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OVER VIEW OF HEALTH FINANCING IN INDIA – NEED OF AN ALTERNATIVE FINANCING MECHANISM: REVIEW OF HEALTH FINANCING IN INDIA

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Introduction:

India is the world's largest parliamentary democracy and has a federal system of government with 28 States, 7 Union Territories, 640 Districts, almost 6,000 Sub districts, more than 5,000 Towns and 600,000 Villages. India is also one among the fastest growing economies of the world. The gross domestic product of the country grew by an average of 7.5 percent per year during the first eleven years of the second millennium, from the start of 2000 to the end of 2010. This gave India the world's second fastest growing economy, after China's (IMF, 2011). Over the past 50 years since independence India made significant achievement in terms of improvement in health. India could make progress in mortality rates, nutrition and maternal and child care. However India is still way behind many fast developing countries such as China, Vietnam and Sri Lanka in terms of many of the health indicators (Satia et al 1999). It is also important to note the vast variation in health indicators across the country from the worst cases to the best cases. States like Kerala with the best health indicators to the states like Bihar with not so good indicators in health. India is a country with one of the oldest and decentralized health care systems of the world. In case of government funded health care system, the quality and access of various health care services including primary and secondary has been an important concern. The various factors that influence the quality and access are yet to be addressed effectively in the India health care. India also piloted a number of health development schemes including many popular flagship health care programs.

Health and health care need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Heath is clearly not the mere absence of disease. Good Health confers on a person or group freedom from illness - and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of wellbeing. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care and current bio-medical understanding about health and illness.

Health care covers not merely medical care but also all aspects pro preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure- within the government sector alone but must include incentives and disincentives for self-care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost financing health care, the effects are bound t be regressive. Heath care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible had of the market. Nor can it be established on considerations of utility maximizing conduct alone.

Health Financing a Big Challenge:

One of the big challenges of India's health care system is the financial burden it puts on households in terms of out-of-pocket spending, which, as more than three quarters of the health care expenditure is met by households, remains one of the main causes of impoverishment (Balarajan et al. 2011). About 39 million additional people fall into poverty each year as a result of this expenditure (Balarajan et al. 2011). While most health insurance schemes focus on providing coverage for hospitalization, studies have shown that it is the outpatient care that leads to more impoverishment than inpatient care (Berman et al. 2010).

Institutional Structure of Public Health Care in India:

India's health care system was carefully structured at the time of Independence to provide primary, preventative, and curative health care within a reasonable distance of the population even in remote, rural areas. It was envisaged as a three-tiered system – a vast network of primary health centres with referral linkages to

secondary and tertiary care. Primary Health Centres (PHCs) were set up; one for every 30,000 people in the plains and every 20,000 people in hilly and tribal areas. Community Health Centres were set up to provide more specialized health services (Duggal and Gangolli 2005). A district-based system of secondary care was the next level of care; the last level was tertiary care. However, the system did not function as envisaged. Posts remained vacant as doctors were reluctant to go into far-flung rural areas, essential medicines were in short supply, and staff was unsympathetic. As a result, a large number of people, both in urban and rural areas, used the services of private providers.

Quality of Private Sector:

The private sector filled in the gaps, but the quality of this care was and is highly varied. In rural and poorer urban areas, even people without medical degrees set up practices to fill in the huge vacuum for services. The private sector now provides most health care services, and it is where the bulk of manpower and infrastructure rests: approximately 80 per cent of all doctors, 75 per cent of all dispensaries, and 60 per cent of all hospitals in India are now in the private sector (Narayan et al. 2003, cited in Baipai and Goyal, 2004). The National Commission on Macroeconomics and Health (NCMH) found that the distribution of the health services was highly skewed towards urban areas, with an absence of uniform standards, treatment protocols, or even regulations (NCMH 2005). Private sector health care is provided on the basis of fee-for-service and is for profit. Private corporate hospitals, registered under the Indian Companies Act, are owned by shareholders and are run like any other private limited company. Some also offer their services for a premium paid to them directly or through medical insurance companies (Garg 1998). Government hospitals, unable to compete with the resources of this high-end private care, have suffered a further setback as the best teaching faculty, specialists, and other medical staff have left for better infrastructure, work environments, and remuneration in the private sector.

