A Study On Government Sponsored Health Insurance Schemes In India - GSHIS

Submitted To

Indian Institute of Health Management and Research

(IIHMR University)

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Master of Business Administration

(MBA)

In

Hospital and Health Management

By

Piyu Jain

Under the Supervision and Guidance Of

Dr.Piyusha Majumdar

DECLARATION BY STUDENT

I hereby declare that this dissertation titled A Study On Government Sponsored Health Insurance Scheme in India is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Name of Student : **Piyu Jain** **Date :July 4, 2021**

Signature

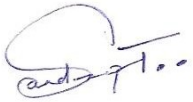
TO WHOMSOEVER IT MAY CONCERN

Date: 02-07-2021

This is to certify that **Piyu Jain** has successfully completed her tenure as a Business Development Consultant from 19th April 2021 to 30th June 2021 at Impact Guru Technology Ventures Pvt. Ltd. Her performance during the tenure was found to be good.

We wish her all the very best for her future endeavors.

Regards,



Sandeep Kumar Tripathy
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CERTIFICATE

This is to certify that dissertation titled A study On Government Sponsored Health Insurance Scheme In India is a record of the research work undertaken by Piyu Jain in partial fulfillment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide IIHMR University, Jaipur **Dean IIHMR University, Jaipur**

Date: **Date:**

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Abbreviation:

FY	Financial Year
CAGR	Compound Annual Growth Rate
GDP	Gross Domestic Product
MOHFW	Ministry Of Health & Family Welfare
UT	Union Territory
OECD	Organization for Economic Co-operation & Development
SECC	Socio Economic & Caste Census
BPL	Below Poverty Line
CGHS	Central Government Health Scheme
GSHIS	Government Sponsored Health Insurance Scheme
SHI	Social Health Insurance
BSBY	Bhamashah Swasthya Bima Yojana
RSBY	Rashtriya Swasthya Bima Yojana
NFSA	National Food Security Act
ASHA	Accredited Social Health Activist
OOP	Out Of Pocket Expenditure
HDD	High Developed District

MDD	Middle Developed District
LDD	Low Developed District
UHC	Universal Health Coverage

Abstract: In India, health improvement over last 50 years has shown tremendous growth. Awareness, accessibility and availability of government funded healthcare system has always remained major concern. Private sector serves as bridge between what government offers and beneficiaries need. **Objective:** To analyze the government health insurance system to further understand the challenges it faces and opportunities it provides and to discuss the implications of GSHIS on health sector from various perspectives. **Methodology:** Articles and published literature from year 2015 to 2021 were analyzed. In total 25 papers were reviewed out of which 10 were chosen for further review and analysis. **Findings:** It was found that though few schemes have strengthen their monitoring system but issues such as general weakness of systems and dearth of data and analysis influence the optimal functioning. Scheme merger into an integrated state based insurance system has been influenced by differences related to the definition of BPL status, coverage caps, benefits packages, price structure, empanelment criteria. Out of pocket expenditure has increased due to low public spending on healthcare which serves as barrier to access health for low socio income group beneficiaries. **Conclusion**: Better coverage and health services should be provided to beneficiaries at lower cost without over use of procedures and technologies in provision of healthcare. Even though government funding facilitates implication and provision of government health insurance, large segment of beneficiaries are unaware about the healthcare provision. As a result they are doomed to opt for out of pocket expense thus increasing their overall health expenditure and financial burden. Therefore there is a need to generate awareness regarding the accessibility and availability of health insurance system. Strategies should be modulated based on the informative data driven from implication of GSHIS.

Keywords: GSHIS, OOP, BPL, Health Insurance Service Utility.

Background:

Health being a fundamental right should be accessible, affordable and available in a uniform manner for population strata in rural and urban areas. Medical treatment escalating cost is beyond the capacity of lower and middle income group individuals. Healthcare being a state of enormous transition in India, various health financing options have been explored by government and private sectors to manage the problem arising out of increasing cost of care and changing epidemiological pattern of diseases. Increased income and health consciousness among the majority of the classes, price liberalization, reduction in bureaucracy and the introduction of private healthcare financing drive the change, health insurance is emerging as an alternative mechanism for financing health. Insurance is a contract wherein one party accepts to tackle the risk of the other party in exchange for consideration known as premium and promises to indemnify the party on happening of an uncertain event. Insurance enables to spread the risk of finite number of people over a large number who are exposed to a similar kind of risk. Over a decade a number of health financing schemes have been modified substantially and new schemes have been initiated by the government. Government supported health insurance schemes serve as a social hostage in India. Government health insurance schemes offer wide coverage at incredibly affordable premiums. Beneficiaries from all income groups are benefited to avail the optimum treatments at affordable prices.

The total per capita government spending on healthcare has nearly doubled from 1,008 per person in FY 15 to 1,944 in FY 20 The total expenditure by the center and states for FY 20 was rupees 2.6 trillion.

Of the total public expenditure, the center share is 25%

Over the last five years the total public expenditure on health has risen at 15% CAGR

India's total health expenditure at 3.6% of GDP as per OECD is lower compared to other countries.

