

HEALTH FINANCING MECHANISMS IN INDIA : AN APPRAISAL OF ITS PERFORMANCE

* Savitha

** Kiran K. B.

ABSTRACT :

The performance of India in achieving Millennium Development Goals (MDG) related to the provision of healthcare is sorely disappointing. Insufficient government funding for health care, inadequate and ineffective health financing mechanisms, poor delivery of health care especially in public facilities & excessive reliance on unregulated high cost private providers has contributed to the poor accomplishment of MDG goals especially in informal sector. This has resulted in massive out-of-pocket expenditures and consequent impoverishment of the poor.

There is an urgent need to restructure the health care system to achieve the Alma-Ata declaration of 'Health-for-all' and to meet WHO health system goals. To envision India with equitable and efficient health care system in the coming years, various mechanisms for financing health expenses are to be integrated and public-private partnership has to be encouraged. This paper examines the performance and challenges faced by diverse health financing mechanisms in achieving health care goals.

Key words: Health care financing, health insurance, impoverishment, financial protection, micro health insurance

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INTRODUCTION :

Millennium Development Goals consider the equitable provision of health care as one of the goals to be achieved by nations. Majority of population in developing countries live in rural areas or work in informal sector and these countries account for 84% of world's population, 90% of the worldwide burden of disease, 20% of global gross domestic product and 12% of global health spending (Gottret and Schieber, 2006). The global magnitude of this problem is evident from various reports that estimated 1.3 billion people do lack access to health care. In addition, 150 million people every year are stated to face financial ruin as a direct result of large medical bills in these countries (ILO, 2005).

India has 16 per cent of the world's population, 18 per cent of the world's mortality, 20 per cent of the world's morbidity and healthcare expenditure in the country is a miniscule one per cent of global expenditure (WHO, 2004). India has low health care expenditure which is just 3.6 % of GDP and public sector spending is 1.36 % of GDP

(WHO, 2009). In addition, almost 75% of total health spending in India constitutes private expenditure of which 91.4% is out-of-pocket (OOP) and point-of-service expenditure and public expenditure is 25 % of total health expenditure (WHO, 2009). At least 24% of hospitalized Indians fall below the poverty line and more than 40% of inpatients take loans or sell assets to pay for hospitalization (Peters et al., 2002).

* Research Scholar, Department of Humanities, Social Sciences & Management,
National Institute of Technology Karnataka, Surathkal, Mangalore, Karnataka
bsbasri@gmail.com 9448103447

** Associate Professor, Department of Humanities, Social Sciences & Management,
National Institute of Technology Karnataka, Surathkal, Karnataka
kbheem@nitk.ac.in 9448888458

Dismal performance of public sector health services has forced people to seek care in unregulated and expensive private sector which has resulted in iatrogenic poverty. High cost healthcare induced poverty is otherwise known as iatrogenic poverty (Messeen et al, 2003). Poorer section of society either postpones seeking care during illness or become impoverished while accessing care. When we consider health care system in India, there are two parts. Bharat belonging to poor who face financial and non-financial barriers to health system and India that belongs to middle and rich class who can access quality care easily.

Health financing aims to mobilize adequate financial resources to ensure timely access to health care and involves government spending through budget, social insurance, private insurance, community-based insurance or micro health insurance, and paying out-of-pocket.

The objective of this paper is to analyze the performance of available health financing options in India to understand the contribution of these mechanisms in mitigating iatrogenic poverty. Challenges faced in health financing in India and its remedies are suggested.

Public sector health financing :

Government involvement in health financing takes the form of government spending in public hospitals and social health insurance. One discernible fact is the low and downward trend in government spending on health as proportion of GDP. The public health investment as a percentage of GDP (table 1) has increased from 0.22% of GDP in 1950-51 to 1.05% in 1985-86. But it declined then onwards from 0.96 % in 1990-91 to 0.86 % in 2003-04. It was 1.36% in 2006-07 but decreased to 0.9% in 2009 which is very low in global comparison (WHO, 2009). The aggregate expenditure in the health sector (table 2) has decreased from 4.2% of the GDP in 1997 to 4.12 % in 2006 but later increased to 5.1% in 2009. Public expenditure as per cent of total health expenditure was 25% in 2006 which increased to 32.76 % in 2009, and the remaining balance is the private expenditure (75% in 2006, of which 91.4 % is out-of-pocket expenditure). Insurance contributes only 1.1% of total expenditure on health. Private health expenditure as per cent of total health expenditure was 78.43% in 1975-76, 77.8 % in 1998 and increased to 80% in 2009 (table 2) (WHO,2009). The public expenditure on health was 34.4 crore in 2005-06 and has increased to ₹ 58.6 crore in 2008-09. The private expenditure during the same period was ₹ 115 crore and ₹ 157.39 crore respectively. Total health expenditure was ₹ 151.59 crore in 2005-06 and ₹ 219.77 crore in 2008-09 (MOHFW,GOI).

