INDIA'S MISSING MIDDLE: A CRITICAL ANALYSIS OF HEALTH INSURANCE COVERAGE DISPARITIES AND CHALLENGES

Tridibesh Dasgupta, LLM, School of Law, Christ University

ABSTRACT

Despite efforts to achieve Universal Health Coverage (UHC) by 2030, significant disparities persist in access to healthcare, particularly for those who fall between government-subsidized schemes and private health insurance. This group termed the "missing middle," lacks adequate financial protection for medical emergencies due to affordability issues and limited coverage options. Challenges include high out-of-pocket expenses, insufficient public awareness, and barriers to accessibility, especially for those in the unorganized sector. The analysis evaluates existing healthcare infrastructure, including government-subsidized, social, and private health insurance schemes, highlighting their limitations in adequately covering the missing middle. Policy recommendations address these challenges, emphasizing the need for increased public funding, primary healthcare investment, and improved distribution systems. Additionally, proposals include expanding the coverage of programs like the Employee State Insurance Scheme (ESIS) to encompass formal and informal sector workers, updating databases, and empowering state governments to play a more active role in healthcare provision. Achieving universal health coverage in India requires a comprehensive strategy prioritising equitable healthcare access for all segments of society. By addressing the needs of the missing middle and strengthening healthcare infrastructure, India can move closer to realizing the vision of affordable and accessible healthcare for all its citizens.

Keywords: Universal Health Coverage (UHC), Missing Middle, Health Insurance, Out-of-pocket Expenses (OOPE), Public Health Initiatives, Employee State Insurance Scheme (ESIS), Healthcare Infrastructure

Introduction

Universal Health Coverage (UHC) is one of the Sustainable Development Goals (SDGs)'s health-related targets. It implies that everyone in need of medical treatment may get enough of them without having to worry about financial concerns. It speaks of a system or initiative of the government that ensures that everyone within its jurisdiction has access to the health care that they need. The system will offer these services as needed and when needed, all without putting the person receiving them in financial hardship. UHC programs by design offer all essential and quality health services, namely, health promotion, preventive health, medical treatment, rehabilitation, palliative care, and hospice care[1]. Achieving this objective is a significant and essential task: Over half of the world's population now lacks access to at least one basic healthcare component.

The delivery of healthcare is inconsistent around the world with regard to equity, quality, and accessibility. During the Millennium Development Goal (MDG) period of 2000–2015, the UHC idea was established. The United Nations Millennium Declaration was adopted during the 2000 UN millennium summit, which led to the establishment of the Millennium Development Goals (MDGs). Every goal has a set of objectives with a deadline for achieving them. 21 targets were used to measure a total of 8 objectives. Over the past two decade, the Millennium growth Goals (MDGs) have succeeded in drawing attention to and creating worldwide political agreement around the need for a framework that would enable nations to plan their social and economic growth and donors to effectively assist the healthcare sector at the national and international levels. Health disparities continue despite efforts to provide access to healthcare services for all populations, especially for marginalized groups and those with lower socioeconomic status. Due to a lack of access to health services and exposure to risk factors including paying for healthcare out of pocket, these people are more probable to suffer from noncommunicable diseases (NCDs), which forces them into poverty. Noncommunicable illnesses, which cause 71% of deaths worldwide, include diabetes, cardiovascular disease, cancer, and chronic respiratory disorders. These diseases are also major sources of disability and mortality worldwide[2].

[1] World Health Organization (WHO). *Health Topics/Universal Health Coverage*. Geneva: World Health Organization; (2021)

[2] *Universal Health Coverage (UHC)* (2023) *NCD Alliance*. Available at: https://ncdalliance.org/why-ncds/universal-health-coverage-uhc (Accessed: 20 March 2024).

The healthcare agenda for India is being determined within the worldwide movement for Universal Health Coverage (UHC). India aims to achieve universal health coverage by the year 2030. India has made efforts to enhance the healthcare system sustainably, but there are nevertheless substantial disparities in health across states, between people living in rural and urban areas, and between socioeconomic strata. A large proportion of the population is impoverished because of high out-of-pocket health-care expenditures and suffers the adverse consequences of poor quality of care[3]. India's healthcare is financed by multiple sources, such as domestic government sources, private sources, and external/global sources. Out-of-pocket expenditure (OOPE), a major source of health financing in the country, contributes to 54.7% of total health expenditure[4]. The self-employed class in rural regions and a number of structured and unorganized jobs in urban areas are referred to as the "missing middle" and constitute as one of the OOPE groups in India.

