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Missing Middle: Extending Health Insurance Coverage in India

Pankhuri Jain[1], Aditya Kumar[2], Nidhi Agarwal[3]
[1, 2, 3]*Scholars of Indian School of Public Policy (ISPP)*

Abstract: ***In India's stride towards achieving its goal of Universal Health Coverage, an important and sometimes neglected aspect is that of health insurance. The pandemic has served to highlight the state of healthcare infrastructure along with the impact of government spending on the healthcare sector. However, in the current Union Health Budget (2022-23) there has been only a marginal increase of 0.2 percent over the revised estimates of 2021-22 which clearly indicates that the financial protection extended by the government does not amount too much. Consequently, the public is directed towards the private sector which results in high out-of-pocket expenditures. Though the government schemes include insurance coverage for the ultra-poor, and there is a portion of the population that is covered by private and voluntary insurance, that leaves 30% of the population devoid of any insurance. They have been referred to as the "missing middle." This paper looks at the health insurance landscape of countries like the USA, China, and Canada. We also look at the data regarding coverage of different schemes and took inputs from hospitals and private insurance providers to gain a perspective on how health insurance coverage in India can be expanded and be made more inclusive. Factors determining demand and supply are analyzed. We recommend that both the private and public sectors need to collaborate to achieve this outcome.***

Keywords: Universal Health Coverage, Missing Middle, Health Insurance, Employee State Insurance Corporation (ESIC), Private Health Insurance, Pradhan Mantri Jan Arogya Yojna (PMJAY).

I. INTRODUCTION

Universal health coverage is a goal that all countries across the globe strive for, and many have affirmed their commitment to the United Nations General Assembly in 2019. There is a growing awareness amongst the public that good health is essential for the development and growth of children to adults that can earn and sustain themselves. It is also a factor without which one cannot move above poverty, and it is one of the fundamental factors that form the basis for long-term economic development. The pandemic has served to highlight the importance and relevance of having health insurance, and the lack of which can push one deeper into poverty.

II. BRIEFING PAPER

This paper explores the prevalence of health insurance in other countries to gain a deeper perspective on global health insurance coverage. We have opted to analyze China's health insurance landscape since it is an emerging market economy like India and has a similar population size. The United States healthcare system has some similarities with India with regards to high healthcare costs in the private sector. Its insurance landscape also has certain similarities with India. The Canadian healthcare system is often touted as one of the best because of its low costs and high accessibility. This is a model that deserves attention.

A. China

China's healthcare landscape has changed tremendously over the years. The ever-growing population and demand for healthcare in China widened opportunities for private insurers.

In China, almost 97% of the population is covered by state-run health insurance (Sekhar, 2022). However, the social insurance scheme is insufficient to meet the increasing demand. According to (Sarwal & Kumar, 2021), 3 main health insurance schemes cumulatively cover nearly the entire population of China:

These are -

1) Urban employment-based medical insurance (UEMBI)
2) Urban resident basic medical insurance (URBMI)
3) The new rural cooperative medical scheme (NRCMS)

According to (Sarwal & Kumar, 2021), the UEMBI is a contributory scheme (compulsory) for the urban formally employed population. It covers nearly 20% of China's population. The URBMI is a government-run scheme (voluntary) at the city level i.e., for urban residents who are not formally employed. It covers around 23% of China's population including the unemployed, students, elderly people without previous employment, etc. The NRCMS is a partially subsidized scheme (voluntary), like the URBMI scheme, but covers rural areas. Later in 2016, the process of merging URBMI and NRCMS into the Urban and Rural Resident Basic Medical Insurance (URRBMI) started because of the great similarity between the two. The integration was a response to the difference in benefit packages which led to unfair utilization of services. However, the integrated URRBMI also faces several challenges. One of the key challenges is to clearly state the role of the governments to establish a sustainable and innovative financing mechanism.

According to (Sekhar, 2022), it is the limitations of social insurance in China that have encouraged policymakers to take appropriate steps to encourage consumers to opt for private insurance. According to McKinsey Report, as consumers are increasingly becoming health conscious amid the stress, and pollution of urban living, they are expecting to increase their spending mainly on categories related to health and lifestyle (Sekhar, 2022). However, the unique needs of the middle class and wealthy Chinese families will not be met by the public health sector alone. There is an ever-increasing demand for high-quality and diversified commercial health insurance. By winning the trust of consumers and adapting to a dynamic digital environment in collaboration with government stakeholders, the insurers will be able to size up the situation and take appropriate measures to capture emerging opportunities.