Table 1: Trends in Government Health Expenditure (GHE) in India

Year	GHE as % of GDP	Year	GHE as % of GDP
1950-51	0.22	2000-01	0.9
1955-56	0.49	2001-02	0.83
1960-61	0.63	2002-03	0.86
1965-66	0.61	2003-04	0.91
1970-71	0.74	2004-05	1.16
1975-76	0.81	2005-06	1.23
1980-81	0.91	2006-07	1.22
1985-86	1.05	2007-08	1.23
1990-91	0.96	2008-09	1.37
1995-96	0.88	2009-10	1.45
1999-00	0.9		

Source: RBI as obtained from Budget Documents of Union and State Governments

Table 2: Expenditure ratios and financing sources measurement

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total Expenditure on Health as % GDP	4	4.3	4.5	4.5	4.2	4	3.8	3.6	4.1
General Government expenditure on health as % of total expenditure on health	23.2	21.8	20.1	20.3	20.4	20.9	22.4	25	26.2
Private expenditure on health as % of total expenditure on health	76.8	78.2	79.9	79.7	79.6	79.1	77.6	75	73.8
General Government expenditure on health as % of total government expenditure	4.5	4.3	4.2	3.9	3	3	3.2	3.4	3.7
External resources on health as % of total expenditure on health	1.3	0.6	2.4	0.3	0.6	0.7	0.5	1	1.4
Social security expenditure on health as % of general government expenditure on health	6	5.8	5.8	5.6	5.8	5.8	5.2	4.9	17.2
Out of pocket expenditure as % of private expenditure on health	91.9	91.3	92.1	92.5	92.4	92.3	92.3	91.9	89.9
Private prepaid plans as % of private expenditure on health	1.1	1	1	1	1	1	1	1.1	2.1

Source: World Health Organization (2009), Central Bureau of Health Intelligence

As a percentage of total expenditure of government, health outlay didn't change much from 2001-02 to 2006-07 although it mildly increased to 2.11% in 2007-08 (table 3).

Table 3: Health expenditure as per cent of total expenditure of government

2001-02	1.65
2002-03	1.58
2003-04	1.53
2004-05	1.64
2005-06	1.89
2006-07	1.87
2007-08	2.08
2008-09	1.86
2009-10	1.99

Source: Budget documents of the Union and state governments, RBI

Health outlay as a per cent of total plan outlay has decreased from first plan (3.4%) to third plan (2.09%), later increased to 3.97 % in tenth plan. This trend is alarming as lesser funds were earmarked for health in successive plan periods till eighth plan but ninth plan onwards; more but inadequate funds were allocated to health sector (Planning commission of India). This has been summarized in table 4. Despite the government health subsidy aimed at the poor, WHO report observed only one tenth of it going to the poorest while one third of the subsidy is reaped by the richest (Ramachandran and Rajalakshmi, 2009).

Table 4 : Plan outlay for health sector

	Health outlay (in ₹ crores)	% to total plan outlay
First plan (1951-56)	65.3	3.4
Second plan (1956-61)	145.8	3.1
Third plan (1961-66)	250.8	2.9
Fourth plan (1969-74)	613.5	3.9
Fifth plan (1974-79)	1252.6	3.1
Sixth plan (1980-1985)	3412.2	3.1
Seventh plan (1985-90)	6809.4	3.1
Eighth plan (1992-97)	14102.2	3.2
Ninth plan(1997-2002)	35204.9	4.09
Tenth plan(2002-2007)	58920.3	3.97
Eleventh plan (2007-2012)	140135	6.5