India's Missing Middle

Despite the fact that the number of individuals in India who are insured by the government has increased recently, a significant percentage of the population is still financially vulnerable to medical emergencies. This group of people, commonly known as the "missing middle," usually comprises of individuals who work in the unorganized sector now or in the past but are not impoverished enough to qualify for government-subsidized health insurance payments. In June 2021 NITI Aayog launched a report on 'Health Insurance for India's Missing Middle' claims that 30% of the population are devoid of any financial protection for health[5]. The report states that 50% of the population is covered by the Indian government's Ayushman Bharat initiative. Social health insurance and private voluntary health insurance cover around 20% of the population. The remaining 30% of the population lacks any financial backing for healthcare treatment, this segment is termed the 'missing middle' because they are not poor enough to be covered by government-subsidized schemes but not rich enough to afford private health insurance[6]. This category includes individuals who can afford to pay a minimal premium for

[3] Patel, V. *et al.* (2015) 'Assuring health coverage for all in India', *The Lancet*, 386(10011), pp. 2422–2435. doi:10.1016/s0140-6736(15)00955-1.
[4] *Out-of-pocket expenditure (% of current health expenditure) - India* (no date) *World Bank Open Data*. Available at: https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=IN&name_desc=true (Accessed: 20 March 2024).
[5] *NITI Aayog releases report on 'Health Insurance for India's missing middle'* (no date) *Press Information Bureau*. Available at: https://www.pib.gov.in/PressReleasePage.aspx?PRID=1767498 (Accessed: 20 March 2024).
[6] Sheth, V. (2022) '5 reasons India's "Missing Middle" is struggling to access quality healthcare', *Voices, Lifestyle*. Times of India, 14 August. Available at: https://timesofindia.indiatimes.com/blogs/voices/5-reasons-

insurance but are unable to do so due to a variety of factors, including ignorance or the unavailability of products in their price ranges. However, the actual number of uncovered individuals is much higher due to the existing coverage gaps in the healthcare insurance schemes in India.

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

1) **Government-subsidized health insurance schemes** - These can cover a certain area entirely or in part, depending on the segment they serve. These programs primarily target the unorganized sector's populace since they are the most vulnerable. The Ayushman Bharat Pradhan Mantri Jan Aarogya Yojna, which offers completely subsidized comprehensive secondary and tertiary healthcare with an annual coverage of Rs 5 lakh per family, is the largest government programme.

2) **Social Health insurance schemes** - They serve workers in the organized sector, when the government and workers both require contributions. The Employee State Insurance Scheme (ESIS) is one instance of this. 13.6 crore participants were registered in this plan in 2019 and the union government offers the Central Government Health Scheme, which covered over 40 lakh workers, to those who work for the government[7].

3) **Private voluntary health insurance schemes** - This may be broadly classified into two categories: group company and individual/family business. About 4.2 crore individuals are covered by individual and family plans, while over 7.3 crore people are covered by group insurance that businesses provide to their employees[8].

Challenges related to Missing Middle in India

Unexpected injury or disease can be catastrophic for families who constitute this 'missing middle'. A study by the Ministry of Statistics and Programme Implementation placed the average cost of treatment in a government hospital at Rs 4,452 per day and estimated that a day

indias-missing-middle-is-struggling-to-access-quality-healthcare/?source=app&frmapp=yes (Accessed: 20 March 2024).

[7] Jain, P., Kumar, A. and Agarwal, N. (2022) 'Missing Middle: Extending Health Insurance Coverage in India', *International Journal for Research in Applied Science & Engineering Technology (IJRASET),* 10(V), pp. 1331–1339.

[8] *Ibid*.

of hospitalisation could cost Rs 31,845 in the private sector[9]. Even long-term hospitalisation in government hospitals can put families in financial distress. Without a regulatory mechanism to monitor the rise in costs of medical treatments, a lack of health insurance can be particularly devastating for low and middle-income families.

It is important to realize that paying for a product one does not hope to use is an illogical option. It effectively turns health insurance into a pull commodity. Furthermore, the overall intricacy of the product of health insurance, adds to the difficulty of ordinary people making an educated purchasing choice. The usual counterargument is that the demand for health insurance will rise in response to regulatory initiatives and increased public awareness among the youth demographic. We feel that this will always be a mediocre attempt, even if it is a perfectly legitimate argument and partly accurate. It will be necessary for the user's perspective to change because of the product's dominance and low awareness.