B. United States (USA)

Healthcare in the United States has often been dubbed as the costliest on the globe. In 2018, a gruesome video of a woman in Boston with her leg stuck in between the subway and the platform was widely circulated on social media. She was heard begging the bystanders not to call an ambulance as she would not be able to afford it. A New York Times Op-Ed exclaimed that this incident exemplified everything that was wrong with the state of healthcare in the United States.

This particular incident may sound like an outlier, but it is representative of the reality that US citizens face when it comes to accessing quality healthcare.

High healthcare costs have often been attributed to administrative expenses, rising drug prices, and a high prevalence of defensive medicine. Health-care coverage is an important part of having access to quality care. However, health insurance also comes with its complexities.

There is no single national health insurance program that covers all citizens. In the private sector, there has been an increasing rise in premiums, deductibles, co-payments, and out-of-network expenditures.

Public Healthcare Programs in the USA primarily include Medicare, Medicaid, Children's Health Insurance Program, and Military health benefits. Medicare extends health coverage to individuals above the age of 65 years and people with disabilities. Based on the Social Security Act, Medicaid provides coverage to low-income groups who cannot cover healthcare costs. The Children's Health Insurance Program (CHIP) was designed to cover those families with children that did not qualify for Medicaid and also could not afford private insurance (similar to India's "missing middle").

A landmark step toward providing universal health coverage was the Affordable Care Act (ACA) adopted in 2010. The act extended the ambit of existing insurance programs like Medicaid and made it mandatory for citizens to get insured, employers with over 50 employees to provide insurance, and companies to extend healthcare coverage regardless of pre-existing conditions. The benefits of ACA are not very clear and have been debated extensively. Some have argued that the act has not benefited working and middle-class families.

As of 2018, there are 953 private health insurance companies in the USA. The top 10 account for more than half the revenue. 60% of Americans are covered by Employee Sponsored Programs and the benefits of these programs are usually more than public sectors insurance programs like Medicare and Medicaid. On average 75% of the cost of premiums is covered by employers. However, the cost of premiums has been rising faster than wages and the number of small firms that provide group coverage has been going down.

A characteristic feature of the US Health Insurance landscape is what is known as Managed Care. It is predominantly provided by Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO). Techniques of Managed Care are designed to lower costs of premiums and healthcare. There are certain advantages of these arrangements like low premiums and no deductibles. However, some analysts have argued that this increase puts healthcare decisions in the hands of insurance providers as opposed to healthcare specialists.

C. Canada

Healthcare in Canada is known as Medicare, and it is governed under the Canada Health Act 1984. It works in a decentralized fashion where the services are delivered through provincial and territorial systems. The notion of healthcare is founded on the basis that healthcare services should be available based on need not on the ability to pay. Defining features of this system include universality, accessibility, and portability. Portability allows insured residents to access services via their coverage regardless of location in Canada. Universality means that access should be uniform, and no preferential treatment exists for those who can afford to pay privately. Accessibility means that no insured person is charged for publicly insured services.

Healthcare services are provided on a three-tier basis.

1) The first level adheres to public services known as Medicare which includes medically necessary hospital, diagnostic and physician services.
2) The second level caters to a mix of public and private insurance coverage and includes out-of-pocket expenditure.
3) The third level is entirely private-based services and includes dental care, outpatient physiotherapy, and routine vision care for adults by non-physicians.

It is estimated that approximately 65% of Canadians have private supplemental health insurance which is mostly provided by employers. This kind of insurance incorporates insurance for services coming under the radar for the second and third levels of healthcare services based on co-payments or deductibles. An additional 11% of people have access to supplemental services which come under government-sponsored insurance plans. Currently, there are 150 life and health insurance companies operating in Canada. Despite its various benefits, there are significant challenges facing the Canadian healthcare system. There exists a contrast between the urban and rural districts regarding health care and this is proportional to the distance from the urban site. The greater the distance, the more is the disparity in the rural areas. One criticism that exists for the healthcare system is the long wait time that exists when the patients are treated as per the urgency of their condition. Canada is also facing an aging population hence the healthcare expenditure is expected to rise by 2036 from 9% to 12% of the GDP. Patient demand is anticipated in areas that are not currently covered under the universal coverage such as medications, long-term care, home care, and end-of-life care. The government may need to revise the allocation of resources to make additional provisions keeping the aforementioned factors in mind. Though there are gaps that need to be addressed, the Canadian healthcare system remains one of the best examples of healthcare in the world for what it has been able to achieve, and for what it aims to cater to.