Quality of Public Sector:

The quality of public sector services and infrastructure has been steadily declining in many states. Government health care is seen as being poor quality, so only when people cannot find or afford private health care do they go to a government hospital. Staff members are frequently rude and uncooperative, especially with poorer patients. There is a complete lack of accountability, with people having little redress in cases of neglect or negligence. This has all impacted on the ability of other attempts to introduce innovative health schemes in the public sector. For example, the National Rural Health Mission in Uttar Pradesh was severely affected by the poor quality of the public health services in that state (Varia 2009) such that there were no specialists, funds for ambulances, or blood storage facilities.

Rural Urban Differences:

The difference between rural and urban indicators of health status and the wide interstate disparity in health status are well known. Clearly the urban rural differentials are substantial and range from childhood and go on increasing the gap as one grows up to 5 years. In spite of overall achievement it is a mixed record of social development specially failing in involving people in imaginative ways. Even the averaged out good performance ides wide variations by social class or gender or region or State. The classes in may States have had to suffer the most due to lack of access or denial of access or social exclusion or all of them. This is clear from the fact that compared to the riches quintile, the poorest had 2.5 times more IMR and child mortality, TFR at double the rates and nearly 75% malnutrition - particularly during the nineties.

Not only are the gaps between the better performing and other States wide but in same cases have been increasing during the nineties. Large differences also exist between districts within the same better performing State urban areas appear to have better health outcomes than rural areas although the figures may not fully reflect the situation in urban and peri-urban slums with large in migration with conditions comparable to rural pockets. It is estimated that urban slum population will grow at double the rate of urban population growth in the next few decades. India may have by 202 a total urban population of close to 600 million living in urban areas with an estimated 145 million living in slums in 2001. What should be a fair measure for assessing success in enhancing health status of population I any forecast on health care?

India is the second most populous nation in the world with nearly 1.2 billion inhabitants (WHO, 2008). India is divided in to 28 states and 7 union territories. Each state is governed by an elected government and the union territories are under the central administration. If health is defined ‘as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’, it follows that existence is a necessary condition for aspiring for health. Like most cultures across the world, Indian society has deeply entrenched patriarchal norms and values. Patriarchy manifests itself in both the public and private spheres of women’s lives in the country, determining their ‘life chances’ and resulting in their qualitatively inferior status in the various socio-economic spheres. It permeates institutions and organizations and works in many insidious ways to undermine women’s right to dignified lives. There are similarities in women’s lived experiences due to such gendered existences. However, in a vast and socio-culturally heterogeneous country like India, women’s multiple and often special needs are played out on a variegated terrain of age, caste, class and region resulting in a complexity of experiences. Traditional bases of social stratification such as caste and class reproduce themselves in women’s lived experiences as also do rural-urban and regional disparities. New needs emerge as

women progress through the life cycle. Talking about women's health and access to healthcare in such a complex setup thus pause a challenge.

The best documented and largest system of health care delivery in India is the diverse network of hospitals, primary health centers, community health centers, dispensaries and specialty facilities financed and managed by the central and state local governments. These facilities are officially available to the entire population either free or for nominal charges. Along with some other networks of village health workers, maternal and child health programs and specialty disease prevention programs these public facilities carry out a central role in India's primary health care system.

Threat to Girl Child – Preference of Male Child:

The girl child in India is increasingly under threat. In recent decades, there has been an alarming decrease in the child sex ratio (0-4 years) in the country. Access to technological advances of ultrasonography and India's relatively liberal laws on abortion have been misused to eliminate female foetuses. From 958 girls to every1000 boys in 1991, the ratio has declined to 934 girls to 1000 boys in 2001. In some states in western and north western India, there are less than 900 girls to 1000 boys. The increasing abortion and the female feticide are problems that need to be addressed in a different manner. The Indian society still hold the preference for male child and there is a bias to the services provides and the socio political and cultural expectation of a female child and women as a whole. The increasing violence, the suicide rates among the women etc are also concerns that needs to addressed on a broader health perspective.

