of the community and what they think to be appropriate, like the kind of benefits, choice of providers and payment mechanisms could be worked out by the NGOs and *Panchayati Raj* Institutions. The study works out a targeted health insurance plan for the poor. It needs to be seen here whether cross subsidies could be made across income levels than leaving the onus completely on the poor households.

Berman (1995) questions the possibility as to whether we can expect the rural population to finance their health insurance or is significant redistribution needed from urban population to rural population. From the perspective of equity he suggests that different populations may bear burden in proportion to their ability to pay and significant financial

transfers for rural health care financing are needed. Cross subsidies should include net additions to rural health care financing overall, as well as transfers from wealthier to poorer rural residents. Financing within rural areas will need to be significantly progressive. Berman goes on to state that there will be differences between states, regions, districts, towns, one needs to address the question of how much resource transfers will be needed across administrative regions. New financing strategies must be combined with efforts to improve access to and quality of services for rural populations. Financing without reforms to health care provision and demand may result in poor impact and waste of resources. He says that the challenges of devising socially acceptable institutions that can collect these funds and reorient them to meet health needs for rural India are daunting.

Jain (1999) makes a case in favour of an area-based social insurance covering the unorganised sector in India. He states that the major change that is recommended is in terms of doing away with an approach that is sectoral and is oriented towards employment relationship. The importance of the specific individual employment would still be there but mainly for administrative and procedural purposes. The scope and applicability should include all categories of unorganised worker. He excludes the organised and those workers under *National Social Assistance Programme* (NSAP) who already have access to benefits. His list of benefits includes work related injury resulting in death or disability, maternity benefits, health care, old age benefits of pension and provident fund, insurance of economic assets like crops, cattle etc. He proposes that few defined rates of contribution amounts including a minimum amount could be prescribed. For purpose of implementation he suggests that existing institutions should be used. The state, *panchayat* and municipalities are to be fully involved and social security agencies like EPF and ESI could be linked.

Guhan (1998) says that a predominant reliance on formal social security is inequitable when 90 percent of the workforce is in unorganised. He states that reliance on this kind of social insurance will further widen the gaps between classes as the beneficiaries of the formal social security system are articulate, organised and have pressure groups while the

vast majority who lack social protection are scattered, unorganised and powerless. He calls for a radical restructuring of the entire framework of existing social security programmes along with legal and administrative reforms. Social security programme in India includes medical care and sickness benefits, unemployment, old age, employment injury, maternity, and invalidity benefits under different legislation and programmes. He observes that in the Indian context social security would need to be addressed in a wide framework of approaches to poverty alleviation as most of these benefits reach out only to the organised sector. Some of these are provided through ESI Act, the Workmen's Compensation Act, the Maternity Benefit Act, the Payment of Gratuity Act, Industrial Disputes Act and Employees' Provident Fund. At the level of working out a structure he expresses interest in creation of a *National Social Insurance Agency* (NSIA). He argues that the combination of provision and insurance has hindered coverage under ESI and hence he is of the view that medical provision should be separated from ESI and the ESI could be transformed into a National Social Insurance Agency. The NSIA can have the mandate of providing sickness, disability and employment injury insurance. He further states that a *National Health Insurance Agency* can take over activities of GIC in order to provide the institutional basis and provide compulsory coverage to not just the organised sector but other occupational groups as well. He suggests bringing different kinds of health insurance programme under one institution and provisioning could be through hospitals and clinics in public, private and voluntary sectors. He proposes a combination of social insurance and private insurance based on regulation. He further suggests the need for social assistance programmes for the unorganised workforce and poor in general. This could be achieved through promotional schemes such as employment, nutrition and health care and should also cover contingencies like old age, widowhood, maternity, disability and employment injury. According to him the *National Social Assistance Programme* initiated by the government will ensure a basic minimum of social protection for poor households. Guhan's arguments provide an interesting basis to look at the present state of social security and insurance schemes. He suggests the expansion of social insurance to the unorganised and social assistance programmes for the poor within a framework of anti-poverty measures.

It is essential to highlight all these debates that have been surfacing every now and then in the past decade because the basic idea behind all these debates is equity. Most of them stress on the growing importance and need to reach out to the informal sector and the poor who form the majority of the population as the rest of the population already enjoy certain benefits. These debates put forth pertinent issues and arguments for developing social security and health insurance programmes targeted towards them. Most of the debates fall short of talking of a universal programme but have used the principle of universality as the base on within which the ideas have developed. Are these leads to a comprehensive and universal health insurance or universal social insurance system?

Emerging Trends

Let us examine the *emerging trends* and various possibilities of health insurance for India and base them on principles of equity, universality and comprehensive coverage. These are:

- private health insurance
- targeted health insurance for the poor
- social health insurance
- community based health insurance systems around the country
- different health insurance systems covering the entire population that could be brought under one administrative umbrella to make it a NHI.