D. India

India envisions the accomplishment of Universal Health Coverage by 2030. However, India stands at a juncture where due to its low investment in the health sector, often the public must resort to the private sector for care and services which leads to high out-of-pocket expenditures, pushing those who are already poor further into poverty. The government has been successful in ensuring that the bottom 50% of the population has been insured by Ayushman Bharat – Pradhan Mantri Jan Arogya Yojna (PMJAY). The scheme entails subsidized health insurance which has provisions for free secondary and tertiary care. Around 20% of the population amounting to 24 crores are those who avail of social health insurance or private voluntary health insurance. A substantial portion of the population amounting to 40 crores approximately are those who are devoid of any insurance which makes up 30% of the remaining population and is also known as the ‘Missing Middle’ (Kumar & Sarwal, 2021). This group is inclusive of those who can afford to pay a nominal amount of insurance but factors such as lack of awareness or unavailability of products within their price ranges prevent them from subscribing to health insurance.

The current health infrastructure encompasses three main components. These are:

1) Government-subsidized health insurance schemes- These can provide full or partial coverage depending on the segment they cater to. Primarily these schemes are focused on the population in the informal sector as they are the most vulnerable. The largest scheme of the government is the Ayushman Bharat Pradhan Mantri Jan Aarogya Yojna as it provides fully subsidized comprehensive secondary and tertiary healthcare with annual coverage of Rs 5 lakh per family.
2) Social Health insurance schemes- These cater to employees in the organized sector where contributions are mandated by both employees and the government. An example of this is the Employee State Insurance Scheme (ESIS). In 2019, there were 13.6 crore members enrolled in this scheme. For government employees, there is the Central Government Health Scheme provided by the union government which catered to nearly 40 lakh employees (Kumar & Sarwal, 2021).
3) Private voluntary health insurance schemes- This is largely divided into 2 categories i.e individual/ family or group business. The individual/family schemes encompass nearly 4.2 crore people whereas the group insurance that is availed by companies for their employees covers nearly 7.3 crore people.

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Recognizing the imminent crisis facing the nation due to a large section of the population without financial protection, the government has urged the participation of the private sector in increasing the coverage of health insurance. The government has provided incentives by way of allowing taxpayers to waive off the premium amounts from their taxable income and has also maintained the status quo on the tax component that the insurance services are liable to under the goods and services tax rules. The government opened the insurance sector to Foreign Direct Investment of 74%, which was earlier 49% (Hdfcergo, 2021). This move incentives foreign companies to invest as they will be allowed to own operations in India, and foreign penetration in the market should lead to unprecedented growth for insurance.

The health insurance market is growing at an increasing speed where the total health insurance market which can be assessed based on the premium paid has more than doubled in 4 years. Statistics reflect the market worth was Rs 20,000 crores in 2015 and by 2019 the market standing reflected Rs 45,000 crores as published by the Insurance Regulatory and Development Authority of India (IRDAI).

From the case studies we have examined above we can conclude that in the case of India expenditure on health must be increased. However, we have seen from the USA that increased spending on healthcare may not necessarily lead to better health outcomes. We need an insurance model in place that harnesses the capability of both the public and private sectors and makes quality healthcare affordable to all citizens. The Canadian health care model is a good example of that, but the waiting time must be mitigated. A functional healthcare system is a prerequisite for a stable and growing economy.

III. METHODOLOGY

Our primary method for collecting data has been a semi-structured interview. The objective was to gain insights into hospitals and private insurance providers. However, due to the small sample size, we remained cautious of generalizing these insights. To substantiate our findings from primary data we have also gathered resources from secondary data and have presented our analysis on the same.

IV. HYPOTHESIS

This paper hypothesizes that by investing in public health facilities and fostering public-private affordable health insurance, India will achieve its goal of Universal Health Coverage.