Source: Planning Commission of India

Global comparison reveals a dismal picture in terms of central government outlay as per cent of total outlay in social sector as summarized in table 5. In 2003, India's outlay was 1.63% whereas Sri Lanka (5.1%), Nepal (5.44%), Tunisia (5.7%) and other comparable underdeveloped countries had higher outlay for health (Report of NCMH, 2005). At about 1.39% of the GDP in 2007-08, India's public health spending appears even poorer in comparison with China, Srilanka and Thailand, for which this proportion was 1.95%, 1.8% and 3.06% respectively (WHO,2009). In terms of total health expenditure on health, India (3.6% of GDP) stands behind other countries like Srilanka (4.2%), China (4.6%), Nepal (5.1%) and Chile (5.3%).

Table 5. Central government outlay as per cent of total outlay in social sector-Global comparison

	2000	2001	2003
U.S.	20.5	21.87	23.44
U.K.	15.42	15.42	15.42
Tunisia	6.31	6.31	5.7
Bhutan	10.11	10.19	10.83
India	1.61	1.8	1.63
Malaysia	6.26	6.26	6.26
Srilanka	6.43	5.1	5.1
Philippines	2.27	1.93	1.93
Chile	10.41	12.67	13.92
Nepal	4.76	5.77	5.44

Source: MOHFW GOI

Preventive and promotive health care spending in India is far less compared to other countries and major proportion of curative care spending is incurred on tertiary hospitals located in urban areas.

Government of India initiated National Rural Health Mission as a measure to provide health insurance benefits for the families below the poverty line in the Union Budget of 2004-05. Due to the restricting nature of the policy and poor awareness of the policyholders, the claims settled were low (₹ 28 lakh) (Rao and Choudhary, 2008). Universal Health Insurance Scheme was started in 2003 with the objective of providing coverage to 10 million in its first year but only 1.16 million persons have been covered of which 11,408 persons belong to BPL families. Public and private insurance companies have not shown interest in promoting the scheme due to high transaction costs, adverse selection and lack of profitability (Bhat and Saha, 2004). Another scheme launched by the government was the Rashtriya Swasthya Bima Yojana in 2008 to provide insurance coverage to BPL families up to Rs. 30000/ per annum for inpatient treatment including transportation charges. Premium was fixed at Rs.30 per family that enables cashless transactions. The scheme was jointly implemented by central and state governments along with private health insurance companies.

Social Health Insurance (SHI) :

The mandatory social health insurance schemes in India are Employees' State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) which collect contributions from employees in the formal sector and pool them to pay for health services.

ESIC (Employees' State Insurance Corporation) surplus has increased over the years due to an increase in the income by 155 per cent between 2000-01 (₹ 1564.28 cr) and 2007-08 (₹ 3989.31 cr) and the expenditure increased by 43 per cent over the same period from ₹ 1083 crore to ₹ 1549 crore. Annual surplus more than doubled from around ₹ 1132.65 crore in 2005-06 to ₹ 2,383.6 crore in 2008-09, largely on the strength of an increase in new memberships, leading to a rapid rise in income from contributions which would facilitate the construction of 11 medical colleges as planned by ESIC. Despite of having surplus income over a period of seven years, it was unable to provide quality services to the insured (Srinivas, 2009). Table 6 shows the income and expenditure of ESIC over the last ten years, incurred claims ratio (claims settled divided by contribution), incurred expense ratio (administrative and other expenses divided by contribution) and combined ratio. Table 7 shows the performance of ESIC in terms of number of employees, hospitals and insured members over a period of ten years from 1997 to 2005. Low claims ratio indicates sound financial health of ESIC. It has been less than 100 per cent implying that less claim has been made per rupee of contribution. Expenses ratio was lower which tells that administrative and other expenses were, on an average, one tenth of the premium collected. Combined ratio, which shows the outgo of the scheme compared to premium, was the lowest in 2007-08.

CGHS experienced higher expenditure on professional services especially to private providers in the last decade. The scheme had deficit as the revenue was lower by more than ₹ 1000 compared to expenditure (Raghavan,2008). Budget allocation for CGHS has increased from ₹ 252.85 crore in 2000-01 to 407.14 in 2003-04. It decreased to

₹ 203.5 crore in 2004-05 but later increased to ₹ 387.85 crore in 2008-09 (MOF, GOI).