Private health insurance is posed as an alternative for India. One of the most recent debates on health insurance has surrounded the introduction of private health insurance. The privatisation and liberalisation of various insurance systems was discussed more seriously with the passage of the Insurance Regulatory and Development Authority (IRDA) Bill in December 1999. The bill allows the entry of private sector in the Indian insurance sector, including health insurance. Several large health care providers, international and national, are already prepared to enter the market and have entered in to pacts with Indian firms. But the apparent lack of attention to health insurance by the government is a grave concern. It might be relying a lot on IRDA to regulate and study the entry of the insurance companies carefully and at the same time it is important to note

that the IRDA Bill contains no reference to the health sector or the health insurance (Mahal, 2002). Private insurance is being viewed as a source of supplementary insurance for better off sections of society and those in the organised sector who could afford it, whereas basic health services would be taken care by the state. However, the vast majority of health spending and delivery is already occurring in the private sector. One significant risk of insurance liberalisation is that it could further drain resources away from the poor. If private health insurance gets introduced in a big way, there is a lot to learn from the other experiences especially United States (US) and Chile. India has to be very cautious if it is planning to follow a similar path. Such an insurance system becomes selective and depends on peoples paying capacity and therefore will be available mostly for urban and the better off population. More than 40 million are uninsured in USA (Iglehart, 1999). Similarly, India may have a big market for private health insurance takers as is being perceived by the multi-national companies (MNCs) who are ready to enter, but it will have greater number of people uninsured and underinsured and this will include not just the poor but significant portion of the Indian middle class, retired elderly, unemployed and disabled. Fee for service payments to providers based on indemnity insurance, is the main type of insurance expected in an unregulated market in India. This has led to cost escalations in health care in countries where this has been introduced and if this happens in India it would lead to higher out of pocket expenses by the poor. Private health insurance has increased costs of services despite managed care organisations that were brought in to manage costs. No managed-care plans have been able to slow the rate of inflation in costs (Relman, 1993). The US model has shown that all insurers try to keep prices high because of competition. The Chile experience highlights the problems that have arisen from a class-based system of financing. While the poor and the lower income level are expected to access state run health services the upper class and higher income group has the choice of seeking private services through a private insurance mechanism. The rise in costs of services due to market competition has made the poor vulnerable because the underfunded public services system is neglected and private health insurance is beyond their reach. A 'wait and see' attitude to regulate health insurance is a high-risk approach. Other countries have found it almost impossible to change the rules for insurers or providers once there are established interests. For instance, in Chile, the present

democratic government is facing difficulties in increasing state financing and regulating the private health services system because of strong resistance from private interest groups like the insurers and the health professionals whose interests have already been established and was given impetus during the military rule. In India, GIC, although a public enterprise, runs the hospitalisation insurance scheme as a commercial one. It too selects out people in terms of income level and pre-existing diseases. A private health insurance system would therefore be regressive, profit maximising and inequitable. When private insurers use a more generous fee schedule for providers, a two-tier system of health care may result, and providers will be more inclined to give a better level of care to those with private insurance. In addition, the purchaser of private health insurance often uses more medical services than the purchaser of public health insurance because private insurance provides for patient co-payment. The better off always have the choice of both the public and the private. Therefore health care provision to private and public insurees would become increasingly inequitable. An important component of any private system is that of strict regulation either by the state or professional bodies themselves or some form of combination of the two. In health services it becomes even more important because it is not like any other good for consumption that can be left to the market. In the 'health services market', the consumer does not have a choice to choose from goods and services. Expenditure by the consumer is made on the advice of the physician. A patient is often ignorant of his need and type of service required. In a fee for service situation the income maximising doctor tends to expand the volume of services provided particularly those which generate high income (Veeranarayana, K, 1991). The question of equity has greater weight than that of efficiency. If people cannot access basic health services because of inability to pay what good can an efficient health care market do? The term efficiency is mostly used loosely to promote the private sector.

A *targeted health insurance scheme* directly follows the above discussion on private insurance. It is for those who cannot afford purchasing a private insurance scheme or cannot access private health service. Such targeted interventions have been discussed as possibilities to provide coverage for the poor in India but they have their limitations. Firstly, the means testing as to who is poor, deprived and indigent is a task in itself. One

has to be very sure while carrying a means testing as to who falls under this and who does not. In India there are large sections of population who live precariously, even those who fall above the poverty line are without adequate minimum needs. A targeted scheme could be something like the US Medicare/Medicaid public health insurance programmes where insurance coverage is provided to the poor and elderly. As the US experience shows, this section has been further neglected by the profit oriented service providers and by the state too. The services provided are not comprehensive and the private providers at times refuse to attend to this group as reimbursements for this group is lower than the market rate. The most affected are the poor insured under Medicaid. There have been major cuts in the programmes since its inception and most pay out of pocket. The recent health budget in India (2003-2004) has proposed a rural health insurance programme for India. This is a targeted health insurance system. Under this scheme the GIC has been encouraged to pilot the programme. A premium equivalent to Re. 1 per day for an individual, Rs. 1.50 per day for a family of five and Rs. 2 per day for a family of seven has been proposed. This would entitle eligibility to get reimbursement up to Rs. 30,000 towards hospitalisation, cover for death due to accident for Rs. 25,000 and a compensation due to loss of earning at the rate of Rs. 50 per day up to a maximum of 15 days. The government has decided to contribute premiums for those below poverty line. Both private and public providers will be allowed to be part of the scheme. Some experts have observed, "most important is the setting up of health insurance system with which we hope to create hospitals in small villages where basic health facilities can be provided" (Financial Express, March 2003). Although the interest shown towards having such a rural health insurance system has received a positive response from many, a senior government official in the health ministry observes that, "it is still an ad hoc programme and has not been thought through". How is the system going to be administered, from whom does one buy services, how is the system going to be linked with existing institutions of health services are being questioned. The government has said that it would contribute a part of the premium on behalf of the people below poverty line but the premiums from other section of the population does not seem to be progressive. After all, the rural does not comprise of a homogeneous class of people.