V. FINDINGS AND ANALYSIS

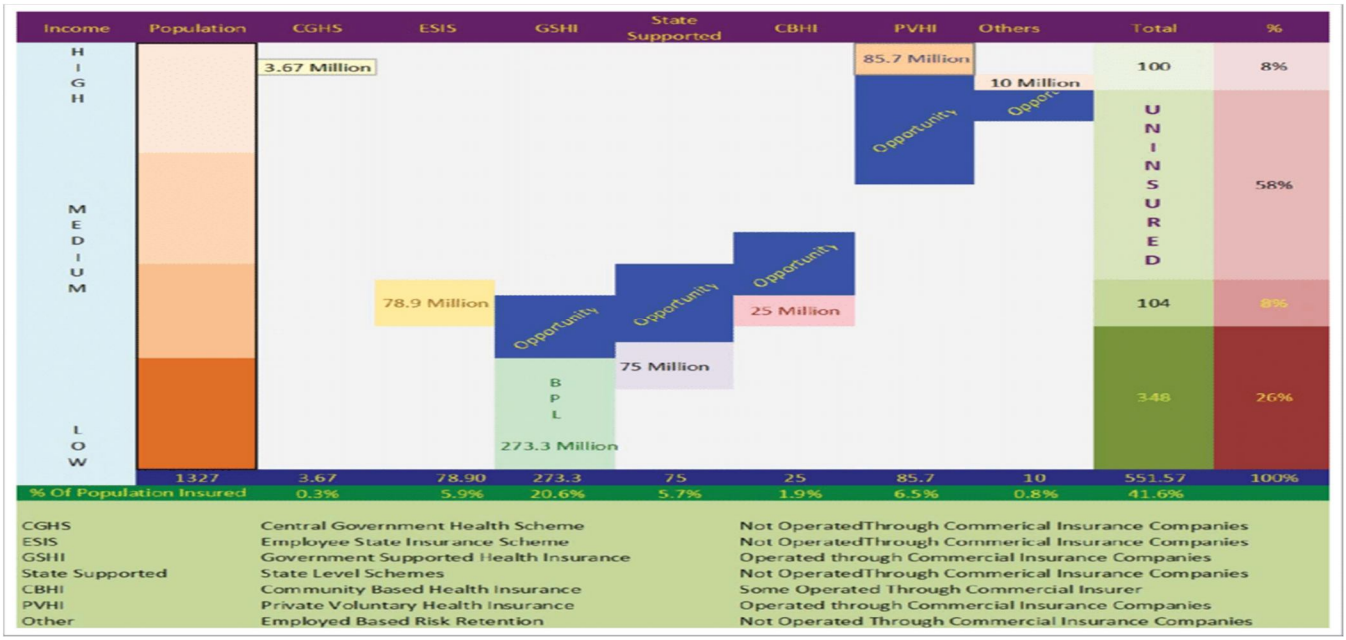
Healthcare spending in India has remained woefully inadequate. As an example, in the actuals of the 2018-19 estimates, the expenditure on Medical and Public Health was only 0.9% of the total expenditure. As a percentage of GDP, health expenditure has ranged from 1-2%. Despite high utilization, the allocation under the Ministry of Health and Family Welfare has been low. As an example, the budget estimates for 2022-23 have increased only 0.2% from the Revised Estimates for 2021-22 under allocation for the Ministry of Health and Family Welfare. Despite the pandemic, the expenditure allocated to the states for vaccination came down from 35000 crores in 2021-22 to 5000 crores in 2022-23. Data analyzed by the Reserve Bank of India (RBI) from the National Health Accounts showed a negative correlation between the amount of Out-of-Pocket Expenditure and Public Expenditure on Health in different States.

The budget estimates for the year 2021-22 increase by 41% for the health insurance scheme as shown in the figure below. This signified the increased weightage that the government put on health insurance in the backdrop of the pandemic.

Major Heads	2019-20 Actuals	2020-21 Revised Estimate	2021-22 Budget Expenditure	Annualized Change (Actuals 19-20 to BE 21-22)
PMJAY	3,200	3,100	6,400	41%

Expenditure Budget 2021; PRS

In India, the healthcare industry is facing a highly fragmented landscape in addition to rising healthcare costs and an increase in the spread of non-communicable diseases. Over time, it is evident that current public health insurance schemes are unsustainable and inadequate. To mitigate this gap, integrating primary care with health insurance is a solution that is highly sought after. Increasing opportunities for the urban poor via investing in public health facilities, subsidizing and facilitating public-private affordable health insurance, and thereby enhancing access to information and rights. By reducing hospitalization and emergency visits, primary health care also proves to be cost-effective.



Health Insurance Landscape of India. OHI (in blue) D Opportunity to Expand Insurance
Source- (Bhat et al, 2018)

The above diagram depicts the healthcare coverage in India by various schemes and provisions of state and central government, government-aided schemes for those below the poverty line (BPL). Also included are the existing schemes in the formal sector (ESIS), coverage via community-based health insurance as well as employment and private voluntary insurance. In this coverage, the gap is highlighted for those who are not under any coverage of any kind. The population belonging to this gap is known as the missing middle highlighting the untapped area in which health insurance has scope to expand. The chart shows that those who are uninsured are 58%.