Health care is one of the most important basic needs and there is vast variation in the health conditions of different category of population. There are vast variation in health care situations and heath care services across the states and the conditions of those livening in vulnerability also have vast variations across various states. The state of women and children is another important concern and we could find vast variation in the health status and health care services of the women and children across various states and locations. The public health care services though more or less arte equally distributed across the country in physical terms the quality as well as the services available in various states differ considerably. These differences are also reflected in the health status of the various population groups. There are also variations in terms of the quality and quantity of services available at various locations and at various facilities. The performance of the various public sector health care services is not uniform. While some are highly utilized many are underutilized because of various factors. Before launching any major health initiative, there ought to be a well-articulated vision of health care system for the country, and public health policy must be devised to realize that vision. Ideally, certain basic health services, including inpatient care, must be made available to every member of the society. Many health sector reforms have been implemented in the country including the National Rural Health Mission which is an initiative to make health interventions at the local level more coordinated and effective. NRHM has brought various health interventions and ministries working on health undergone single umbrella. India is also the home for a very huge and rapidly growing private health care sector. A very rapidly growing private health market has developed in India. This private sector bridges most of the gaps between what government offers and what people need. The population of India also is growing and this demand a growth in the health care needs and services. Indian health care market is one of the largest and sees lots of future growth potential. From 2001 to 2011, India's population grew by 181 million people to 1.21 billion. Now down to around 1.4 percent per year, its rate of growth is on the decline but India is still on course to overtake China as the world's most populous country by 2025 (MoHA, 2011).

Health Financing in India:

The health care in India as of today is more of private sector dominated. Especially in state like Kerala private sector is the major and preferred provider of health care services to the majority. Except few places where there are less private players most of the districts have a large number of private health care providers. The public sector has been the pioneer with various primary, secondary and tertiary health care services spread across the country. However the mal functioning and the low quality performance of the various health care facilities in the public sector in India led to the emergence of private sector in large way in the India health care scenario. As of today the public services are largely underutilized the private health care services is the most preferred heal care provider for many people include the low income families. The spending by the state on health care is one of the lowest in the continent and this is often pointed as a reason for low quality of services and the growth of the private sector. The private sector development in the health care industry has significantly changed the health financing scenario increasing the cost of carte and transferring the burden of care to the public with a heavy out of pocket expenditure. The service in the private sector is highly charged and it includes many unhealthy care practices like high dose of antibiotics and bad prescription practices. The primary care and health promotion is more or less is given loess priority. India as whole spend less on health care and as a strategy to increase the health care spending the cash transfer programs like health insurance programs and various schemes have been implemented in the country both by the central governments and state governments.

Historically health care services in India particularly in many predominantly rural states are owned and managed by the state. India is a country with a very vast network of public owned health care network starting from the sub center to the medical colleges which cater to the smaller population to the large majority of population. Institution like the All India Institute of Medical Science serves patients from all over the country. However the share of public financing in total health care financing in the country is considerably low--just around 1% of GDP compared to the average share of 2.8% in low and middle-income countries or even relative to India's share in disease burden. WHR (2000) estimates private spending in India to be 87% of total health spending. Of this, 84.6% is out-of-pocket expenditure, lower only to Cambodia, the Democratic Republic of Congo, Georgia, Myanmar and Sierra Leone (see Misra et al. 2003). At present, the insurance coverage is negligible. Most of the public funding is for preventive, promotive and primary care programs while private expenditure is largely for curative care. Over the period the private health care expenditure has grown at the rate of 12.84% per annum and for each one percent increase in per capital income the private health care expenditure has increased by 1.47%. The World Bank (2002) comes up with some other startling observations: that, on average, the poorest quintile of Indians is 2.6 times more likely than the richest to forego medical treatment in the event of illness; that more than 40 percent of individuals who are hospitalized in India in a year borrow money or sell assets to cover the cost of health care; that hospitalized Indians spend more than half of their total annual expenditure on health care. The world health report 2008 emphasized universal coverage as one of the four pillars of primary health care and said such coverage required patient-centered care with no financial or other barriers preventing access to care (WHO, 2008).

Number of private doctors and private clinical facilities are also expanding exponentially. A significant proportion of government spending on health goes into supporting tertiary care whose beneficiaries are mainly the non-poor. In the order of priority, public funding needs to be allocated primarily for promotive and preventive health care which benefits the poor the most. Another feature of public health spending is that total states' spending on health, which accounts for three-fourth of the total public health spending, is more regressive than central government spending. Reliance on out-of-pocket payments is not only inefficient and less accountable than other methods of financing, it is also iniquitous to the poor on whom the disease burden falls disproportionately more, who are more susceptible to disease and who are much likely to be pushed into poverty trap (Gumber 1997, Visaria & Gumber 1994). The World Bank (2002) estimates that one-quarter of all Indians fall into poverty as a direct result of medical expenses in the event of hospitalization.