Social health insurance already exists in India but has a very limited coverage. The ESI funding is through a tripartite system (contributions by employer, employee and state) and the CGHS is a bipartite system with contributions from the employees and the central government that is the employer. The principle of universality does not get addressed in this type of insurance. A recent initiative in expanding health insurance system to the unorganised has been through extending the ESI programme to construction workers. The Act had already been passed by the centre in 1996 but has yet to be implemented by the individual states. The labour movement has had a major role in pushing this Act. Construction workers will be registered through workers unions and a list of people's names who will be insured will be passed on to the ESI. The workers will have to contribute a sum of Rs 20 quarterly and will be able to get the benefits listed under the ESI Act (conversation with an NGO worker in Delhi). Coverage of population based solely on employment status will have its problems in a country like India and will select out many who are casual workers, unemployed, disabled and the elderly.

Community based health insurance system (CBHI) is presently being talked of in a big way. The focus here is on financing health services for the rural population where accessibility and availability of services has been a major concern. Some successful experiments as in SEWA, ACCORD and Sewagram are being cited as examples to expand CBHI programmes through networks of voluntary organisations. SEWA's experience with health insurance points to the need of developing a social security fund at the national level for the unorganised sector so as to extend integrated health services to the workers. Such a fund would be contributory in nature: workers, employers and the state. Its administration could be decentralised through local tripartite boards. Sewagram's experience with CBHI emphasises the importance of strengthening primary health care and linking curative services with basic services. The Sewagram experience has been a progressive system where people who are unable to give cash can pay in kind a small portion of their agricultural produce according to size of their land and those who are landless pay a minimum amount in cash. In some cases the health service providers listed with the voluntary organisations as providing services to the insured are at times inaccessible to many because of distances. In other cases, basic health services are

provided by community health workers who make referrals if needed. So providers need to be evenly spread across the insured population rather than being distant and concentrated at one place. A successful community health insurance system must take in to account the following principles:

- In order to pool risks at least 75 percent of households should participate in the scheme. This should include the well-off, unorganised sector, unemployed, and the poor.
- Local non-governmental organisations (NGOs), community groups like *mahila mandals* and youth groups could be actively involved in initiating such a scheme.
- Payment of premium has to follow a progressive system based on income level and ability to pay. Government should participate in the system by subsidising for those who are unable to pay.
- If NGOs run their own health services then benefits could be provided through these institutions or else there has to be some network with primary health centres, other referral services and other private providers for in-patient and out-patient services. Basic health services essential drugs, preventive services based on knowledge of common infections and diseases prevelant in the community could be covered through community health workers. For referral services, which require hospitalisation, or certain diagnostic services unavailable at the local level, links could be made with government secondary level hospitals and with some private nursing homes.
- Physician fees, hospital fees could be paid a monthly sum given the number of treatments of insured persons.

On the whole, if community health insurance system needs to be successful and expanded across the country, the state must play an active role in collaboration with local initiatives and by providing official recognition to private service providers who are part of the insurance system or else the onus will be again on individuals. China's experience with rural co-operative medical system was first of its kind. It was in the lines of a community based insurance system operated at the local level and was integrally linked to primary health care. It had witnessed 90 percent coverage through local government

administration. Such a system can be made universal and equitable if addressed and formulated meticulously.

The last alternative I will be interested in looking at in detail is a *National Health Insurance System*, an insurance system that is universal, compulsory, comprehensive and progressive.

Key features of a National Health Insurance should include:

1. *Universal and comprehensive coverage*: Such coverage ensures access and avoid a two-tier class based structure of services. It has also proved to be administratively less expensive.
2. *No out-of pocket expenses*: Direct payments are barriers to access and it is difficult to regulate such payments.
3. *A single insurance plan in each region, administered by public or quasi-public agency*: A private system of administration will work on for-profit mechanisms that would result in two-tier and inequitable system.
4. *For-profit health care providers should be under strict regulation.*
5. *Progressive system of pre-payment*

Source: adapted from Himmelstein, D.U. (2003)

Let us put down certain points that are important for discussion when working on a viability of a NHI for India:

- 10 percent of India's workforce is in the organised sector while the rest is unorganised labour, what kind of an administrative system can bring them under one health insurance umbrella? There is large section of dependent population too comprising of the unemployed, elderly, disabled and children who need to be covered. There are tribal populations who are far flung without health services and need to be covered. There are also large sections of populations living in inaccessible areas. Can the existing structures be utilised for the purpose?