Some unresolved problems plague the scheme such as low quality of care in terms of lack of staff, medicines and facilities. Up scaling of SHI in India is limited due to various constraints such as large informal sector, lack of cohesion and solidarity, and poor institutional capacity to organize schemes.

Table 6. Income and Expenditure of ESIC in India

Head of Account	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010
Income								
Contribution	130238.61	138071.97	153240	193356.47	245348.37	326283.98	369853.27	362250
Interest ad Dividend	32697.79	51334.11	49228.25	39839.26	57880.99	62836.03	66327.23	106182.65
Fees, Fines & Forfeitures	329.89	569.04	255	789.03	906.76	1076.88	937.41	746.95
Rent, Rates and Taxes	5874.56	5762.01	6278.45	5662.03	4885.2	6821.87	6586.05	6431.2
Other Income	1340.2	1826.47	5170.35	1414.98	1789.87	1913.07	1541.74	1900.85
Total Income	170481.05	197563.6	214172.05	241061.77	310811.19	398931.83	445245.7	477511.7
Expenditure								
Benefits								
A. Medical Benefits	56520.05	62038.29	82763.75	72411	77978.47	92479.29	112322.31	223605.35
B. Cash Benefits	28561.37	27396.86	32185.05	27355.94	27231.39	28728.15	38070.45	46210.7
C. Other Benefits	79.74	80.69	110	115.04	242.6	209.4	252.3	220.7
Total Benefits	85161.16	89515.84	115058.8	99881.98	105452.46	121416.84	150645.06	270036.8
Administrative Expenditure	17722	18277.01	2383.05	21096.22	22139.27	24797.39	41276.17	54573.65
Contribution to Capital Construction Fund	6511.93	6903.6	7662	1933.56	2453.48	3262.84	3698.53	3622.5
Other Expenses	2436.62	2351.0	2503.45	4984.4	4971.93	5408.73	11263.2	11671.9
Grand Total	111831.71	117047.53	148407.3	127896.16	135017.14	154885.8	206882.98	339904.9
Incurred claims ratio (a)	65.4%	65%	75%	52%	43%	37%	41%	75%
Incurred expense ratio (b)	15.5%	15%	3.2%	13.5%	11%	9.3%	14.2%	18.3%
Combined ratio (a+b)	80.9%	80%	78.2%	65.5%	54%	46.3%	55.2%	93.3%

Source : Employees' State Insurance Corporation. (ON71)

Table 7. Performance of Employees State Insurance Scheme in India

	31-03-1997	31-03-1998	31-03-1999	31-03-2000	31-03-2001	31-03-2002	31-03-2003	31-03-2004	31-03-2005
Progress									
No. of Centres	632	640	642	655	677	678	687	689	718
No. of Employees (in Lakhs)	77.31	83.61	80.85	78.62	77.54	71.59	70	70.82	75.7
No. of Insured Persons/Family Units (in Lakhs)	84.45	90.95	88.19	86.01	84.93	80.04	78.28	79.13	84.98
No. of Beneficiaries (in Lakhs) (Including Insured Persons for Medical Benefits)	327.66	352.9	342.1	333.72	329.5	310.5	303.7	307.0	329.73
Hospitals	125	127	130	136	140	140	142	143	144
Annexes	43	43	43	43	43	43	43	42	42
Dispensaries	1443	1450	1452	1443	1453	1451	1447	1452	1427
Functioning in Corporation Building	348	355	361	365	370	370	373	375	375
Functioning in Rented Building	1071	1068	1066	1037	1042	1042	1044	1036	1011
Mobile Dispensaries	24	27	25	20	20	15	10	21	21
Employees Utilization Dispensaries	23	22	22	21	21	21	20	20	20

Source : Ministry of Health Family Welfare, Govt. of India

Private or voluntary health insurance :

Despite the reforms in insurance sector, coverage of PHI is limited to less than 5 % of population and to less than 1 % of overall healthcare financing. In the total Indian non-life market share by value, health insurance revenue contribution was 1.8% in 2004 (Data monitor, 2005). Health insurance is the fastest growing segment of the non-life industry in the country today, but it still remains vastly underdeveloped. It is almost one fifth of the total non-life insurance market and is the second biggest component of the total non life premium in the country (Mayur,2009). Since the foreign players can hold 26 per cent equity in insurance company, there is huge potential for development in this sector.

