

# Coverage and Buying Constraints of Health Insurance: Findings from Kolkata

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**Abstract :** *In India, the available options of health insurance are employment and income centric, but the coverage in the formal sector is still weak and assuming if income is not a constraint for many, all potential buyers are also not insured. This paper focuses on two aspects; firstly, health insurance coverage of households and their choice patterns of coverage in Kolkata by analyzing NFHS- IV (2015-16) data, and secondly, to understand the household's buying decisions for insurance subscription through a perception based survey in Kolkata.*

*The study findings reveal, Kolkata has significant number of households with insurance coverage (25.4%) with a higher number of households enrolled in Rastriya Swastha Bima Yojana (53.6%), followed by privately purchased schemes (18%) and employer-based coverage in 2015-16. The coverage rate has gone up by 7% since 2005-06 but shows a sweeping change by type of coverage. In addition, socio-economic factors rule out to some extent the coverage rates. Finally, buying constraints point out that a large number of potential buyers exist and are inadequately trapped because they lack information, many are risk-takers and do not value the importance of health insurance.*

**Keywords :** *Health insurance coverage, types of health coverage, employer-based insurance, potential buyers*

## Introduction

Government expenditure on health is usually low in India forcing many households to pay out-of pocket which is almost two-thirds of total health spending and this spending is majorly on private health care which includes two-third of the spending on outpatient care and one-fourth on inpatient care (Chaudhuri et al, 2015).

The demand for financial security opens up discussions and there has been continuous review of health financing system by experts and henceforth, numerous suggestions have been proposed. The guidelines suggested were on the principles of equity and universality and proposes universal health coverage to promote health at cost-effective price (Baru, 2006; Mahal and Fan, 2011; Reddy *et al.*, 2011).

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Though universal health coverage is still a distant dream in India; a mixed system of health financing models exists. These are state or public means providing insurance to the most under-privileged, employer-based coverage, and private health insurance to improve access to health financing, and market provisions are available for the general population. The state or public funded health schemes namely Rashtriya Swasthya Bima Yojana (for all states), SEWA in Gujarat, Yeshasvini in Karnataka, Dr.YSR Arogyasri in Andhra Pradesh, Rajiv Arogyasri in Telengana and Kalaingar in Tamil Nadu have supported thousands of low income families. As a result, in a short span of three years post 2007, there has been an increase in the number of beneficiaries in the informal sector of India. The growth of beneficiaries is from 75 million people in 2007 to 302 million people in 2010 (Reddy *et al.*, 2011). However constant review of many of these schemes mainly RSBY shows a large number of targeted group are being missed out (Ghosh and Datta-Gupta, 2017; Barai-Jaitly and Ghosh, 2018). Though, other sections of the population draw coverage from employer-based schemes and state-run schemes (Employee State Insurance Scheme and Central Government Health Scheme) and from market schemes, under insurance persists here too.

### **Methods and Materials**

The present study is based on two types of sources, both secondary and primary sources. Qualitative and quantitative information is collected from literature, government documents, health insurance scheme websites and offices for the study. In the present analysis the National Family Health Survey (NFHS) 4th Round conducted in 2015-16 which provides unit level information has been the principal secondary data source. The primary data captures 'buying' attitude mainly in form of anecdotes which has been collected through a household sample survey in Kolkata in 2012-13. This was done to understand the perception of households on the importance of enrolling in health insurance, the issue which is currently under-researched.

In India, data on the current coverage from all sources is not readily available otherwise it would have been easy to tap the actual coverage rate. The National Family Health Survey has been conducting sample based household surveys which began collecting health insurance coverage data for India since its third round. The other data source available is the information released by National Sample Survey Organization (NSSO).

A systematic sampling technique has been used to cover a total of 389 households for the primary survey, covering both insured (244) and uninsured (145) households. Insured households are further classified into employer (105) and marker-based (139) insured households for various levels of analysis.

The analytical methods involve univariate, bivariate and multivariate techniques. Univariate analysis involves finding out%ages, whereas bivariate

analysis is used to understand the association between dependent variables or two nominal variables with the help of cross-tabulation. Regression analysis is a subset of multivariate analysis that includes methods for predicting values of one or more response variables from one variable or more predictor variables.

## Results

### *Coverage in India*

Tapping actual health insurance coverage in India is still a difficult task, most information available are either sample based studies or population specific studies. According to a report released by NSSO, the 71<sup>st</sup> Round report showed a low coverage rate of health insurance. Nearly 86% of rural population and 82% of urban population were found not covered under any health scheme. About 13% rural and 12% urban poor was covered by Rastriya Swastha Bima Yojana and various other State-government and Central government schemes for both unorganized and organized sector workers (NSSO, 2016).

Table 1 illustrates the coverage rate in India and the respective urban-rural proportions. NFHS-III results for India show that around 5% of the sampled households, where at least one usual member is covered by a health scheme or health insurance in 2005-06. One-tenth of the households have coverage in urban India and rural households have very scanty coverage due to the problems of reach out. The %age change in health insurance coverage in 10 years has been commendable. In the current NFHS survey round (2015-16), 29% of the households in India are covered by health insurance. The urban-rural coverage gap is minimal depicting the success of various state and government sponsored schemes in reaching out to rural households.