Fg 1.1: Source National Health Profile, 2020

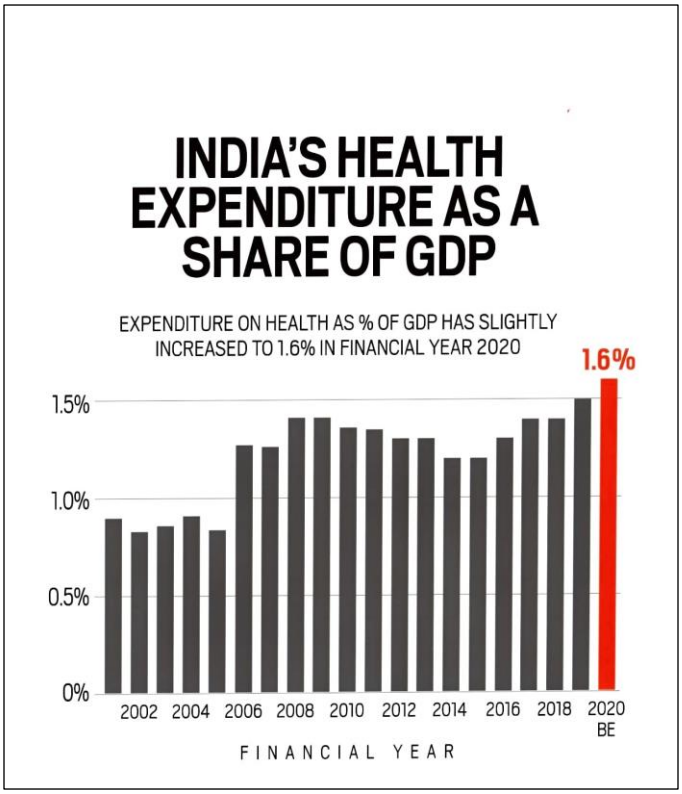
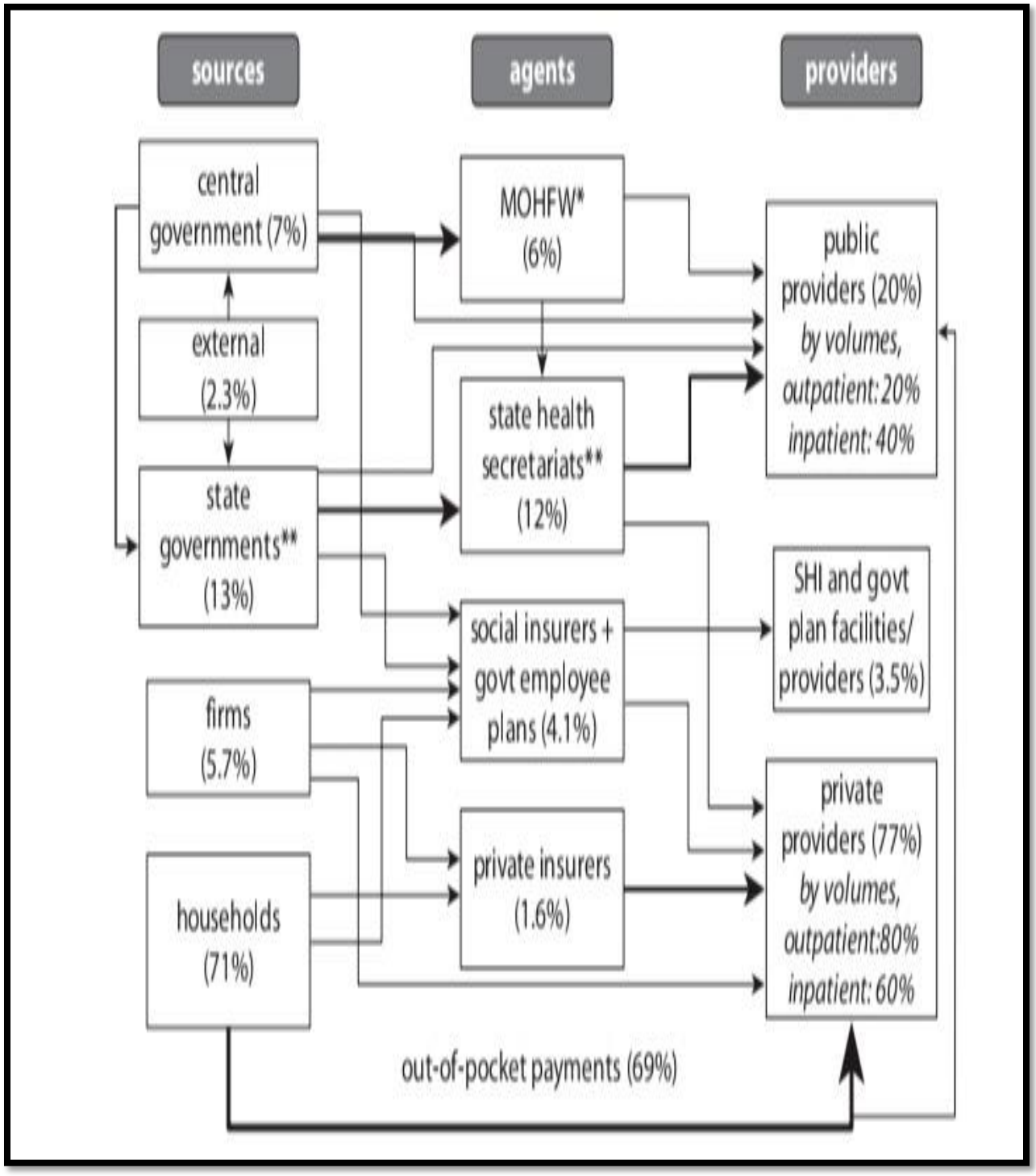