There are presently 25 general insurance companies with four public sector companies and eighteen private insurers. In 2001-02, 7.5 million policies were sold. By 2003-04, the number of policies issued had increased to 10.3 million. The total number of insurance holders was reported to be 5.17 million in 2006-07, 8.64 million in 2007-08 and 10.66 million in 2008-09 Almost 90% enrolled with the four public sector insurance companies in 2003-04 but the market share of these companies gradually declined to 65 per cent in 2006-07, 62.7 per cent in 2007-08 and 57.7 per cent in 2008-09 (IRDA,2009).

In the years 2002–2011, health insurance premiums increased five-fold from ₹ 6.75 billion to ₹ 114.79 billion. In 2006-07, the industry registered a premium of ₹ 32.08 billion, in 2007-08 ₹ 51.25 billion and in 2008-09 ₹ 66.25 billion. The premium collection in 2009-10 was ₹ 83.05 billion and in 2010-11 ₹ 114.79 billion (IRDA, 2011). The market share of private insurers has increased from 62 per cent in 2006-07 to 64 per cent in 2007-08, and it has been continuously increasing and is 73.5 per cent in 2010-11 (IRDA, 2011). This implies a decline in the market share of the public sector insurers. Health segment registered higher growth rate compared to non-life industry as a whole.

Despite impressive growth, the penetration of private voluntary health insurance is extremely poor despite the existence of a huge market and is a highly cost-inefficient mechanism owing to significant administrative costs, lack of regulation and control on provider behaviour, unaffordable premiums and high claim ratios, exclusion of many diseases from the coverage, and co-variate risks (NCMH,2005).

Out of pocket expenditure :

Out of pocket payments are made when the households pay from own savings or borrow or sell assets while availing health services. This has given rise to medical cost induced poverty known as iatrogenic poverty. In India, iatrogenic poverty is evident from the study by Peters et al., 2002. This study reported that one quarter of hospitalized Indians face iatrogenic poverty and two fifths of them resorted to strategies with negative consequences namely borrowing and asset sale. In 1995-06, 15 per cent of rural ailments were untreated that increased to 28 per cent in 2004. The story is no different in urban areas. The per cent of ailments untreated due o financial barriers was 10 in 1995-06 and 20 per cent in 2004 (NSSO,2004). In addition, indirect cost of care is high in rural areas due to travelling to nearby providers in city or towns, and loss of wages as most of them are daily labourers (Sodani, 1997).

The World Health Survey-India, 2003 revealed that one fifth of households surveyed borrowed to meet healthcare costs, one tenth used savings, seven per cent of households sold assets and less than one percent relied on health insurance to meet health payments. Out of pocket expense on drugs was the highest followed by outpatient expenses. The lowest 4 per cent share of out of pocket expenditure was for in-patient care.

Micro Health Insurance (MHI) or Community Based Health Insurance :

Financing health expenses has been a difficult task especially for poor households in India. Although the constitution of India promises to provide health care to the population, the failure of the governments has forced poor population to seek alternative methods of financing expensive care and one of the alternatives is MHI.

Since the Bamako initiative in Africa in 1987, several countries have promoted micro health insurance as a promising health financing mechanism. In some of the developed countries (Germany, Japan) MHI preceded the establishment of SHI and at present is found only in developing poorest countries. Student's Health Home was the first scheme initiated in India in 1952. BAIF, DHAN, RAHA, SEWA, ACCORD, Karuna trust, Yeshaswini trust, VHS, and Navsarjan are some of the successful MHI scheme. At central government level, the National Rural Health Mission supports micro health insurance by subsidizing the premium of the poor (NRHM, 2005).

The partner-agent model is the dominant type of health insurance model although there are other two types; type I (HMO design) and type II (insurer design) (Devadasan et al., 2004). These schemes stipulate individual as the unit of enrolment, and focus on the poor in the informal sector. The coverage is restricted to inpatient services, and other risks such as life, assets and natural calamities are also covered. Majority of the scheme provide cashless benefits at any network hospitals (Devadasan et al, 2004).