Health care services have been predominantly dominated by the public sector in India. According to the constitution of India health care is a state responsibility. The health services are therefore organized and managed by the respective state governments. However the major national health problems like malaria, TB, Leprosy etc. have been addressed nationally through the central government by formulating various flagship national health care service programs.

Most of the discussions on health care financing in India have centered on the financial constraints of the public sector and the efficiency of resource allocation by the government. 'Health for all' has been seen as the central assumption of the health sector debate, thus making the government the central player. While we admit that the 'health for all' objectives are laudable, the overwhelming focus on a public health care delivery system appears somewhat unrealistic, particularly in view of the fact that health spending in India is mostly private.

The majority of the Indian population is unable to access high quality healthcare as a result of low awareness of Quality issues, non-reporting of Quality indicators, limited regulatory impact on provider quality and often high costs attributed to perceived higher quality. Many are now looking towards insurance companies for providing alternative financing options and somehow being able to influence provider quality, so that they too may seek better quality healthcare. Health insurance penetration is especially important to make equitable, affordable and quality healthcare accessible to the masses especially the poor and vulnerable sections of society. The recently launched schemes like Rashtriya Swasthya BimaYojana and Aaryogyasri have proved that there is a viable way of reaching out to the large mass living below poverty line by creating products and instituting public private partnerships in various forms. However, the aspect of Quality still remains nebulous, whether in mass schemes like the above, or even in the voluntary private health insurance context.

Health Insurance in India:

Global experience, both in highly industrialized countries as well as in low- and middle-income economies clearly demonstrate the importance of achieving universal coverage through either a purely tax-based regime or social health insurance mechanisms or a mix of both. Although India followed a mix of these strategies since 1950s, the penetration of health insurance remained low for the next six decades. India's tryst with health insurance program goes back to the early 1950s, with the launch of Employees State Insurance Scheme (ESIS in 1952) and Central Government Health Scheme (CGHS in 1954).

However, India's landscape of health insurance has undergone tremendous changes in the last three years with the launch of several more health insurance schemes in the country, largely initiated by central and state governments. It is fascinating to observe the rapid and significant change in the geometry of health

insurance coverage in the country. The country that has been witness to three health insurance programs until 2007 (ESIS, CGHS and Private Health Insurance - PHI), is now swamped by a plethora of insurance programs, in less than three years' time. The breadth, depth and height of health insurance coverage has witnessed enormous leap during this period.

Central Government Health Scheme:

The Central Government Health Scheme (CGHS) was introduced in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families. It was basically designed to replace the cumbersome and expensive system of reimbursements (ministry of health and family welfare, Annual Report 1993-94). Separate dispensaries are maintained for the exclusive use of the central government employees covered by the scheme. Over the years the coverage has grown substantially with provision for the non-allopathic systems of medicine as well as for allopathic. By 1993, there were a total of about 308 dispensaries – of which 230were allopathic dispensaries. In addition, there were several polyclinics, laboratories and dental units under the scheme. The total number of beneficiaries was 4.5 million by 1993. In addition, the CGHS reimburses patients for part of their out of pocket costs on treatment at the government hospitals and some other facilities. The list of beneficiaries includes all categories of current as well as former government employees, members of parliament and so on. Since the large central bureaucracy in India definitely belongs to the middle-income and high-income categories, they are likely to make above average use of health services. The CGHS is widely criticized from the point of view of quality and accessibility. A study by the NCAER (1993) on public hospitals in Delhi highlights many such problems. For instance, it suggests that people used hospitals disproportionately for access to specialist consultants and notes that individuals showed up without any referrals in 83 per cent of these cases. Other problems included long waiting periods, significant out of pocket costs of treatment (Rs 1,507 for first treatment in an episode), inadequate supplies of medicines and equipment, inadequate staff and conditions that are often unhygienic.