The National Sample Survey Office (NSSO) survey data indicates 18.1% of the urban poor are covered by health insurance which means out of a population of 438 million, 359 million lack insurance and health and risk protection. It is estimated that 27% of the population is poor which underlines the fact that approximately 97 million people have no other option but to avail of out-of-pocket expenditure on health. (Bhat et al, 2018).

Schemes that were introduced mitigate inequity in health care-

1) National Rural Health Mission (NRHM) was introduced in 2005 by the government to address the health needs of the rural population.

2) In 2014, the government established the National Urban Health Mission (NUHM) to focus on the urban poor and strengthen the health system in urban areas.

3) The NUHM was absorbed into NRHM to create the National Health Mission (NHM) in 2015. NHMs aimed to reduce household out-of-pocket health spending, particularly on medicines and diagnostics.

4) In 2018, the National Health Protection Scheme (NHPS) was implemented aiming to provide health insurance benefits of up to INR 500,000 (7,692 USD) per family per annum.

However, with the integration of schemes and services for increasing the coverage of health insurance in the country, by 2021, the missing middle amounts to 30% of the population whereas 70% of the population is covered by some form of insurance whether it is private or social insurance or government schemes.

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A. Key Findings

Primary data collection: Hospitals and Insurance Companies

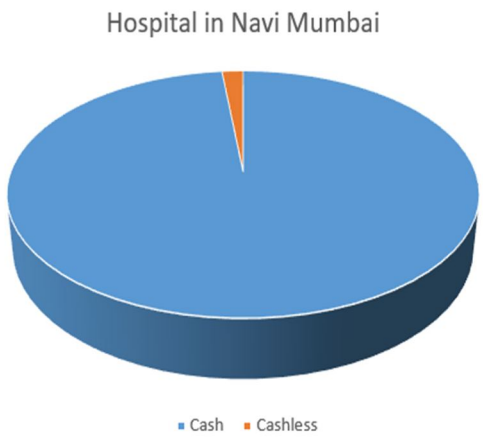
1) Hospitals

Government issues PM-JAY cards to most people. Private hospitals usually have 30% of patients registered under some sort of public insurance scheme- most often it is PM-JAY. For government hospitals, almost 90% of patients are covered under a government insurance scheme.

For private hospitals schemes like Ayushman Bharat sometimes do not cover the entire cost of treatment. Private hospitals prefer not to register under these schemes but sometimes have to do so to be included in what is called the "Preferred Provider Network" (PPN) to get patients.

The Ayushman Bharat scheme has an upper limit of 5 Lakhs INR. However, expenses at private medical facilities can exceed this amount. However, certain private hospitals feel the need to register under these schemes to gain access to a PPN. A PPN is essentially a network of healthcare providers that have contracts with insurance companies to rationalize and lower healthcare costs for customers subscribed to insurance policies. Hospitals that have access to a PPN get a steady supply of patients and the patients also benefit from the lowered healthcare costs.

An example of a Private Hospital in Navi Mumbai not in a PPN network:
From 01/012022 to 31/01/2022
Total patients -58
Cash patients -57
Cashless - 01



2) Insurance Companies

The key insight from 2 private insurance providers is that most people are insured because of group health coverage by their employers. Insurance market penetration relative to other countries is still very low in India. In FY22 it grew by 5.8% perhaps reflecting some change in attitude towards insurance due to shocks like the pandemic.

Most of the policies purchased are by middle and upper-income groups. Almost all of them are group insurance policies by large corporations for their employees. There are also a considerable number of Micro, Small, and Medium Enterprises (MSMEs) that purchase group insurance. Group insurance policies are often customized to include families.

In India, most policies have a Preferred Provider Network (PPN) which caters to a specified number of hospitals. Deductibles are not very common in India. However, there are sub-limits to various diseases.

The important point to note is that the demand for health insurance is driven mainly by employers. Individual insurance demand is scanty. Another important insight is that individuals who do subscribe to policies do so not because of healthcare concerns but because of tax deductibles they get on premiums paid. People who buy individual policies do so sometimes if they have personally had to spend out of pocket for health expenses in the past and are now aware. However, in the wake of the pandemic demand for both individual and group insurance is increasing.

B. Analysis

1) Determining Demand

The insights from the insurance companies indicate that demand is primarily driven by tax benefits for individuals and group insurance from employers. Healthcare is hardly ever the primary reason.

Demand for individual health insurance policies is low for a variety of reasons. Insurance providers do not view them as attractive customers and are more inclined to cater to large corporations.

