

2006 | ASIAN DECENT
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International
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SERIES:

SOCIAL SECURITY EXTENSION
INITIATIVES IN SOUTH ASIA

INDIA:
EMPLOYER BASED HEALTH
PROTECTION MECHANISMS
- A PLURALITY OF ARRANGEMENTS -

ILO Subregional Office for South Asia



Decent Work for All

Asian Decent Work Decade

INTRODUCTION

The Employees' State Insurance (ESI) Scheme is a statutory scheme governed by the Employees State Insurance Act, 1948. The Scheme was started in 1952. The Act applies in the first instance to non-seasonal factories using power and employing 20 or more persons. There is a wage ceiling, presently Rs 10,000 for coverage under the Act. Since ESI only covers the low income group, the corporate sector has to look at other ways to provide health protection to their other employees.

Employers in the private sector may offer employer-based protection schemes through their own employer-managed facilities by way of lump sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual irrespective of actual expenses, or through a group health insurance policy.

STATUTORY PROVISIONS

Plantation Labour Act , 1951

The Plantation Labor Act is a Central Act administered by the State Governments through the rules framed by them on the basis of a model provided by the Centre. It applies to tea, coffee, rubber, cardamom and cinchona plantations admeasuring 5 hectares or more and in which 15 or more persons are employed. Skilled, unskilled manual and clerical employees whose monthly wages do not exceed Rs.750 per month are covered. The Act regulates the hours of work, weekly days of rest, employment of women and children, annual and sickness leave, maternity benefit overtime work etc. It also makes it obligatory for the employer to provide free of cost facilities such as medical care, housing, drinking water, conservancy and sanitation crèches, canteens, education of children and protective clothing.

The Act provides that in every plantation there should be provided and maintained so as to be readily available such medical facilities for the workers and their families as may be prescribed by the State government. If in any plantation medical facilities are not provided and maintained as required the Chief Inspector may cause to be provide and maintained therein such medical facilities and recover the cost thereof from the defaulting employer. For the purpose of such recovery the chief inspector may certify the costs to be recovered to the Collector who may recover the amount as an arrear of land revenue

All the Plantation States have framed rules which spell out the details of these facilities.

OTHER HEALTH PROTECTION ARRANGEMENTS

Given the limitations of state owned health insurance programmes, major employers have developed two approaches to providing health care to their employees. The first approach, "empanelment" bears some similarities to preferred provider arrangements in the United States. The employer develops a panel of private hospitals and clinics or practitioners' offices where employees are encouraged to seek care and which, in return for being recognized as approve providers, offer discounted rates. In many cases, empanelment arrangements are layered on top of group mediclaim coverage, with the provider agreeing to a service contract for payment rather than indemnity arrangements.

The second approach used by employers is direct provision of services. Many large plants have on site emergency services and dispensaries. The provision of ambulatory care through house doctors is part of a cost containment strategy. Such practitioners act as triage agents, both sorting through the complaints of workers to determine the need for referrals and adjudicating absenteeism. Some major corporations, such as Tatas and Hindujas, have gone further and developed hospitals as trusts and societies. In so doing, they have blurred the boundaries between employer owned facilities and the NGO sector facilities such as the Tata Memorial Cancer Hospital. In Mumbai are internationally recognised for their research and teaching.

One of the most innovative employer run institution is the Sundaram Medical Foundation (SMF) Community Hospital, a 100 bed secondary level hospital in Madras. The hospital was established by the Sundaram Finance Corporation, a subsidiary of the massive TVS industrial group. However, TVS and Sundaram employees are not given priority for admission and the facility draws heavily on the 300,000 residents of Anna Nagar who live within a 2.5 km radius. The hospital has forgone CAT scanners, cardiac surgery and other tertiary services.

As might be expected, pluralistic payment arrangements are the norm for large industrial groups. For example, the Reliance Group of Industries, a US\$ 8 billion investment company headquartered in Mumbai has an approach similar to that of other major industries. Reliance Group companies offer periodic health examination to all 14,000 employees at on site facilities, with emergency services available at some manufacturing plants. Low income employees are covered by the ESIS with a group mediclaim arrangement available for staff in higher income brackets. Discretionary medical grants are made to individual employees or their family members in order to meet special expenses that are not completely covered by mediclaim.