Employees State Insurance Scheme:

Established in 1948, the Employees State Insurance Scheme (ESIS) is an insurance system which provides both the cash and the medical benefits. It is managed by the Employees State Insurance Corporation (ESIC), a wholly government-owned enterprise. It was conceived as a compulsory social security benefit for workers in the formal sector. The original legislation creating the scheme allowed it to cover only factories which have been 'using power' and employing 10 or more workers. However, since 1989 the scheme has been expanded, and it now includes all such factories which are 'not using power' and employing 20 or more persons. A useful overview of the ESIC programme is provided in Subrahmanya (1995). Mines and plantations are explicitly excluded from coverage under the ESIS Act. As of January 1995, the programme covered 1,62,191 employers employing 6.6 million people, or altogether 29 million employees and dependents. Only employees earning basic salaries of less than Rs 3,000 (recently enhanced to Rs 6,500) per month are eligible for ESIS cover. Any establishment offering benefits similar to or better than the ESIS is exempt. However, it is not clear how many persons are currently being exempted [Subrahmanya 1995]. The premiums for the ESIS are paid through a payroll tax of 4 per cent levied on the employer and a tax of 1.5 per cent levied on the employee (recently changed to 4.75 per cent and 1.75 per cent respectively). As of 1993-94, medical benefits have comprised nearly 70 per cent of the total benefits provided under the scheme which also include cash payment for illness, maternity, temporary or permanent disablement, survivorship and funeral expenses. Health-benefit expenses grew 82 per cent from 1992-93 to 1993-94, as against a small decline in the number of employees covered [Subrahmanya1995]. The primary way in which the medical benefits are provided under the ESIS is through the facilities dedicated to those on the rolls of this scheme. As of 1993-94, there were 1,427 dispensaries with 5,320 doctors, and 23,348 hospital beds (4.5 per cent of the national total) in 118 dedicated hospitals and 42 hospital annexes [Subrahmanya 1995]. Patients requiring treatment from specialists not available at the ESIS hospitals can receive them at the specialty facilities, with the ESIS program bearing the expenses [Shariff 1995]. The program has come under serious criticism from users, internal review committees and outside researchers. Subrahmanya (1995) quotes extensively from several such reviews and studies. A three part article in the Times of India (Bombay, May 14-16, 1995) described the ESIS in Maharashtra as "falling to pieces in more ways than one". A committee for review of the scheme noted that "the criticism has been persistent and scathing" and that "the medical benefits provided have not kept up with the standard of facilities provided by the private clinics and diagnostic centres". A similar opinion was expressed by Ratnam (1995), who notes that "the operation of the ESI scheme and administration of hospitals and dispensaries under the scheme are also seriously faulted and scorned by both the employees and employers".

Medi-Claim Policy of the GIC:

The GIC was set up by the government in 1973 as a public sector organization to market a range of insurance services, including hospitalization cover. It introduced the standard 'Mediclaim' health insurance scheme in 1986, and became operational in 1987. This policy was modified in 1996 to allow for differentials in premium for six age groups: 5-45,46-55, 56-65, 66-70, 71-75 and 76 plus. This policy was framed by the GIC for both groups and individuals. Before the GIC came into existence, a number of private insurance companies

were engaged in offering group health insurance cover to most corporate bodies. With the formation of the GIC these companies were merged into four of its subsidiaries: the National Insurance Corporation (Calcutta), New India Assurance Company (Bombay), Oriental Insurance Company (New Delhi) and United Insurance Company (Madras). All the four companies operate nationally, although each has a regional concentration reflective of the location of its home office.

Specialized Insurance Scheme:

The Life Insurance Corporation of India (LIC) introduced a specialty insurance program in 1993 which covered medical expenses for only four dreaded diseases. This program was withdrawn subsequently, but reintroduced in 1995. By definition, it is very limited in scope. It does not, therefore, serve to reduce the risk of financial burdens to any significant extent. It also remains to be seen whether or not this program will be a popular method of insurance. The GIC's Jan Arogya Bima Policy is yet another scheme of medical reimbursement being offered to people on an individual basis. The annual premium for the youngest people age group is only Rs 70, as against the coverage limit of Rs 5,000 per year. Higher premiums are charged for older persons or those with spouses or dependents. Yet the premiums remain low in relation to the maximum coverage. Even this low-maximum coverage level will provide considerable coverage against low cost hospitalizations. Another significant difference is that it also covers maternity expenses. Apart from these few differences, this policy retains most of the Mediclaim features. It remains to be seen how successful is in comparison to Mediclaim.