On the consumer's side, a lack of awareness of health needs as well as health insurance benefits plays a very big role in low demand. Even if awareness is present, long-term benefits or costs are heavily discounted- especially for people in lower-income groups. Lack of trust in insurance products, distorted risk perceptions, and a reliance on a community-based model of healthcare are other key factors that have contributed to low demand for insurance products.

2) Determining Supply

The key issues with the demand and supply side of the insurance market have often resulted in information asymmetries in the healthcare insurance market (Ashraf et al, 2021).

The entry decision by any firm into the health insurance market can only be guaranteed when the market players can save enough to make profits and cover the unexpected losses. It is important to create a market structure that can allow for better pooling opportunities. Another concern on the supply side is to design an ideal contractual agreement between the insurers and the insured which can address the problem of adverse selection and moral hazard. It is expected of the insurer to disclose accurate information about the underlying health conditions, however, that is not always the case. To overcome the problem, insurers may end up increasing the premium to cut financial losses and cover increased costs. However, this results in the creation of a vicious cycle with low-risk pooling and high-cost premiums.

Most of the time, the service provider is a technical expert in healthcare-related matters. This again leads to a situation of information asymmetry where the consumers lack the expertise in health care matters. This could result in the exploitation of the consumer by the providers who might prescribe expensive treatments. To ensure quality treatment to the consumer at affordable prices it is important to build a strong relationship between the service provider and consumer and by empowering the insurers in the health insurance market.

It is extremely important to undertake an inclusive and integrated approach to bring the two sides of the market together. The health insurance market in India faces enormous challenges but one should never forget that there is always room for bringing in structural changes leading to a radical transformation in the healthcare insurance market in India.

3) Policy Recommendations and its Implication

There is a clear need to increase public expenditure when it comes to the provision of healthcare. The emphasis on that expenditure must be placed on Primary Health Care Systems to minimize the number of people needing secondary and tertiary healthcare. This will serve to reduce out-of-pocket expenditure and reduce the burden on health systems. Expenditure on Public Health measures like safe drinking water, sanitation, and clean air should also be emphasized. Preventive measures like this are important to minimize the number of people that require healthcare.

Updating the database of the PMJAY and expanding its scope to include more income groups and sections of the population can serve to diversify the risk pool and increase coverage to more people. This is important as one of the key challenges is the identification of the beneficiaries for public health insurance benefits.

Public health measures and healthcare facilities are usually provided by the States. Therefore, it is essential to make sure that State governments have an adequate amount of revenue to take on these activities. This may involve giving state governments the right to levy more taxes or cess charges for healthcare services. Empowering the states financially and decentralizing finances is one way of increasing the expenditure on healthcare and public health.

4) Engagement with the Private Healthcare Sector

There is a need for government intervention in the existing private healthcare system to address its failures in delivery of the social healthcare benefits. The government must focus on the creation of a well-functioning healthcare system that caters to the needs of both rich and poor. Issues such as rising cost of drug prices, price-gouging specialists, induced demand for unnecessary diagnostic tests, fake miracle cures, and wide gaps in coverage, all are due to systemic failures which need to be addressed on a priority basis to improve sector functioning (Healy & Braithwaite, 2006).

The government must create an enabling ecosystem in the near term by increasingly turning to interventions that encourage private providers to improve the quality and coverage of their care, without compromising their financial interests. The government cannot solely rely on self-regulation as in most cases it is observed that professional organizations function more like trade unions than effective regulators. This is not to say that regulation will have no value, however, regulation and training could be an important first step when provider knowledge is highly imperfect. Approaches such as social marketing of commodities, accreditation ensuring widely shared improvements in quality norms, voucher programs, and contracting can also encourage private providers to improve the quality and coverage of their care while advancing their own financial needs and interests. Around 70% of the healthcare services are provided by private healthcare in India which is highly indicative of the private sector's ability to be responsive to consumers' needs and ability to undertake rapid developments. The combined efforts of the public and private healthcare sectors can result in the creation of a robust private healthcare service delivery.

The increasing engagement with the private healthcare sector will encourage the expansion of private voluntary insurance through commercial insurers. With the support of the government, India can develop a modified standardized health insurance product for the missing middle segment of the population (Sarwal & Kumar, 2021).

To create a robust healthcare infrastructure, the private healthcare sector cannot be ignored. The choice of appropriate approach will however vary substantially, depending on the health system failures being addressed, the nature of the healthcare product or service, the type of provider, and the level of development of the country both in terms of income levels and health system organization (Montagu & Goodman, 2016).

Moving forward, we advocate the expansion of the ESIC scheme to encompass not just the blue-collar workers, but to extend its realm to include all formal sector workers and upon the success of that, the scheme can then be extended to incorporate informal workers as well.