- Who pays what i.e. what type of financing system can be worked out? It could be through general taxation, it could be a tripartite financing system or it could be different types of health insurance systems pooled in together.
- The health insurance system will have to provide a basket of services so what benefits or services would be provided? Will it include all preventive and curative services? Will it include both in-patient and out-patient curative services given the public-private mix of services?
- How does the payer purchase health services given the public-private mix of services?
- Does the socio-economic and political context that is necessary for the creation of NHI exist today?

A Possible Working Model of a NHI in India

If NHI is to be a legislation it will imply that it is a compulsory system of insurance. The idea behind such a system is to enrol all citizens in the programme in order to avoid adverse selection, social inequity and thereby also have health services financing mechanism in place. A social security number system as in US could be seen as one possibility.

Funding of NHI: Who pays what?

Can we have a single financing system? One possibility is that the State gives priority to health and spends considerable part of its GDP on health but a system of financing through only general taxation as in Canada may have its problems in India as the direct tax revenues are limited. Public investment in health is as low as 1.3% of the GDP. Expecting the government to increase public spending by another 3-4 % may not bring a positive response. Centre spending has remained stagnant and state expenditures in health have reduced over the last decade. A part of funding through general revenue is no doubt imperative but the part of out-of pocket that is being spent for so called personal health services needs to be tackled. The percapita expenditure on health care on an average comes to Rs. 320 per year out of which Rs. 240 is directly from household (Berman,

1995). One has to find ways to pool in resources to finance the health services system through a pre-payment mechanism. The system will admittedly have to be progressive where the better off will contribute more and the source of fund for the indigent and disabled will get subsidised by the government.

Most of the other developed countries discussed in the country experiences follow the social health insurance model. Contributions as seen in most cases are made to a health fund and the most common basis for contributions is the payroll, with contributions from employer and employee. The health fund(s) as in the case of Germany, Korea and Taiwan is usually independent of government but works within a tight framework of government regulations. India has a small percentage of its population in organised sector unlike other developed countries. It cannot have a single source for funding because of its diverse and heterogeneous population but compulsory SHI for the organised sector can be worked out where higher income group makes a greater premium contribution and the lower income contributes less. The existing institutions of GIC, ESI, CGHS that already provide health insurance through payroll contributions in public and private sector could be brought under one institute and resources pooled together. Thus, a National Health Insurance Agency (NHIA) can be formed. As Guhan has suggested that medical care provision can be delinked from the ESI with its institutions being handed over to the state governments. Going along with this suggestion further, a tripartite system could be made possible for the organised section with contributions from employer, employee and the state government.

The major task is to work out an arrangement to collect contributions from the large unorganised sector and their dependants. Unemployment is as high as 17 million and according to Census (2001), 40 percent of the population is in the work force (organised and unorganised). The other GIC policies initiated for the lower income group like *Jan Arogya* and *Bhavishya Arogya* policies could be merged and compulsory premium collections could be made from the self-employed and informal sector workers.

Non-governmental initiatives in community based health insurance have been successful to some extent, the problems faced have been more to do with administration. Studies on willingness towards a pre-payment system have elicited positive responses from respondents (Gumber, 2002). For a community based collection system differentiation has to be made in terms of rural and urban. For rural population certain NGOs can be marked and made nodal points of collection of premiums from residents and households who are not part of any other kind of insurance like the ESI, GIC. Where voluntary organisations are not present some local government initiative through the *panchayat* office could be made the collection point. A list of names of residents within the given area could be prepared and then a rough estimate of total income and assets in terms of landholding for each household could be specified. Progressive collection of premium will be easier this way where landless and the poor have to pay less than the ones who are landed and the rich. The collection can be on an annual basis. The obstacles here would be the unwillingness for cross-subsidies from the better off to the poor. Will the better off be prepared to subsidise for the poor? An analysis of all community based insurance schemes shows that most have been initiated for the poor and there are really no experiments of cross subsidisation.

The large unorganised, migrant population in slum settlements needs to be covered in a similar way. NHIA can cover these populations through the local government and NGOs. Most unemployed may be part of a family that has some income coming in, the very poor, indigent, homeless and disabled have to be subsidised by the government and through the progressive system. State has to work out on premium estimates of various section of the population so that there are no discrepancies at the point of collection. Funds collected need to be redistributed across rural and urban centres by the state because similar risk type funds as was in Korea will lead to risk selection. The experience of pluralistic insurance systems turned out to be regressive and small funds were vulnerable to financial shocks. Similarly funds coming from the Centre have to be distributed according to the needs of the different states by giving greater share to the poorer states.

Benefits Provided

As mentioned before health services include preventive, promotive and curative services. Most countries have focused on benefits for curative services in the form of in-patient and out-patient care as part of health insurance. Certain services have been excluded for which people have to make out of pocket expenses like certain referral services, dental services and certain drugs. Preventive services are mostly separated and provided by local governments. Canada and Israel for one give more stress on primary level care. Specialisations are regulated so that there is more emphasis on primary care physicians who are the initial contact point of the health care system. India has a large network of public delivery system but has the most privatised health services system in the world and in spite of this more than 40 percent of the population seeking care visit the public institutions. The strengthening of basic health services at the primary level of care is an essential responsibility of the state. Epidemiological studies to prioritise diseases and illnesses in terms of their incidence and distribution is necessary to chalk out services that need to be insured. As in Canada it must be left to individual state's discretion as to what services they want to cover but the focus on primary level care needs to be stressed by the centre. Preventive services are provided directly by the state for water, sanitation facilities and communicable diseases. These cannot be separated from other health services. Although NHI will fund 'personal health services', all preventive, promotive, curative services need to be integrated by the state.