Some scholars or policy advocates argue that the statement "there is no financial capacity to purchase a policy" does not apply to health insurance. OOPEs, or the missing middle group, have the means to pay a yearly premium. Just the fact that the insurance is priced at a little more affordable level would have a big impact on the choice for purchase. As a proportion of overall healthcare spending, India has among of the highest Out-of-Pocket expenses (OOPEs), and insurance benefits are insufficient to entirely cover OOPEs. Therefore, from an economic standpoint, it is not feasible for the public to obtain health insurance if they must pay for a contingent occurrence with more than half of the cost coming from their own pocket.

One of the issues that the insurance industry brings up the most is accessibility. The majority of modern businesses attempting to address the issue of health insurance make the case that improving the nation's distribution system could increase the percentage of individuals possessing health insurance. One of the most significant challenges still seems to be identifying the target demographic, or purchasers. Since insurance is a push product, one must raise enough consumer knowledge of it to pique their interest. However, since a substantial percentage of the missing middle works in the unorganized sector, there is an absence of reliable employee's databases and other resources for outreach and identification. More issues arise when there are

[9] Migrator (no date) *The perils of India's lack of medical insurance*, *Deccan Herald*. Available at: https://www.deccanherald.com/india/the-perils-of-indias-lack-of-medical-insurance-1099251.html (Accessed: 20 March 2024).

insufficient user records and little information.

Justification for Covering the Missing Middle

Improving financial equity may result through extending health insurance program coverage to the missing middle class. Since the missing middle is composed of up of a mix of middle-class and near-poor people as well as upper-class individuals, increasing coverage to at least a portion of the poorer members of this group would increase their access to affordable medical care. If the additional resource costs of covering this group are not too high, including the healthier and more prosperous segments of the missing middle could also help cross-subsidize poorer groups and garner political support for more government funding. Extending coverage to this group could enable additional economies of scale benefits arising from a larger enrolee base, including benefits from integrating preventive care and health promotion with curative services[10]. Creating efficient strategies to provide coverage to these missing middle households would promote social welfare and safeguard them from financial risk.

Public Health Insurance Coverage

The National Rural Health Mission (NRHM), established by the government in 2005 to address the health needs of the rural population, aims to reduce disparities in access to healthcare. The National Urban Health Mission (NUHM), which was established by the government in 2014, aims to improve the health system in urban regions and concentrate on the urban poor. In 2015, the National Health Mission (NHM) was established via the integration of the NUHM and NRHM. The goal of NHMs was to reduce individual out-of-pocket medical expenses, especially for medicines and diagnostics. In 2018, the National Health Protection Scheme (NHPS) was put into effect with the goal of offering up to INR 500,000 (7,692 USD) in annual health insurance coverage per family.

India launched two of the biggest Government-Funded Health Insurance schemes (GFHIS), Rashtriya Swasthya Bima Yojana (RSBY) and Pradhan Mantri Jan Arogya Yojana (PMJAY), to protect its vulnerable populations[11]. Low enrolment, unequal service delivery, use, and a stagnant financial coverage cap were among the problems facing RSBY. Because RSBY was

[10] Mahal, A. *et al.* (2024) 'The "missing middle": How to provide 350 million Indians with health coverage?', *National Council of Applied Economic Research,* WP (162).
[11] National Health Authority, India. Ayushman Bharat pradhan Mantri jan Arogya yojana homepage. Ayushman Bharat Website Homepage. published online Feb 8. https://pmjay.gov.in/; 2021. Accessed 20 March, 2024.

framed within the Ministry of Labour's jurisdiction, its growth was mainly divorced from global health concerns such as UHC and the Millennium growth Goals. Another flaw in the scheme's architecture was that state-level GFHIS and RSBY coexisted but operated separately in a number of states, creating dispersed risk pools[12].

PMJAY increased coverage and lessened several of RSBY's shortcomings. The scheme provides a cover of Rs.500,000 per household for secondary and tertiary-level health services to about 50 crore beneficiaries belonging to the bottom 40% of the population[13]. PMJAY is based on selective coverage of deprived people for comprehensive health conditions. The "missing middle" segment of the population is not shielded from health-related financial shocks, which is one of the scheme's shortcomings. This group does not purchase insurance on their own unless it is highly subsidized. The lack of strong political incentives makes it difficult to include this segment gradually into GFHIS. In fact, in a recent Lok Sabha discussion, the MoHFW clarified that there is no plan as of now to expand PMJAY to other economic classes[14].