The companies also provide a Rs.10,000 grant per annum per employee as part of their salary packages which is the maximum tax free medical allowance, Reliance Group is considering construction of an 80 bed secondary hospital in a township populated primarily by its own employees and their families. The strategy under consideration is to vest the hospital with Reliance Foundation open it to employees and their families and accept members of the general public on a fee for service basis. Physicians and surgeons will be employed on a salary basis and close attention will be paid to cost effective care.¹

Indirect provision under collective agreements

Medical care and health benefits for employees should provide for sickness maternity employment injury and occupational diseases. Of these there is statutory provision for maternity employment injury and occupational diseases. There is however no such provision for medical care except under the ESI Act and the Plantation Labor Act. However, over the years the employers have been making provision for medical care of their employees under collective agreements in the form of allowances or otherwise. Most employers today pay their employees a medical allowance either at a fixed rate or as reimbursement of the expenses incurred by the employees. The amount of such allowance or reimbursement ranges from Rs.30 per month to one month's wages for annum for domiciliary treatment and /or hospitalization. Employers in most large scale private sector firms typically provide for medi-

¹ A Fine Balance by C.David Naylor, Prabhat Jha, John Woods, and Abusaleh Shariff, The World Bank, 1999

claim insurance facility to those workers who are not covered under the Employees State Insurance Scheme Separately insurance cover is also provided for accident relief etc. In some cases several companies pay milk or cash allowance to person exposed to vitamin deficiency. Most of such benefits form part of collective agreements

In the public sector, particularly in banks core sector industries like steel coal petroleum etc. the medical benefits are virtually unlimited to all full time permanent employees. Reimbursement of expenses for major ailments is at least 75 % of the total expenditure incurred, if not 100 percent. But, in the private sector, with the possible exception of certain organizations like Tata Iron and Steel Co. medical benefits for non executive employees is usually limited to a maximum of a few thousands for domiciliary treatment as well as hospitalization expenses. Rarely do the entitlements exceed Rs.20000 and in exceptional cases Rs.100,000. In a few public sector companies the life time limit per employee was raised to Rs.250,000. In rare cases, there are annual limits of Rs.300,000 per employee subject to a limit of Rs.150,000 per illness. In contrast, it is rare to find private sector companies providing insurance cover on such liberal terms Also, in small private sector firms the maximum a company would spend on an employee and his /her family in a year for health care would be one month's pay.

Employers are gradually switching to health insurance plans, rationing health care and introducing cost-sharing schemes to minimize the high and spiralling health care costs to them. The emerging trends in collective agreements seem to indicate that employees may be willing to accept slower rise in wages and benefits in return for higher protection of incomes and benefits in post-retirement period (Venkata Ratnam, 1995).

Contributions for Medical Care

Employer-provided medical care costs are usually borne by the employer. However, in a few cases, the cost is shared by the employees also. In Thermax, employees contribute to medical care costs by way of two days work on weekly off days or through surrender of two days privilege leave in a financial year. In Sandoz, medical reimbursement cost is entirely borne by the employer but the costs of special schemes for hospitalization is shared equally by employer and employee at the rate of Rs.20 per month by each employee and a matching contribution by the employer. As discussed earlier, in several cases, mediclaim insurance premium is adjusted from the entitlements for medical allowances/ reimbursement.

Free medical Check-Ups

Employers provide free medical check-ups, in some cases for employees in all age groups, but usually to those who cross middle age, or say, 45 years of age. Such free medical check-ups could be annual in a few cases but usually once in three years (for example, ITC Bhadrachalam).

In several cases, employees shun free medical check-ups if they are mandatory than voluntary for fear that employers may dismiss them if found medically unfit. To alleviate such misgivings, some employers have provided for clauses in collective agreements in recent years that on medical advise, concerned employees may be moved to lighter jobs (Flender Macneil Ltd.).

Post Retirement Health Care Benefits

Private industrial employers in India provide one or several of the three types of post-retirement health plans: (a) medical benefits to those who had to retire on being found medically unfit; (b) medical benefits for those who took voluntary retirement under the company's voluntary retirement scheme; and, (c) extension of medical benefits to superannuated employees.

Typical post-retirement medical care facilities provide for: (a) extension of benefits similar to those available to employees of same rank and status while in service, in company hospitals/ dispensaries; and, (b) in case of retired employees residing in places other than those where company's hospitals/ dispensaries are located are allowed reimbursement of medical expenses at specified rates/ limits.²

State owned (quasi-private) Health Insurance Schemes

India nationalized its insurance industry in 1973, merging all private insurers under the control of the General Insurance Corporation. The GIC has four subsidiaries (since 1999, separated and made independent entities) that offer health related coverage. the National Insurance Company, the New India Assurance Company, the Oriental Insurance company and the United India Insurance Company. Each of these is a national government owned entity with a focus on the region where the head office is located.