A study conducted in Gujarat showed that among the specific medical care benefits, coverage of hospitalisation expenditure is desired by more than 90 per cent of the respondents in both rural and urban areas. Hospitalisation being expensive, there is a strong demand for the coverage of the costs among the respondents. The coverage includes fees, medicines, diagnostic services, and hospital charges in rural areas. The expectation of coverage of OPD and MCH followed next (Gumber, 2002). As shown by Berman (1997), more than 60 percent of the out of pocket expenditure is for non-hospital treatment, which is greater for rural areas. Out of this expenditure private non-hospital treatment takes a major share. 82 percent of funding for primary health care comes directly from households.

The possibility of working out an insurance system for out-patient and hospitalisation for acute care is essential as most of the times people pay out of pocket for out patient care as mentioned above. The NHI could provide benefits for in-patient, out-patient care at primary, secondary and tertiary level of care.

Health care services at the primary level is available through primary health centres (PHC), private general practitioners, traditional practitioners or at government hospital out-patient departments. A list of certified physicians and other providers have to be established by the local government/local health department who could be part of NHI providers. Services insured at the primary level should be essential drugs, provider fees, and diagnostic services. The physicians providing out-patient services at the primary level should act as gatekeepers of the health care system. For any further specialised diagnostic tests or in-patient treatment referral slips could be provided to every individual. Similarly a list of accredited referral institutions should be made available. This will include government hospitals, private specialists, and private hospitals. Services that could be insured are: hospital accommodation, diagnostic services, drugs, surgery costs. Minimum coverage may be provided for dental costs and some specialised services. As has been seen in other countries, after economic reforms the type of benefits have reduced to some extent and people have started spending out of pocket for certain services. In Canada, there have been cuts made in acute care hospitals and emphasis has shifted to primary health care and in number of provinces devolution of responsibilties has been passed to local governments. The basic services and medically necessary services are taken care of.

Provider payment mechanisms

The main idea behind the payment mechanism is that no direct out of pocket expenditure is made by anyone. Therefore, one has to also do away with user fees and reimbursement mechanisms where the patient gets reimbursed by the insurer after submitting bills. The state already provides free services and has salaried professionals and medical personnel to some extent but there is a large private health care system that needs to be tackled. Is it

therefore, possible to have a common fee schedule for providers and to fix prices for services provided as in most countries with health insurance? A common fee schedule and price fixing of services has been an essential component of most State regulated health insurance programmes as seen in countries like Canada, Israel, Germany, Korea and Taiwan. It becomes more important to regulate prices where private provisioning is present and international experience shows that curative service market failures can be corrected through price and quantity regulations such as using capitation to pay primary care physicians, performance related prospective budgets for hospitals, budgeting for physician services, reference drug prices, and manpower planning. In Germany, one way of controlling costs is through budget controls that have been superimposed on each part of the health care system. If doctors claim for more services given to patients, the level of all fees is decreased proportionately in each quarter. Similarly, every service may be listed and priced with operating, maintenance costs of equipment used. There is no check on the kind of fees attributed to each service. The centre and state governments have to work out on specified fees on the range of services that are to be insured. It could in a way help to regulate and check the otherwise unregulated and undisciplined private health care system. Institutions can be reimbursed for the bulk of services they provide directly by the local and state government and the medical personnel too get reimbursed for their services. The problem here is now whether there should be a capitated form of payment or fee for service payment to providers. In capitation payment the person is allowed to register with a particular doctor of their choice. From then onwards, the doctor is paid regularly a flat rate sum for that patient, whether the patient needs the service or not. This can work specifically for primary level provider services. But with the large migrant and mobile population in India is it possible to have a capitated form of payment? The physicians may get a fee for service reimbursement for migrant workers while the rest of the services may be paid under a capitated system. Reimbursing doctors for every service they provide may lead to doctors providing more services than usual or declaring that they have provided more services than they actually have. The providers in a fee for service have to deposit each and every bill to the insurer. It needs to be seen whether this will be administratively a viable proposition. This is where the regulatory mechanism has to function like a watchdog. A common and similar fee schedule across

provinces in Canada has been able to redistribute doctors from urban to rural centres. Market forces have redistributed physicians from over-doctored to under-doctored areas. It has meant that a blue collar worker or a poor farmer in an industrial area is just as good a source of income as a wealthy urbanite. This has helped population that is far flung to access health services. According to the Indian Council for Medical Research (ICMR) and Indian Council for Social Science Research (ICSSR) in 1981, there was an overproduction of doctors that was leading to a colossal waste of human resources. At that time itself two thirds of the allopathic doctors were in the private sector and these were mostly concentrated in urban centres. There is therefore a large vacuum that has been created in rural areas as a result of market forces. It is a problem of distribution and not of supply. A budgeted NHI can help bring down this difference in urban and rural areas where common fee schedules are maintained. It has also been observed that a high level of specialists tends to push up health costs. A study conducted in US showed that a 10 percent increase in surgeons would increase surgical operations by 3-4 percent. This was a direct result of supplier induced demand (Thomas. G, 2003). When the focus is primarily given to the primary level physicians it would also help regulate growth and proportion of physicians and specialists as is seen in Canada.