Policy Recommendations

It is evident that more public funding is required for the delivery of healthcare. To reduce the number of individuals in need of secondary and tertiary healthcare, primary health care systems must get the majority of that funding. This will serve to lower out-of-pocket expenditure and reduce the burden on health care systems. It's also important to prioritize spending on public health initiatives like clean air, hygienic conditions, and safe drinking water. Such preventive actions are crucial to reducing the number of persons in need of medical attention. To diversify the risk pool and provide coverage to a larger population, the PMJAY database should be updated and expanded to include new socioeconomic categories and demographic segments. This is significant since identifying the recipients of public health insurance coverage is one of the main obstacles. The States often offer healthcare facilities and public health initiatives. Consequently, it is crucial to guarantee that State governments have sufficient funding to undertake these initiatives. This might entail granting state governments the authority to impose additional levies or fees for healthcare services. Increasing the amount spent on public health

[12] Prinja, S. *et al.* (no date) *Impact of publicly financed health insurance schemes on healthcare utilization and financial risk protection in India: A systematic review*, *PLOS ONE*. Available at: https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0170996 (Accessed: 21 March 2024).
[13] National Health Authority, India. About pradhan Mantri jan Arogya yojana (PM-JAY). About Pradhan Mantri Jan Arogya Yojana. published online Feb 8. https://pmjay.gov.in/about/pmjay; 2021. Accessed 21 March, 2024.
[14] Choubey AK. Expansion of PMJAY scheme. Lok Sabha: Government of India; 2020. http://164.100.24.220/loksabhaquestions/annex/ 174/AU2081.pdf. Accessed 22 March, 2024.

and healthcare can be achieved in part by giving the states more financial authority and decentralization. To solve its shortcomings in providing social healthcare benefits, particularly to the missing middle class, the government must intervene in the current private healthcare system. The development of an efficient healthcare system that meets the requirements of marginalized classes must be the primary objective of the government. In the near future, the government must foster an environment that is supportive of private providers by stepping up its interventions to push them to raise the calibre and scope of treatment they offer while protecting their bottom line. A strong private healthcare service delivery system may be created by the combined efforts of the public and private healthcare sectors.

It is suggested that the Employee State Insurance Scheme (ESIC) be expanded in the future to cover not only blue-collar workers but also all formal sector workers. If this proves successful, the program can then be expanded to cover informal workers as well. In India, the Employee State Insurance Scheme (ESIS) is the most traditional health insurance program still in existence. It all started in 1948 when a parliamentary legislation put it into effect. The Employee State Insurance Corporation (ESIC), an independent government organization in India, is in charge of this program. Beyond overseeing this program, ESIC serves a variety of healthcare providers and offers contracted tertiary care at private hospitals. Thus, funding, acquiring, and supplying health care services are among the roles and areas covered by ESIC. A huge portion of the population, many of whom fall into the category of the "missing middle," would receive health insurance coverage much promptly if the ESIC program's scope was expanded. From a personal standpoint, this would strengthen India's ability to combat poverty and improve regulatory capacity, all the while guaranteeing that those who are most in need of assistance receive facilities and treatment when they need it. One of the main factors for individuals to fall into poverty has been out-of-pocket expenses, and the start of the epidemic has made matters worse. ESIC's role and jurisdiction need to be reorganized in order to support this extension of the current system.

Conclusion

In summary, the discourse around India's healthcare system exposes a complicated environment with notable differences in coverage, accessibility, and care quality. Although the government has made great attempts to solve these problems with programs like Universal Health Coverage (UHC) and other health insurance plans, a significant portion of the

population is still at risk of financial ruin because they do not have enough coverage. This group, also known as the "missing middle," consists of people who can neither afford private health insurance nor are they eligible for government-subsidized programs.

Covering the missing middle presents a variety of challenges, from difficulties with accessibility and pricing to flaws in the structure of the healthcare system. Even while there has been progress in increasing coverage, government-funded health insurance programs such as the Pradhan Mantri Jan Arogya Yojana (PMJAY) still do not fully cover this important group of people.

A comprehensive strategy that places equitable access to healthcare for all societal groups at the top of the list of objectives is needed to address the demands of the missing middle. This means investing in basic healthcare infrastructure, encouraging preventative measures, and increasing collaboration between the public and private sectors in addition to broadening the scope of current health insurance schemes.

The policy proposals include broadening the scope of formal and informal sector workers covered by the Employee State Insurance Scheme (ESIS), modernizing and diversifying the PMJAY database, and enabling state governments to take a more active role in the provision of healthcare.

In the end, India's goal of attaining universal health care would require a deliberate attempt to close the gap between desired policy outcomes and practical implementation. India may go closer to achieving its goal of providing all of its residents with inexpensive and accessible healthcare by attending to the particular requirements of the missing middle and strengthening the country's healthcare infrastructure at all levels.