Figure 1.2: India Main Contributors & Fund Flows in Health System



Source: National Health Accounts for 2018-2019 (MOHFW 2019)

Table 1.1 Premium structure, benefits received and claim ratio of different GSHISs

Scheme	**Launch year**	Ministry & state/district covered	**Vision**	**Budget**	**Services**	**Beneficiary**
Ayushman Bharat	23 September 2018	MOHFW All states/UTs	To ensure access to quality and affordable healthcare and financial protection against fatal health expenditure.	8,088 Crore (2021-2022)	• 50 crore beneficiaries. • 5 Lakh per family per year.	Deprived rural families and identified occupational category of urban workers (SECC)
Awaz Health Insurance Scheme	November 2017	Kerala State Government	To identify and provide coverage for about 5 lakhs inter state laborers living in Kerala.	10 crore	• Health Insurance – Upto 15,000 • Accidental Death Coverage – Upto 2 Lakhs	Migrant laborers (18 – 60 years)
Aam Aadmi Bima Yojana	2 October 2007	Ministry of Finance	To dispense financial aid to the rural poor who fall below the poverty line and support their families in the event of dearth or disability of the insured.	150 Crore	Life cover – Natural Death : Surviving Beneficiaries 30,000 Accidental Death/Permanent Disability: 75,000 Partial Accidental Disability: 37,500 50% of premium amount is subsidized and paid by the government from social security fund.	Member (18 -59 years) head of the family or one earning member of BPL family under identified vocational group/ rural landless

						household
Bhamashah Swasthya Bima Yojana	December 13, 2015	Rajasthan State Government	To reduce the financial risk of surplus expenditure by offering financial cover to beneficiaries against illness.	1,800 Crore	General Illness Cover: Rs 30,000 Critical Illness Cover: Rs 3 Lakhs Pre hospitalization expenses – Cover for seven days Post hospitalization – Cover for 15 days Transport allowance for polytrauma and cardiac cases – Rs 100 to Rs 5000	Beneficiaries who are covered under NFSA and RSBY are eligible for BSBY
Central Government Health Scheme	1954	Ministry of Health & Family Welfare	To be the first choice in providing quality healthcare services and ensuring holistic well being across beneficiaries entire life span	1,350 crore (2019 – 2020)	Maximum Duration Of Indoor Treatment • 12 Days for specialized (Super Specialty) Treatment • 7 Days for other Major Surgeries • 3 Days for Laparoscopic Surgeries/normal deliveries • 1 day for day care/normal deliveries	Provides comprehensive health care facilities for central gov employees and pensioners and their dependents residing in CGHS covered cities.
Chief Minister Comprehensive Insurance Scheme	January 11, 2012	Tamil Naidu State Government	To provide quality healthcare through empanelled government and private hospitals. To reduce the financial hardships to the enrolled families and move towards universal health	750 crore (annual allocation)	The scheme seeks to provide cashless hospitalization facility for certain specified ailments. The scheme provides coverage up to Rs 5,00,000 per 1.34 crore family per year.	Resident of Tamil Naidu (Name must be mentioned in family card) with

			coverage by effectively linking with public health system.			annual income less than 72,000/annum.
Mukhyamantri Amrutum Yojana	September 4, 2012	Gujarat State Government	To provide quality medical and surgical care for the catastrophic illnesses involving hospitalization, surgeries and therapies through an empanel network of hospitals to the BPL families.	Rs 64,255 crore	Medical Expenses: Rs 5 lakh per family per annum Travel charges-Rs 300 per hospitalization Repatriation of remains: Rs 6/ per kilometer from hospital to place of residence	Families whose annual income is less than Rs 4 Lakh. ASHA Workers Class 3&4 employees appointed by government who are on fixed pay. U-win card holders.
Rashtriya Swasthya Bima Yojana	April 1, 2008	MOHFW	To provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization.	Until 2020-Expenditure 2.27 billion rupees	30,000 per family per annum. Pre –existing diseases to be covered Cashless attendance Transportation cost within an overall limit of Rs 1000	Unorganized sector workers belonging to BPL Category and their family members

Source : https://financialservices.gov.in

Review of Literature:

Sr no	Author (Published Year)	Study Location	Sampling Technique	Sample Size	Salient Features
1	Title- Government sponsored health insurance in India. Year 2015 Author – G La Forgia, S Nagpal	India	Secondary Data	Population	Major Central and state staked health insurance schemes were analyzed. Two lines of inquiry institutional and operational were the focus of this research article. This article focuses on how proliferation of various healthcare technologies and general price rise leads to unaffordable expensive healthcare and how government has started exploring various health financing schemes to

					overcome burden.
2	Title- Hospital Utilization and out of pocket expenditure in private and public sectors under universal government health insurance in India. Year -2017 Author- Sulakshana Nandi, Helen Schneider, Priyanka Dixit	India	Secondary Data	Population	Despite of several functional government sponsored schemes, majority of the beneficiaries still incurred OOP. On analysis it was found that 65% of the beneficiaries were unaware about government insurance services.
3	Title: Universal health insurance in India: ensuring equity, efficiency and quality. Year – 2017 Author-Shankar Prinja, Manmeet	India	Secondary Data	Population	Socio-demographic, economic and epidemiological transition has led to increase in healthcare cost. High out of pocket expenditure poses barrier to