Administration of NHI in India

Taiwan, Israel, Korea demonstrate working of NHI through one health insurance institute. Korea merged its sick funds into one insurance fund so as to make the health insurance system universal, progressive and administratively more viable. The pluralistic health insurance funds caused concerns of equity and many were too small and vulnerable to financial shocks. Israel too realised that there were differences between the four sick funds and these four were brought under the regulation of single insurance institute. Taiwan has a Central Bureau for NHI and has its six local branches to collect premiums. The US example financing has shown that administratively it is more expensive to have a private system and there is waste of resources. This results from the federal governments less direct control over costs. HMOs keep 20-25 percent of premiums for overhead costs and profit as compared to 1 percent in Canada (Himmelstein, 2003). As percentage of GDP, US therefore spends more than the other

developed countries and in spite of its huge expenditures it is unable to provide universal coverage. Canada with its provincial insurance systems as the single insurers spends less on administrative costs. China had separate rural and urban based insurance systems administered through communes in the rural settings and government in urban settings. For a country as large as India it cannot be feasible to have a single insurance institute at the centre and since health is a state subject, states have to take independent responsibilities under national guidance and national principles. Since health is a state subject in India, the responsibility of premium collection falls on the state. Working of health insurance can be through local governments and funds collected can then be redistributed among rural and urban institutes after making estimates of where greater funds are required. The different sources of funds for urban areas could be: compulsory social health insurance funds by the employed, compulsory premium payments by self-employed made to the local insurance institute. The rural health insurance programme could be community based. The centre has to contribute its share of resources directly to the state. NHIA can have its subsidiaries in every state where health funds are collected from the organised sector and unorganised sector. For the rural unorganised, funds through local government and NGOs can be brought under the town or district level where the insurance institute is located. Separate funds can be maintained for rural and urban and cross subsidies can be made across funds. Each state might have its district wise insurance institute. The working of a NHI for a large country like India has to be through local governance. This will make it more comprehensive and easy to administer. This should be done through existing institutions.

Although Canada shows administrative viability, the province and federal confrontation regarding inadequate resources is always present. The provinces have the major responsibility towards providing health care to all and federal funds have decreased in the last two decades. In India the state governments have the responsibility of generating 70 percent of the funds while the centre transfers its limited share to each of the states. India too faces a similar confrontation between the state and the centre but with the funding from NHI some of that can be sorted out.

A card must be issued to every adult that may be shown at every visit to health care. The names of children may be listed with any of the parent. People moving from one state to another need to register immediately with the local insurance institute. The large migrant population, the poor and all those who are part of national social assistance programme may be issued separate social security cards that could enable them to seek health services wherever they are. This also brings up the interesting proposition of giving all citizens a social security number as in United States.

Regulating NHI

Price regulation and control of supply are two important regulatory measures. The role of Insurance Regulatory Development Authority has to be strengthened with regard to health insurance. They can work in tandem with Consumer Protection groups. The state governments have established district forums, state level commission and national commission to handle redressal (Bhat, R. 1996). The most basic thing that needs to be done is to provide information to all regarding the rules and regulations of the insurance system. The principles need to be clearly stated, what benefits are to be provided should be listed for all, the list of providers that can be accessed at a given time have to be made available at the local level so that people know who the accredited health providers are. This right to information can help people report for malpractice or extra billing. Regulatory power has to be handed down to the local level by keeping random checks on quality of services and providers.

NHI in India has to function in unison with local, state and central government. To begin with, pilot projects can be taken up in selected districts by state governments and then gradually spread its implementation. It involves several issues that might not be handled in a go. The most important task is stating the principles at the national level, setting priorities for integrated coverage of health services. This will help in organising health services in a comprehensive manner and regulating it via this insurance system. The system has to work on a no-profit basis under strict government regulations.

Desirability for a NHI in India

The process of initiating a debate and putting a National Health Insurance to work will entail numerous debates and resistances. The role of the State, political parties, interest groups (both external and internal), social movements and class has been highlighted to understand viability of health insurance in other countries. Any change in social policy has to be analysed within this framework to get a more comprehensive picture.

It has previously been discussed that private financing in health care is a regressive system whether it is private insurance or out of pocket spending. Targeted insurance systems will create a class-based system as in United States and will not be universal. Social insurance systems have to fulfil the prerequisite of employment. All the three systems will select out large sections of population in India and will create inequities, overlapping of services, inadequate coverage. The idea is to have a *comprehensive, universal* system that will be based on *equity*. The underlying theme is that health service is a public good and hence a right. Therefore no one can be denied this essential service and it cannot be dependent on the purchasing power of an individual. A larger group of risks and resources if pooled in together will be able to fulfil these principles. So one has to assess viability in India from these experiences and study trends. One also needs to visualise the hurdles that will be evident in bringing about a NHI.