Employer-Managed Facilities:

Most discussions of health insurance in India end after the ESIS and Mediclaim are dealt with. Yet these are not the only forms of health insurance in India. "Employer-managed health facilities" and the "reimbursements of health expenses by employers" are also ways to insure people against the risk of illness. These facilities are common for large public and private enterprises. Expenses incurred on these facilities are generally not tabulated in official records. Certain observations by Ratnam (1995) on this issue are very revealing, as is this one: Nearly half of the public sector companies did not specify financial limits because almost all public sector manufacturing enterprises covered, being large in terms of size of employment, invariably have their own dispensary and hospitals and provide medicines, etc, across the counter, usually within the company premises/township. The same applies to large private sector companies, which too have similar facilities and practices (1995:4). Ratnam also describes the medical benefits provided by 18 public and 99 large private establishments. In Table 3 we speculate that perhaps about 30 per cent of the expenditure incurred on curative health by the public sector employees and their dependents is provided directly by the employers. This may be about 10 per cent for the large-scale private establishments. Krishnamurthy (1995) documents another segment of the Indian population that is covered by employer-managed facilities: the plantation sector. This sector employs about 1.6 million workers, and health services are regulated by the Plantation Labour Act of 1951. This Act (and subsequent legislation) specifies minimum standards for dispensaries and hospitals. Krishnamurthy also tries to show that some plantations more than comply with the hospital standards, while others do not (1995:34).

Employer Reimbursement of Health Expenses:

A common but frequently-ignored segment of the health insurance system in India comprises numerous reimbursement plans offered by the employers for private medical expenses in the private sector, as well as in autonomous institutions and organizations – including commercial banks. For many workers this is the only form of insurance other than public facilities. All the firms we spoke to said they offered reimbursement schemes in addition to GIC or ESIS cover. Two kinds of reimbursement systems are predominant. In about half the cases, the system requires employees to set apart a share of their own income to save towards medical expenses. In all such plans, employees are able to spend up to the annual level of their own contribution. Typically, limits are set which depend upon a given employee's salary. In some cases contributions are voluntary, but in most cases they are not. Coverage for outpatient expenditures is more common than coverage for hospitalization expenses.

The other common system of reimbursements an employer self-insurance system, generally known as the medical benefit or medical allowance scheme. Under this arrangement, employees incurring medical expenses are required to submit claims to their employers for reimbursement, and reimbursements are not linked to the individual's contribution. In general, such programs have coverage limits which vary according to the employee's salary or job category.

The NGO Sector:

An important part of private health finance in India is the services provided by voluntary and charitable organizations. As noted by Berman (November 1996), while such groups do not account for a large share of health care, they are oft en the only source of health services, or the only trusted one, for the population they serve. While it is very difficult to estimate even approximately the exact coverage of these varied services, Berman speculates that they cover more than 5 per cent of the population .A review of non-governmental approaches to community health has been provided by the Ford Foundation under its Anubhav project. This

project has looked into all aspects of NGO involvement in the provision of health services, and may therefore be used as an important source of information about the NGOs and their activities. Some of the important NGO offering health services are Child in Need Institute (CINI), Self Employed Women's Association (SEWA). Most of these NGOs offer comprehensive assistance packages with the underlying assumption that health is only one aspect of development and should therefore be tackled along with other social problems in a holistic fashion. The government has realized quite early that NGOs could complement – the services they offer. One encouraging feature of this realization has been the co-operation and help extended to many NGOs by the government. Each five-year plan has a stated amount for allocation to the NGO sector .For example, the Seventh Plan earmarked Rs 150 crore for them.

Private Out-of-Pocket Expenses:

Almost all segments of the Indian population bear some direct out-of-pocket expenses for the utilization of the health care services (Table 3), the lightest burden being borne by workers in the public sector or those employed in large private firms. The heaviest burden is borne by the people engaged in non-formal rural and urban activities. Even government employees with other forms of coverage bear considerable out-of-pocket expenses because they use private facilities and pay for drugs and services which would otherwise be cost free. Though firm evidence does not exist we estimate that approximately 65 per cent of all spending on curative and diagnostic care in India consists of direct out-of-pocket expenses which are not reimbursed and which therefore impose a significant burden on consumers.

Limitations of Insurance Sector:

An important conclusion emerging from the preceding discussion is that a large proportion of the population in India does not have the choice of facilities available to the workforce of the formal sector. The large number of separate networks of providers tends to make for reduce inefficiency and the choice among providers: only a limited set of providers is offered to a given employee. A majority of the large public and privates establishments are either self-insuring provide reimbursement plans to their employees. These employers may be more than willing to switch over to private third party insurance, should it become available. This is particularly true for the large scale enterprises which provide their own clinics and personnel. Given that the employee demand for quality treatment and specialists' care is increasing rapidly, these enterprises would find it worth their while to switch to an insurance structure

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