	Kaur, Rajesh Kumar.				access healthcare. Government healthcare theories with objective of ensuring equity, efficiency and quality healthcare have been implemented in this article.
4	Title-The rise of government – funded health insurance in India. Year- 2018 Author- lla Patnaik, Ajay Shah, Shubho Roy	India	Secondary Data	Population (Unit level data – NFHS4)	It was analyzed that out of the total population only 25 % were under government health insurance coverage. Out of which 22% was mandatory health coverage. Out of the total households analyzed voluntary health insurance was recorded only about 2 %. Presence of wide inter state and inter class variation was

					found in health coverage.
5	Title: Impact of publicly financed health insurance schemes on healthcare utilization and financial risk protection in India : Systemic Review Year -2017 Author-Shankar Prinja, Akashdeep Singh Chauhan, Anup Karan, Gunjeet Kaur, Rajesh Kumar	India	Secondary Data	During initial research screening 1265 articles were chosen. Among these articles 43 studies were found eligible and were reviewed in full text based on PRIMSA guidelines	Impact on health outcomes was evaluated and it was found that a decline in OOP expenditure. Financial risk, health service utilization was analyzed on the basis of publicly financed health insurance scheme implied and the outcomes were positive.

Rationale

There is much debate at national and state level about how to move and advance as means of providing optimum state of universal coverage to beneficiaries in India. There is limited evidence on the effect of government health insurance on health and well being of beneficiaries in developing countries. This paper presents review of government health insurance system, opportunities it provides, challenges it faces and the concern it raises.

Research Question

How effective and efficient is government health insurance system in providing health coverage to beneficiaries?

AIM

To explore health insurance system in India with an aim of investigating the issues that serve as a blockade to attain universal coverage.

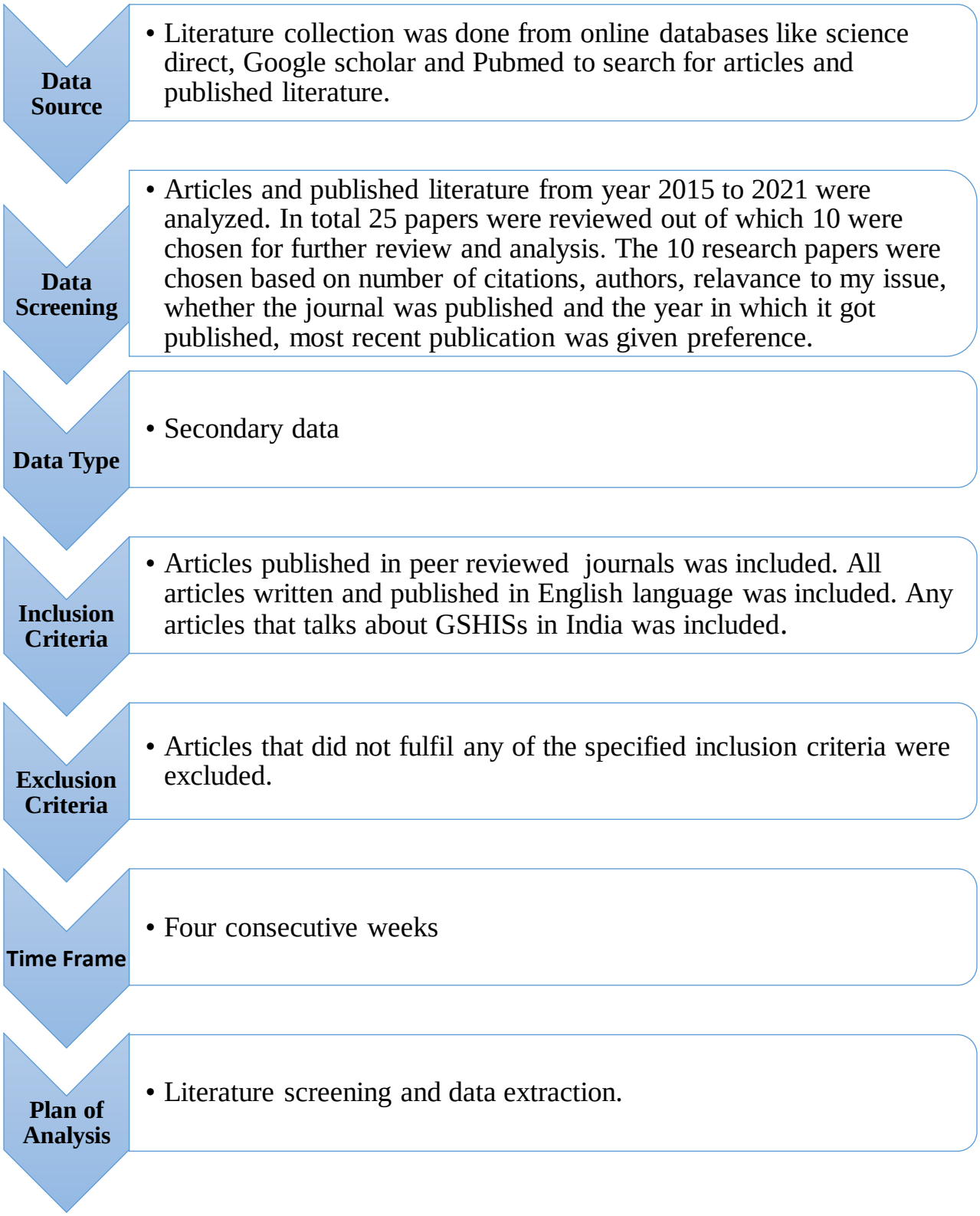
OBJECTIVE

To analyze the government health insurance system to further understand the challenges it faces and opportunities it provides.