A common trend that is seen in the country experiences is that a paternalist and a socialist State have been more open to a nationalised health insurance programme. NHI debate has always been thwarted by other interest groups where liberal ideology has dominated and labour movements have had weak political affiliations as in the United States. On the other hand, Canada, Germany, Israel have had strong political parties like the CCF, Social Democratic Party and the Labour Party respectively to bring in welfare measures and all these have favoured pro labour policies and have had a significant role to play in labour movements. Pressure for health insurance programmes have emerged from workers movements and the movements have been more pronounced where the labour has had some kind of political affiliation through which the voice of the masses have

been articulated and given meaning. This has then helped in shaping health policies. Whenever a more democratic party has gained a stronger voice as an opposition or as a party in power, pro-people social policies have taken precedence over other policies. For example, Korea and Taiwan have tried to regulate their health services in the last decade. The transition has not been an easy one. Taiwan's selective health insurance system, which was restricted to the elite, was attacked strongly by opposition democratic party and there was a demand to make it universal. Its important to note that the transition from selective insurance to universal insurance has come with the entry of democratic politics to a large extent in both nations and it has come at a time of economic reforms when the whole world is taking a market-oriented viewpoint. This has by all odds met with resistances from vested interest groups who have compared the global market situation with their profit making interests. Canada on the other hand made the transition at a time when welfarist ideology and state intervention was the motto of the day world over. This is not to say that Canada did not face resistances but it was welcomed and supported to a considerable extent by physicians in private practice.

The Indian State had taken a welfarist approach soon after independence. The Preamble of the Constitution of India depicts India as a "Sovereign Socialist Secular Democratic Republic". Some scholars like Jayal (1999) have critiqued India's so called welfarist and socialist paradigm by stating that India embarked in to a "state directed and essentially capitalist path of development". Health as a policy has been considered a right and India had been a signatory to the Alma-Ata primary health care declaration. But how far it has achieved to realise health as a right has already been discussed. Thousands of people live precariously and this brings out the stark reality that basic human needs still remain unfulfilled. The growth of unintegrated and unregulated health services system has further added to inequities in the health system. A *needs-based approach* may adequately meet the requirements of justice but leaves no room for rights-based individual or collective action. A rights based approach would see basic minimum as a moral imperative of bearing responsibility for the citizens. The larger value of conception of these needs and rights lead to justice (Jayal, 1999). Two approaches to social policy have been widely discussed: the human capital approach and the human development approach

(Seeta Prabhu and Selvaraju, 2001). A *human capital approach* would view investment in education, health and nutrition as contributing to higher productivity and hence economic growth in the long run. A significant fact that needs to be noted, however, is that such human capital formation is expected to be accumulated mainly on the strength of individual initiatives. Individuals invest in themselves in expectation of higher returns from such investment, which is reflected in higher private earnings in the future. The role of the state is largely that of a facilitator. Direct state investment is limited and confined to expenditure on 'merit goods' that yield large positive externalities as in immunisation in health care. This paradigm's large reliance on private financing is of concern especially in developing economies where there are distinct class differences and other structural inequalities. This paradigm is similar to the *liberal* viewpoint. The other approach is the *human development approach.* A distinct feature of this approach is that it considers investment in health, education as an end in itself. This coincides with the right-based approach as discussed above and also the *paternalist* viewpoint. The adoption of this approach by societies marked with structural inequalities implies minimising inequalities and providing the basic minimum to all. India started with a human development approach but with the entry of reforms the approach has been increasingly human capital oriented.

This human development or rights based approach may not work in the absence of articulated challenges posed by individual and social movements. It is not that India has not seen workers movements or labour union agitation demanding for rights. What is important is how far these have been taken seriously by the governments in power and how far they have been mulled and resisted by vested interest groups. Welfare measures like poverty alleviation programmes, public health services, minimum needs programmes and so on have been accepted and implemented but they have been realised to the extent that it's a need and not a right.

Role of labour movement in India has been fragmented. It arises from the inability of trade unions to organise the informal sector. Most trade unions exist with the organised sector that is less than 10 percent of the working population. The inability to organise the

informal sector has been due to their low bargaining power, limited employment opportunities in the organised sector and the traditional basis of agriculture (Qadeer and Roy, 1989). The kind of demands that are generally made by the labour union are primarily centred around minimum wages, therefore, demand for other social protection measures does not get any priority. The labour movement on the whole lacks a unified strength in India that was a result of the split in the left ideology during the 1960s. The trade unions have to build effective linkages with the unorganised sector in order to gain unified strength (John, J. and Menon, S, 2000). In both the public and private sectors, employment in industry has substantially declined, especially since the economic reforms. The trend in most industries is to reduce permanent employment and to use more contract, temporary and casual workers. This has resulted in an increase in the unorganised labour.