A number of studies provide evidence that MHI membership leads to higher utilization of health care facilities, in the form of outpatient visits or hospitalization (Jakab & Krishnan 2001; Schneider & Diop 2001). In a systematic review (Ekman, 2004), it was concluded that MHI schemes reduce out-of-pocket payment and increase access to health care in low-income countries, but the poorest were still excluded. Another review found that MHI leads to better access to drugs, primary care, and hospital care although the schemes studied couldn't raise sufficient financial resources from the target population (Preker et al, 2002). Studies conducted in India concluded that MHI provides partial financial protection and no impact on the utilization of health care services (Ranson 2003, Devadasan 2007).

Problems to achieve universal coverage in India :

India offers diverse health financing mechanism that can meet the needs of rural or urban and rich or poor population depending on their affordability. The World Bank and other multilateral and bilateral agencies have stressed the need of private health insurance for better-off section of the society and micro health insurance strategies for those below the poverty line. But sustainable health financing can be attained only with public expenditures, social insurance and donor support which is difficult to achieve in India.

Owing to low tax base, weak tax compliance and ineffective tax collection machinery, a tax funded health system is difficult to develop in India. Highly bureaucratized system of governance in India may not be well-equipped to organize a nation-wide SHI system which is complicated further owing to bad or non-existent roads, telecommunications, and banking facilities. It will be difficult to collect premiums, claim management and monitoring of health and financial information.

Disproportionate out of pocket expenses, shrinking government budget on health, exorbitant private health insurance premium and lower penetration of micro health insurance are the challenges faced by health financing sector. To overcome these setbacks, India has to devise a mechanism to expand risk pools, increase access and utilization of needed services, efficient use of available resources, and ensure better allocation and use of inputs.

Health sector reform requires various incentives and stimulus to invest in health sector, higher outlay for healthcare infrastructure expansion, reallocation of resources of the government towards prepayment schemes to ensure access to healthcare at low cost, impetus to health insurance sector, and encouragement of low cost private sector participation through changes in medical education system.

Public sector hospitals are considered to be of low quality that should be seriously addressed by the government. Furthermore, the governments' spending was mainly concentrated in preventive care and less on curative care that requires re-orientation towards the goals of public health spending. Providers of healthcare should consider cost-effectiveness of particular line of treatment and balance marginal benefits and costs so that iatrogenic poverty can be prevented.

Government has to augment the resources allocated to health sector. It has to increase tax revenue from untapped areas, revamp tax collection system to reduce tax evasion to create funds for health services provision. Innovations to extend social protection in health to poor population include opening voluntary affiliation to self-employed and informal workers; providing public subsidies to social health insurance systems to enrol the poor or subsidizing premiums for poor self-employed or informal workers; mandatory universal participation; and expanding the pool through the integration of private health insurance (Gottret and Schieber, 2006).

Public-private partnerships (PPP) are necessary to distribute the financial burden of illness, improve the quality of services, and to strengthen the capacity of private sector. This can take the form of subsidies to super speciality hospitals, management of primary health centres by NGOs, adoption of villages by corporate sector, and provision of better transport facilities to regional health centres (Kumar, 2003).

Burden on public finances can be reduced by PPPs, appropriate use of technology in diagnosis and treatment such as tele-medicine, and by rationing the services to the needy people. Combining the for-profit private sector with the not for-profit sector through a PPP will facilitate the provision of affordable healthcare to the poor people.

Appropriate legislative and regulatory framework on insurance mechanism favouring microfinance institutions has to be drafted and implemented to facilitate inclusion of health care sector into the social security ambit. MHI should be supported through government intervention in the form of subsidies, technical assistance, and should be regarded as a supplement to other forms of health financing. Corporations could finance the insurance premiums for severely poor families in need of greater access to the health system as part of their corporate social responsibility initiatives.

Conclusion :

Albeit the availability of the Indian health financing systems through government spending, social insurance, private insurance, and community based/micro health insurance, universal health coverage to India's poorest is far from reality. Dwindling government spending on health services, ineligibility to avail social health insurance, exorbitant private health insurance narrows the options available to poor in informal sector to either MHI or out of pocket expenses. MHI is one of the viable mechanisms to tackle iatrogenic poverty. We feel that expansion of MHI on a pan-India scale would require the stewardship role of the Indian government and corporate sector through corporate social responsibility. In addition, the government should catalyze the development of social health insurance in India to achieve universal coverage of health services.

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