GICs medical insurance consists of several levels of group and individual coverage, collectively known as Mediclaim. The policy name, type, premium levels eligibility criteria and benefit coverage are all determined by the GIC (Now by an association of the Companies.). The four subsidiary companies compete only with respect to the servicing of claims and the marketing of policies.

In general, individual Mediclaim policies function on an indemnity basis, whereby the patient (or an employer on his/her behalf) pays the provider and is subsequently reimbursed. Some private provider groups do offer individuals arrangements to process claims. In these cases, a claims processor is established on a no profit basis with tax rebates provided to those who buy memberships. This approach transforms Mediclaim coverage from a partial indemnity to a full service plan for enrollees and helps build a loyal patient base for a particular clinic or private hospital.

As of September 1996, annual premium for Mediclaim ranged from Rs.175 to Rs. 5,770 and coverage from Rs.15000 to Rs.300,000 per policy year. Individuals are eligible for a full or partial rebate on income tax up to a sum of Rs.10,000 per year. Premiums are scaled to age, with minor discounts for claim free years. GIC has imposed a lengthy list of exclusions. For example, no payment for hospital care will be made for any existing illness or disease of chronic nature or for various other conditions during the first year of insurance coverage. Many middle class Indians in small enterprises do purchase individual Mediclaim policies, but expect that large out of pocket expenses will be required in the event of serious or chronic illness.

² Welfare to Money fare: a study of Collective Bargaining and Social Security in India by Dr. C.S.Venkatathnam, Project of the UNDP, 1996

Group Mediclaim policies are available to any centrally administered group or corporate body or more than 50 persons and are also extended to dependants. Benefits are similar to those contained in individual policies. Employees prefer group Mediclaim policies to the ESI because the former offers choice of providers. However ESI is mandatory for lower income employees and requires lower premium contributions from employers. Thus opting out of the ESI has little appeal for most corporations with a poorly paid workforce. Instead coverage is often achieved through a combination of the ESI for those earning less than Rs, 10,000 per month and group Mediclaim benefits for those earning more.

At the end of 1995, only 1.8 million persons were covered by individual and groups Mediclaim policies. Total premium receipts were Rs.1200 million Claims settled led to payments totaling Rs.579 million illustrating that the policies had a high retention ratio.

In late 1996, the GIC introduced a low premium scheme Jan Arogya Bima, that requires payment of Rs.70 to Rs.140 per annum depending on the age of the subscriber, with a Rs.50 charge for each dependent child over the age of five. Such premiums put the scheme within reach of rural middle class and some urban residents who fell outside the ESI coverage. However, Jan Arogya Bima payments are capped at Rs.5000 per insured person per annum which means that beneficiaries still need to rely on free care in public hospitals for any major illness. AIDS related disorders are excluded.

Beginning in 1991, GIC has also offered an old age medical insurance scheme similar in some respects to a medical savings account. Funds accrue during the subscribers working life and are available after retirement. The number of subscribers is small.

The Life Insurance Corporation, another state owned entity began offering a health care endowment policy called Asha Deep II in 1995. It covers individuals 18-50 years of age and provides between Rs.50,000 and Rs.300,000 for four conditions, cancer, paralytic stroke, renal failure/dialysis and coronary artery disease. Terms are 15, 20 or 25 years with the maximum age at maturity fixed at 65 years. Benefits can be claimed for one of the four target conditions only once as a lump sum payment. Residual payments are made at maturity or death whichever is earlier.

Private sector Health Insurance Products

The year 1999 marked the beginning of a new era for health insurance in the Indian context. With the passing of the Insurance Regulatory Development Authority Bill (IRDA) the insurance sector was opened to private and foreign participation, thereby paving the way for the entry of private health insurance companies. The Bill also facilitated the establishment of an authority to protect the interests of the insurance holders by regulating, promoting and ensuring orderly growth of the insurance industry. The bill allows foreign promoters to hold paid up capital of up to 26 percent in an Indian company and requires them to have a capital of Rs.100 crore along with a business plan to begin its operations. Currently, a few companies such as Bajaj Alliance, ICICI, Reliance, Royal Sundaram, and Cholamandalam among others are offering health insurance schemes.

From ILO-CICLASS Study "Developing a conceptual and normative framework for health micro-insurance as a social security instrument in India", ILO Subregional Office for South Asia, New Delhi (2008)