India has a multi-party system of governance and has seen a number of political parties in and out of power since independence. The development of health services was not a rational process as was Bhore's vision. A lot was invested in vertical programmes to combat communicable diseases that led to an underfunding of basic health services. Attempts to reach out to the entire rural and urban population were often piecemeal and through unintegrated services. The rural rich mainly consisting of the rich and middle class peasants who had gained agrarian prosperity started putting pressure on the state to invest more in education and health care in 1970s. But these pressures had a marginal impact on service provisioning (Baru, 2002). In 1970s-80s, there were changes in the social structure as a result of increase in the middle class both in urban and rural areas. Some backward castes also came up the social ladder and invested heavily in educating their children, some even went to UK and US as qualified professionals. This new middle class returned with a new outlook and their dreams did not in anyway coincide with the large sections of poor and soon many started moving out of the public system. This further weakened the public system, as these professionals became advocates of the private sector. Private practitioners existed from a long time. But there was never any debate about nationalising or defining their role. They were just allowed to grow without regulating their supply and distribution. The bulk of private sector still consists of private

practitioners, both qualified and unqualified and essentially provide primary level out-patient care located in both rural and urban areas. Health services system in India is an expression of socio-economic inequalities. The system lacks epidemiological logic as is reflected in its investment patterns, it is largely based on inappropriate technology, its hierarchical structure matches the social hierarchy of the larger society and it has a top heavy organisation (Qadeer, 1985).

The State has historically played a major role in terms of pharmaceutical subsidies, as well as direct and indirect investment in research and development. However, as a direct consequence of the World Trade Organisation's intellectual property rights agreements (TRIPS) state drug subsidies have drastically decreased, raising prices. The complete withdrawal of state subsidies and enforcement of a new patent regime, which will prevent affordable production of generic drugs may be completed as early as 2005. This would result in bringing drug prices up to US levels, while wages remain at Indian levels (Samuel, J. and B. Kunhu, Internet).

The role of finance capital in the health sector is important to understand. Large finance capital was largely confined to the pharmaceutical, medical equipment and insurance industries that operate globally. India has a fairly significant middle class population that is a big market for the multinationals. Relaxation in import duties for medical technology and with the growth of tertiary private sector, the import of medical equipment is on the rise. There is a market for high specialised services (Baru, 2001). The State has subsidised growth of private sector by various means; subsidised medical education for those who later enter the private and even migrate abroad, gives concessions to the private sector for drugs, equipment. Subsidies have also been given to the corporate sector. Professionals from the public system get lured by the private system and there is a drain of good professionals from the public health services system. The Indian Medical Association is a strong pressure group favouring private interests.

At present the pressure from a class of non-resident Indians (NRIs) doctors who have considerable influence in Indian politics because of monetary power have led to growth

of specialisation in medical care and they have contributed to the rise in corporate hospitals but there is an overall lack of vision. An increasing number of the population comprising of the upper middle and higher income groups have started demanding for specialised services. The interest groups of private doctors, pharmaceutical companies, those who are already manufacturing and delivering health care products, corporate and large private hospitals, managerial and financial companies such as HDFC, ICICI are all investing in the 'health market'. This has led to further urban bias and increasing costs in health care. The growth of private interests has been more pronounced after the economic reforms. The growth of private health sector has been justified by all on the basis of efficiency but there have been very few studies that have questioned this logic. The Consumer Protection Act of 1986 was a direct consequence of reported cases of medical negligence in private hospitals. On the whole the principles of universality, accessibility and equity have been largely undermined.

The present coalition government in its last year of governance before the next *Lok Sabha* elections has proposed and launched a rural health insurance but it remains to be seen how it is going to be realised. Are the motivations genuine or was this another election budget has been widely speculated. It was also interesting to note that we have doctors of top corporate/private health care institutes as the spokesperson for promoting rural health insurance. Do they have the vision to fulfil the needs of the masses? One hopes that it is a positive step towards taking an effort to reach out to all. The promoter of Apollo hospitals in an interview opined that the recently liberalised health insurance sector would be the engine of growth for health care in India.

The motivation, priorities and will of political parties in a democratic country is important to understand. It is all about who advocates and brings up the social issues of concern in the forefront. It is about social movements and voices of workers and the poor that seem distant. State has a more proactive role to play in realising that health services cannot be left completely in hands of market principles. The market does not have the will to take the responsibilities of universality and equity and cannot be seen as the panacea. At present health reforms are a must in a country like India but not the kind of

reforms that are happening. NHI could be the answer to the reform and be a tool to regulate the private health care system.

Health care and health financing are important components in public health discourse. Given the present scenario and other country experiences, to seek an alternative that is effectively viable to make this basic service available to all has been central to this study.

The question of viability of a NHI can have a positive answer if all the interests are merged together. The interest of the masses if voiced together along with the State taking responsibilities will be the strongest. Deliberating, debating and discussing issues for a NHI is essential. Other developing countries like Thailand, Philippines have been at least discussing and formulating mechanisms towards possibilities of such a universal system. China too is trying to reestablish its rural health insurance. The debate should be based on the ethical principles of equity and universality. Number of public health experts and scholars have suggested and mentioned the possibility of working out a universal system of coverage. It is now a matter of going ahead with it.

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