To discuss the implications of GSHIS.

To measure the effects of two central and two state based government health insurance schemes on out of pocket expenditure and service utility.

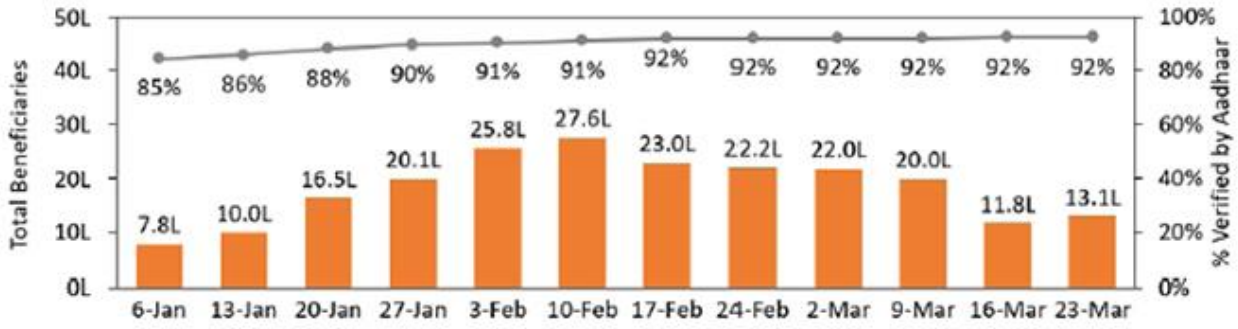
METHODOLOGY


Data Source
• Literature collection was done from online databases like science direct, Google scholar and Pubmed to search for articles and published literature.
Data Screening
• Articles and published literature from year 2015 to 2021 were analyzed. In total 25 papers were reviewed out of which 10 were chosen for further review and analysis. The 10 research papers were chosen based on number of citations, authors, relavance to my issue, whether the journal was published and the year in which it got published, most recent publication was given preference.
Data Type
• Secondary data
Inclusion Criteria
• Articles published in peer reviewed journals was included. All articles written and published in English language was included. Any articles that talks about GSHISs in India was included.
Exclusion Criteria
• Articles that did not fulfil any of the specified inclusion criteria were excluded.
Time Frame
• Four consecutive weeks
Plan of Analysis
• Literature screening and data extraction.

DATA ANALYSIS

Ayushman Bharat Yojana:

Fig 6.1 Beneficiary Identification In Month Of March 2019

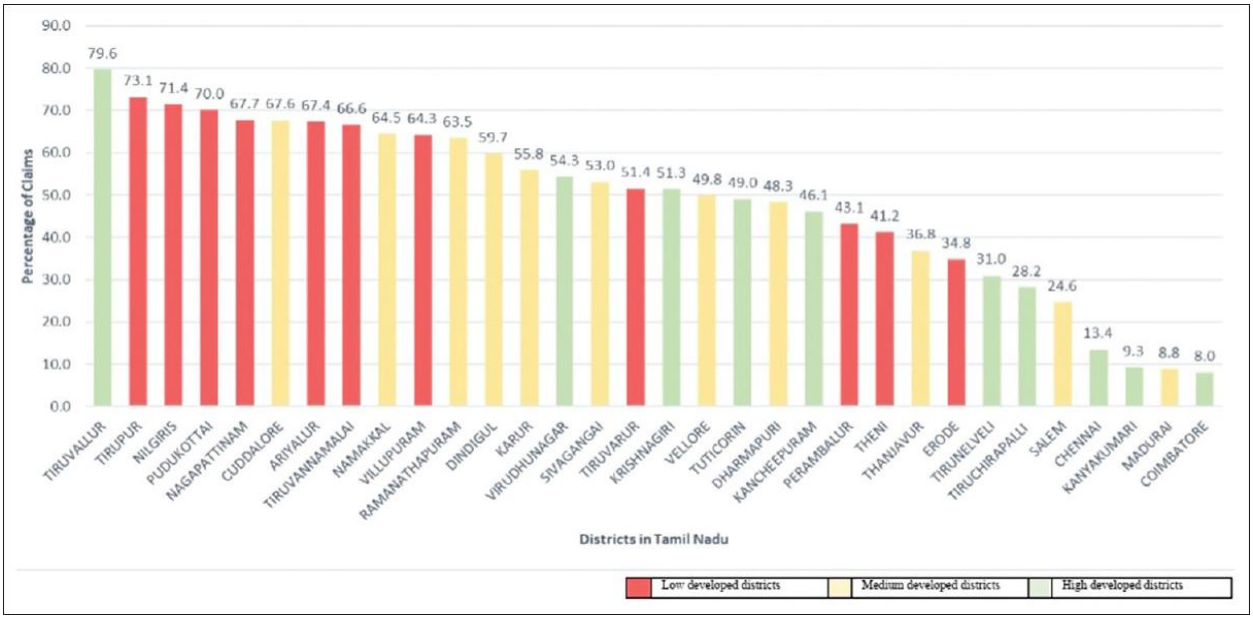


Source: http://www.pmjay.gov.in

The two pillars of Ayushman Bharat Yojana are Health Wellness Centre (HWC) and AB-PMJAY.1,50,000 HWCs are under creation covering a population of 3000 to 5000 to ensure universal comprehensive primary healthcare. By providing over 10,958,358 e-cards, as per 25 February 2019 Analysis, Madhya Pradesh, Uttar Pradesh, Haryana, Jharkhand and Bihar have excelled in performance. Tamil Nadu, Kerala, Gujarat and Chhattisgarh recorded highest number of hospitalization. More than 50 crore beneficiaries have been targeted through scheme that tends to provide coverage for secondary and tertiary hospitalization to underprivileged across country, but the scheme has come under scrutiny under multiple avenues for not being warrantable healthcare. Just like Delhi, Telangana and Odisha have prioritized their own state healthcare government schemes.

Chief Minister Comprehensive Health Insurance Scheme:

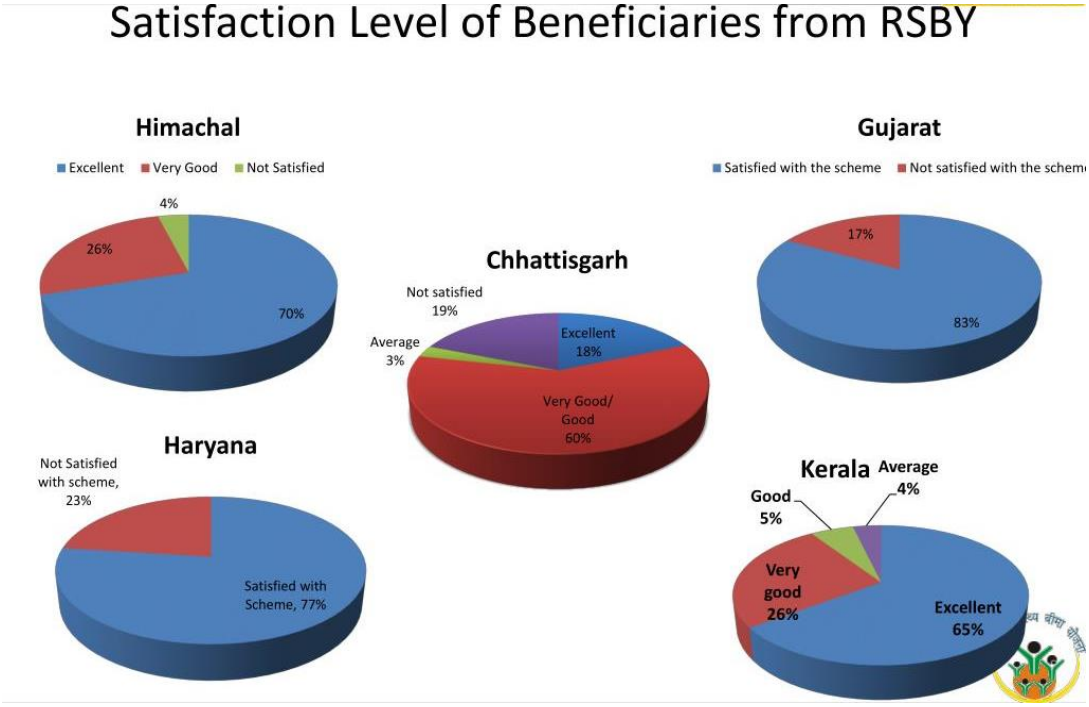
Fig 6.2 Proportion of beneficiaries moving outside for CMCHIS services in Tamil Nadu



Source: Indian Journal Of Community Medicine – Official Publication Of Indian Association of Preventive & Social Medicine (2018)

CMCHIS scheme aims at making health service affordable, available and accessible thus reducing the inequity in both public and private providers. A study was carried out to determine any inter district disparity in the distribution of hospitals empaneled and utilization of services under the CMCHIS scheme. Using CMCHIS data on empaneled hospitals secondary data analysis was conducted. Districts were divided into three major strata's based on human development index, high developed district (HDD), middle developed district (MDD) and low developed district (LDD). Hospital service availability was calculated as number of empaneled hospitals/100,000 families enrolled. Utilization was calculated as number of claims made by beneficiaries living in district per one lakh families enrolled and number of claims made by hospital under CMCHIS/100,000 enrolled. Pearson's Correlation Analysis was used to examine human development index across districts. It was found that LDD (22.8%) had highest enrolment followed by MDD (21.9%) and HDD (18.7%).