The Employee State Insurance Scheme (ESIS) happens to be the oldest existing health insurance in India. Its inception began in 1948 when it was implemented by an act of parliament. This scheme falls under the jurisdiction of the Employee State Insurance Corporation (ESIC) which is an autonomous agency belonging to the Indian government. ESIC, apart from monitoring this scheme, also caters to a host of providers of medical services and provides for outsourced tertiary care in private hospitals. Hence, the functions and domains of ESIC encompass financing, purchasing, and providing health care services. There are two divisions through which ESIC can render health care services. The first is via an array of model hospitals that come under the management of the ESIC and respective state ESI department, and secondly through various contracts and established tie-ups with private and government hospitals for super specialty treatment. ESIC also within its network, runs its dispensaries and Indian System of Medicine (ISM) where at times when required it can acquire medical practitioners.

The eligibility of the ESIC scheme extends to include all blue-collar workers and their employers belonging to the formal sector to contribute to ESIC. Consequently, they and their respective dependents can easily avail prescribed benefits from the ESIS centers. The ceiling limit for this scheme is for those employees earning up to wages of Rs 21,000/- per month in establishments employing ten or more persons in a financial year. As per law, the employee rate of contribution per month is 0.75% of their wages whereas the employer has a contribution of 3.25% of the wages that is paid to the eligible employees. This contribution entitles them to medical care among other benefits as well extending to preventative, outpatient, and inpatient medical care as well as some cash benefits at no further cost. There is no ceiling limit on the treatment that is accessible for those who are insured as well as their dependents. If medical care is received at an ESIC empaneled private hospital, the reimbursement swiftly follows. Hence, the scheme ensures that the out-of-pocket expenditure is eliminated while those insured can avail of the required facilities. Cash benefits include sickness benefits, disablement benefit, maternity benefits, dependents benefits, and any payments for funeral expenses.

At the moment, ESIC is perceived to be the largest health insurance scheme available in India, and there is still sufficient capacity for it to expand further. This is the only scheme that incorporates the largest number of people just above the poverty line, for whom many of the government initiatives and benefits are not accessible as they are meant for the ultra-poor. Expanding the scope of the ESIC scheme would directly increase the formalization of the workforce in India.

Expanding the scope of the ESIC scheme would to a great extent accelerate the coverage of health insurance to a large segment of the population, many of which come under the ambit of the "missing middle". In our perspective, this would empower India to fight poverty, and enhance the government's capacity to regulate, while ensuring that those who are in dire need of protection are granted facilities and care in their time of need. Out of pocket expenditure has been one of the most prominent causes of pushing people into poverty, and the onset of the pandemic has further exacerbated those circumstances.

To facilitate this expansion in the existing scheme, there needs to be restructuring in terms of the involvement and jurisdiction of ESIC.

Our recommendation entails that the scheme allows private health insurers to step in and manage the financing aspect of the scheme. This would result in healthy competition amongst the commercial insurers for the enrollment of the employees falling under the eligibility of the ESIC scheme and ensure no monopoly or undue advantage is being taken of the people being insured. Stepping back from the financing aspect would allow ESIS to provide greater focus on purchasing and providing healthcare services to those entitled but also amplify its resources in monitoring the demand and supply of the insurers and beneficiaries involved in this scheme. ESIC would be able to expand its role in governing the structure and play of the market and establish unbiased rules that will reduce uncompensated risk selection.

Stepping back from the financing aspect would allow ESIS to provide greater focus on purchasing and providing healthcare services to those entitled but also amplify its resources in monitoring the demand and supply of the insurers and beneficiaries involved in this scheme. ESIC would be able to expand its role in governing the structure and play of the market and establish unbiased rules that will reduce uncompensated risk selection. The process of withdrawing from the financial aspect of the scheme would enable ESIC to take up the mandate for sharper monitoring of activities to ensure that those entitled are receiving proper health care and facilities.

We envision ESIS to be a platform through which the private health insurers will be able to access the insured employees and their respective dependents. Registered employees would have a wide variety of insurance schemes and products to choose from and enlist their preferences to ESIS and ESIS would in turn communicate these choices to the respective insurers. Since all communication would take place via ESIS, it would be ESIS's responsibility to ensure that all those entitled are covered under insurance befitting their requirements and none are denied for any reason whatsoever. It would be ESIS's jurisdiction to ensure that the insurance plan meted out to provide the same benefits and care that was accessible earlier under the scheme, and also monitor to provide and adjust risk adjustment keeping in mind that certain beneficiaries or a proportion of the beneficiaries may exceed the risk-bearing capacity of the insurer.