Fig 6.3 Rashtriya Swasthya Bima Yojana

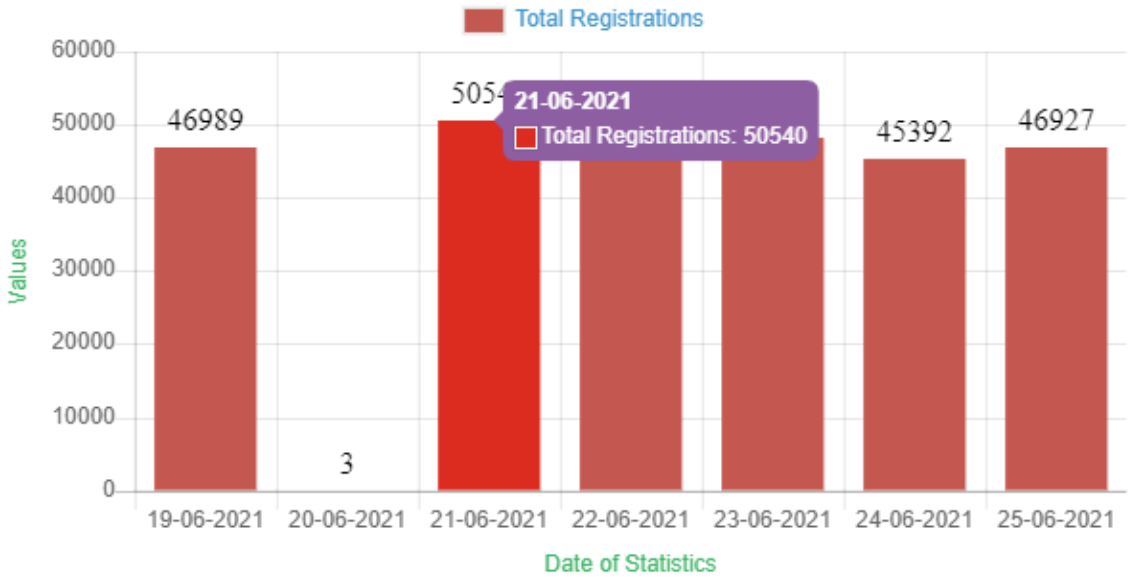


Source: National Sample Survey Organization (2019)

RSBY scheme was launched for poor in the year 2008. Utlizing three waves (2014-2015, 2016-2017 and 2018-2019) data from national sample survey organization (NSSO) N=346,615 and district level data on enrolment, RSBY effect on OOP and satisfaction level of beneficiaries was estimated. Rashtriya Swasthya Bima Yojana provides secondary level healthcare facilities to more than 36 million families across most states in India. The purpose of this scheme is to safeguard marginalized Indian beneficiaries facing economic risk due to hospitalization. However, the scheme is limited only to inpatient treatment or hospitalization. Satisfaction level of beneficiaries from RSBY was analyzed for following states Kerala, Haryana, Gujarat, Himachal and Chhattisgarh. Satisfaction level recorded was highest in the state of Gujarat (83% were satisfied and 17% dissatisfied), followed by Haryana (77% were satisfied and 23% were dissatisfied) and Kerala (65% and above were satisfied). Whereas lowest level of satisfaction among the states analyzed was recorded in Himachal were (19% were not satisfied).

Central Government Health Scheme:

Fig 6.4 Central Government Health Scheme Total Registeration



Source: https://cghs.nic.in/dashboard/dashboardchart.jsp

The Central Government Health System was introduced in Delhi in 1954 and gradually expanded to 24 other cities. CGHS has three million beneficiaries and offers comprehensive package of outpatient and inpatient care. The health services are provided to employees, pensioners and their dependents. Health benefit package despite of fast growing expenditure there is widespread dissatisfaction among beneficiaries. There is double sided moral hazard as there is no cap/co-payment. The beneficiaries may tend to overuse expensive curative care as there is no financial incentive to seek care early. There is need to give emphasize on preventive healthcare services for beneficiaries so that demand for curative services is reduced.

As per the data shared on dashboard 21 June, 2021-50540 registration have been done. To transform CGHS into Universal Health Coverage, merger of finance pools of certainly administered health schemes is suggested as step towards universal health coverage in India.

Table 6.1 GSHISs Strengths & Weakness:

Government Scheme	Launched Year	Beneficiary	Strengths	Weakness
Ayushman Bharat	23 September 2018	Deprived rural families and identified occupational category of urban workers (SECC)	It not only encompasses BPL beneficiaries but also vulnerable and deprived population. The political commitment is of high level. It has potential to cater 80-90% of health needs. It has high potential due to innovative models and strategies for strengthening healthcare system.	It only focuses on primary healthcare system. PM-JAY does not involves out patient department visits. There is high likelihood of moral hazard and impersonation. There is disproportionate focus on one or two initiatives in ABP.
Aam Aadmi Bima Yojana	2 October 2007 Ministry of Finance	Member (18 -59 years) head of the family or one earning member of BPL family under identified vocational group/ rural landless	It provides financial assistance to rural beneficiaries who are not capable to afford nor access basic services of hospital and pharmacy. It has minimal paper work for enrolment process. Quick assistance is provided to beneficiaries with the nearest Life Insurance Corporation.	Death or disablement due to mental illnesses, hospital expenses, death due to substance abuse or self inflicting injuries are not included. Only one member of the family can apply for insurance.
Bhamashah Swasthya Bima Yojana	December 13, 2015	Beneficiaries who are covered under NFSA	Reduces the financial risk of surplus expenditure	Scheme has restriction with respect to

	Rajasthan State Government	and RSBY are eligible for BSBY	by offering financial cover to beneficiaries against illness. General Illness Cover: Rs 30,000 Critical Illness Cover: Rs 3 Lakhs Pre hospitalization expenses – Cover for seven days Post hospitalization – Cover for 15 days Transport allowance for polytrauma and cardiac cases – Rs 100 to Rs 5000	medical emergencies and necessary actions. No facilities are provided for cosmetic or aesthetic treatments. The scheme is not encompassed under Bhamashah Swasthya Bima Yojana scheme. Several circumstances are not considered unless there is a medical emergency.
Central Government Health Scheme	1954 Ministry of Health & Family Welfare	Provides comprehensive health care facilities for central gov employees and pensioners and their dependents residing in	Provides quality healthcare services and ensuring holistic well being across beneficiaries entire life span Maximum Duration Of Indoor Treatment	As per the studies conducted by Public Health Foundation Of India, CGHS fails in implementation and has been ineffective in

		CGHS covered cities.	12 Days for specialized (Super Specialty) Treatment 7 Days for other Major Surgeries 3 Days for Laparoscopic Surgeries/normal deliveries 1 day for day care/normal deliveriesMaximum Duration Of Indoor Treatment 12 Days for specialized (Super Specialty) Treatment 7 Days for other Major Surgeries 3 Days for Laparoscopic Surgeries/normal deliveries 1 day for day care/normal deliveries	offering access to healthcare. It was found in the national capital that delays in payments to empaneled hospitals has plagued the scheme. There is no transparency of inflow and outflow details available at all levels and thus it raises questions about planning process.
Mukhyamantri Amrutum Yojana	September 4, 2012 Gujarat State Government	Families whose annual income is less than Rs 4 Lakh. ASHA Workers Class 3&4 employees	Provide quality medical and surgical care for the catastrophic illnesses involving hospitalization, surgeries and therapies through an empanel network of hospitals to the BPL families. Medical Expenses: Rs 5 lakh per family per annum	No tax benefits are provided under this scheme. Non emergency procedures and cosmetic treatments are not covered under this scheme. Only maximum five family members can avail the

			Travel charges-Rs 300 per hospitalization Repatriation of remains: Rs 6/ per kilometer from hospital to place of residence	benefits of the scheme.
Rashtriya Swasthya Bima Yojana	April 1, 2008 MOHFW	Unorganized sector workers belonging to BPL Category and their family members	Provides protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. 30,000 per family per annum. Pre –existing diseases to be covered Cashless attendance Transportation cost within an overall limit of Rs 1000	The scheme fails to cover outpatient expenses, doctor consultation charges and diagnostic charges. Awareness among beneficiaries is not optimum because of lack of advertisement. Enrolment is low in states which have greater proportion of poor population.

Source : https://financialservices.gov.in

Results:

GSHIS fails to improve the quality of network providers using their financial leverage.

The structural aspects of quality is the prime focus of hospital empanelment.

Scheme merger into an integrated state based insurance system has been influenced by differences related to the definition of BPL status, coverage caps, benefits packages, price structure, empanelment criteria.

It was found that though few schemes have strengthen their monitoring system but issues such as general weakness of systems and dearth of data and analysis influence the optimal functioning.

Due to disparities in central and state authorities RSBY schemes though have rolled out in states in large number, but it has not progressed on the issue of integration with state government sponsored schemes.

Indirect cost associated with hospitalization is not recognized and compensated by Ayushman Bharat Scheme.

Aam Aadmi Bima Yojana has few limitations, death due to substance abuse, death or disablement due to mental illness, hospitalization expenses are not covered under this scheme.

Out of pocket expenditure has increased to 65% -70% due to low public spending on healthcare which serves as barrier to access health for low socio income group beneficiaries.

An estimated 60 million Indians are pushed into poverty each year due to out of pocket payments for health.

Only 30% public expenditure on health is by central government. Remaining 70% of public health expenditure is by states.

As per finance commission, the states and union public health expenditure should be increased in a progressive manner to to reach 2.5 % of GDP by 2025.

Recommendation:

To overcome financing and delivery obstacles to attain universal coverage GSHIS can serve as change agents.

There is a need to introduce quality based purchasing and expand public hospital autonomy.

Governance and co-ordination between private and public health sector insurance reform should be promoted.

The collection, dissemination, analysis and implication of consumer information should be strengthened.

Public hospital autonomy should be expanded.

Reinforce cost containment by consolidating the GSHIS purchasing power, reforming provider payment mechanisms and strengthening utilization management and control system.

Conclusion:

If liberalized health insurance industry can develop rapidly in future. The health insurance model of developed country should be replicated for effective and desirable outcomes. Even though government funding facilitates implication and provision of government health insurance, large segment of beneficiaries are unaware about the healthcare provision. As a result they are doomed to opt for out of pocket expense thus increasing their overall health expenditure and financial burden. Therefore there is a need to generate awareness regarding the accessibility and availability of health insurance system. Strategies should be modulated based on the informative data driven from implication of GSHIS. Better coverage and health services should be provided to beneficiaries at lower cost without over use of procedures and technologies in provision of healthcare.

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