VI. CONCLUSION

To conclude, we would like to reiterate the hypothesis statement considering the insights and recommendations that we have examined in this paper. The public sector needs to increase its expenditure, especially for primary healthcare and public health measures. The private sector needs to be sufficiently engaged and integrated with the provision of health insurance. The Employee State Insurance Scheme provides the appropriate institutional infrastructure to expand insurance to those sections of the population that are unable to access it at present. The scheme can be tweaked to further integrate the private sector when it comes to insurance providers. This will also enable the ESIC to focus on better healthcare provision.

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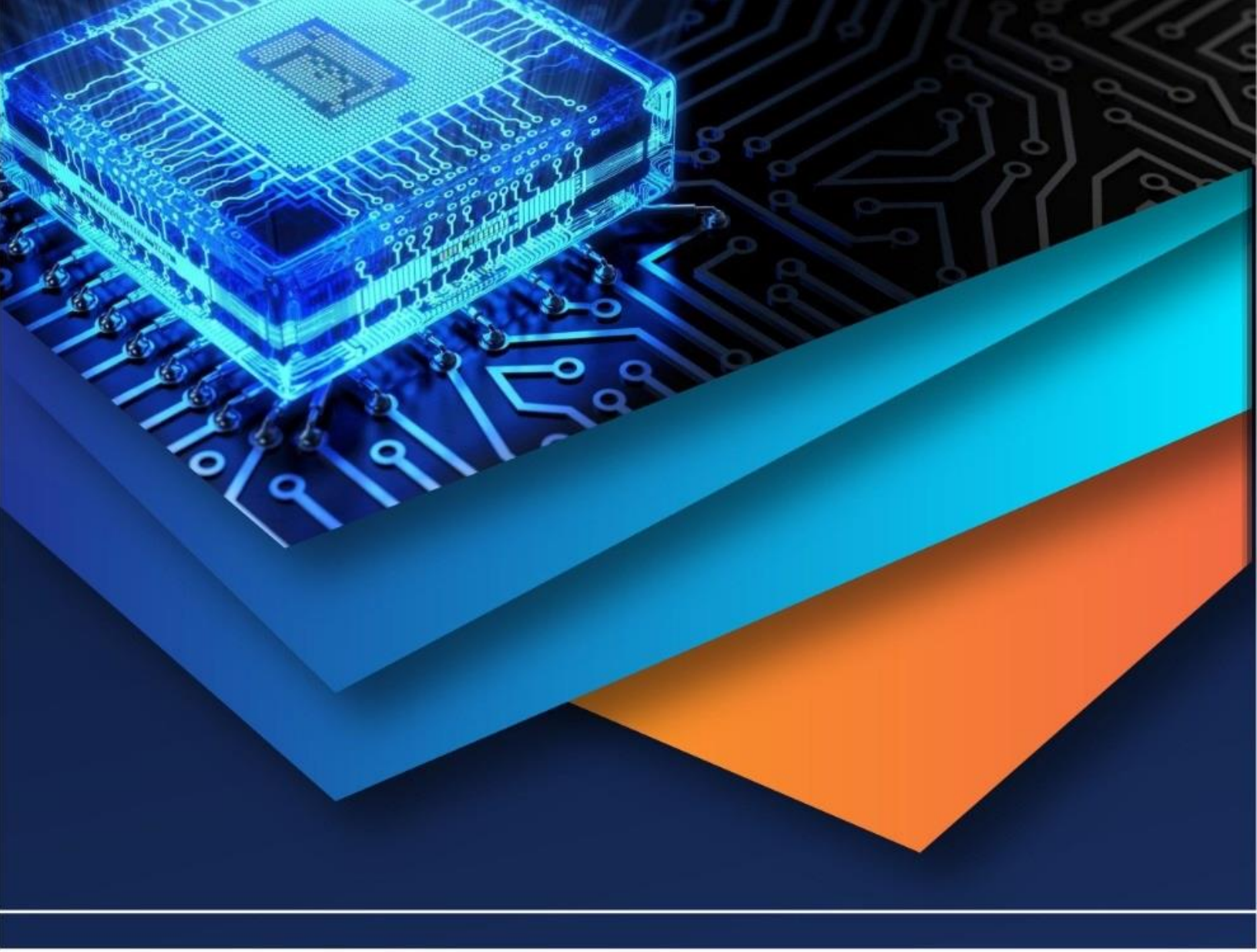

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