**Table 1: %age of households, where at least one usual member is covered by any health scheme or health insurance, India, 2005-06 and 2015-16.**

| Region | %age of households covered by a health scheme or health insurance, 2005-06 | %age of households covered by a health scheme or health insurance, 2015-16 |
|--------|----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Urban  | 10.4                                                                       | 28.2                                                                       |
| Rural  | 2.2                                                                        | 28.9                                                                       |
| India  | 4.9                                                                        | 28.7                                                                       |

Source: IIPS, 2007 and 2018, NFHS – III and IV.

The coverage by types of schemes is shown in Table 2. In the third round of NFHS, by types of health coverage; households with privately purchased schemes and the Employees State Insurance Scheme (ESIS) are higher, followed by other schemes such as Central Government Health Scheme (CGHS) and other type of employer-based schemes. Henceforth, it is clearly evident from the coverage pattern

**Table 2: Type of health scheme or health insurance subscribed by households, India, 2005-06 and 2015-16.**

| Type of Health Scheme or Health Insurance | Percent of households insured by a scheme, 2005-06 | Percent of households insured by a scheme, 2015-16 |
|-------------------------------------------|----------------------------------------------------|----------------------------------------------------|
| <b>ESIS<sup>1</sup></b>                   | 26.1                                               | 4.9                                                |
| <b>CGHS<sup>2</sup></b>                   | 20.2                                               | 4.9                                                |
| <b>CHIP<sup>3</sup></b>                   | 5.4                                                | 0.6                                                |
| <b>OHTE<sup>4</sup></b>                   | 5.8                                                | 1.8                                                |
| <b>MRFE<sup>5</sup></b>                   | 11.5                                               | 1.6                                                |
| <b>OPPCI<sup>6</sup></b>                  | 27.1                                               | 4.1                                                |
| <b>SHIS<sup>7</sup></b>                   | NA                                                 | 48.7                                               |
| <b>RSBY<sup>8</sup></b>                   | NA                                                 | 33.9                                               |
| <b>Other</b>                              | 4.1                                                | 3.6                                                |
| <b>India</b>                              | 4.9                                                | 28.7                                               |

<sup>1</sup> Employees State Insurance Scheme

<sup>2</sup> Central Government Health Scheme

<sup>3</sup> Community Health Insurance Programme

<sup>4</sup> Other Health Insurance Through Employer

<sup>5</sup> Medical Reimbursement Through Employer

<sup>6</sup> Other Privately Purchased Common Health Insurance

<sup>7</sup> State Health Insurance Scheme

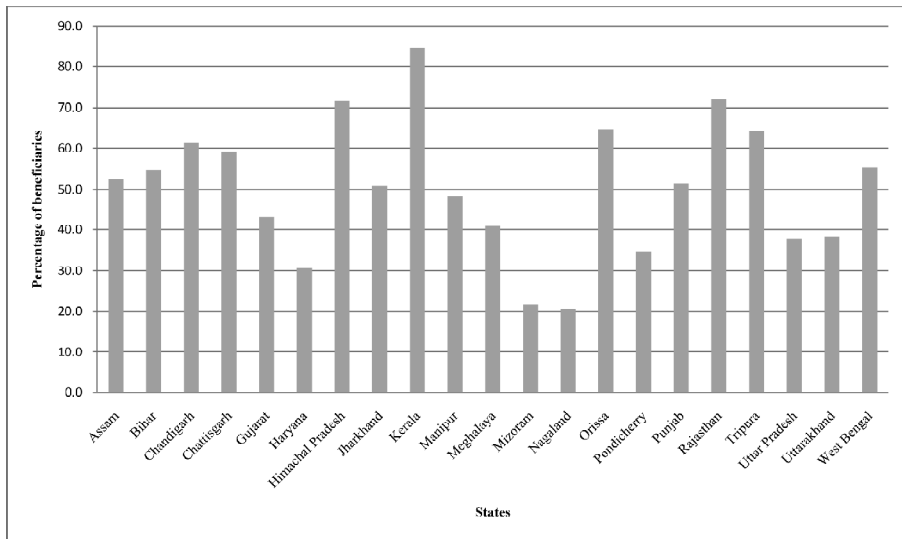
<sup>8</sup> Rastriya Swastha Bima Yojana

*Source: IIPS, 2007 and 2018, NFHS – III and IV. # NA – Non-Available*

that households are mainly covered by employer-based schemes indicating like many other countries, employment status as one of the major sources of obtaining coverage. There are significant numbers of households who obtain coverage by community based health schemes provided by non-governmental organizations (NGO) and other means. These types of schemes are common for the poor in developing countries since poor are not able to obtain coverage by any other means like employment or private health schemes, and also if social or public health insurance schemes are not available for them.

However, fourth round of NFHS reveal interesting results. Nearly half of those with insurance are covered by State Health Insurance Scheme (SHIS) and more than one-third are covered by Rastriya Swastha Bima Yojana (RSBY). These two categories of insurance provider were not included in earlier survey round; RSBY was launched in the year 2008 which is a country-wide coverage for BPL households and many State schemes were launched during the same period for organized and unorganized sector poor. The RSBY statistics are further evident from the actual enrollment data available from the online portal. By 2014 (the latest data available)

there were many States which were able to pull-up their enrollment rate beyond 50% (Figure 1).



**Figure 1: Enrollment of RSBY beneficiaries, India, 2014**

**Note:** Excludes states which have not started enrollment.

**Source:** <<http://rsby.gov.in>> retrieved on 2<sup>nd</sup> February 2014.

### Health Insurance coverage in Kolkata: A Regional Scenario

**Table 3: Percentage distribution of insured households by type of health scheme or health insurance, Kolkata, 2015-16.**

| Type of Health Insurance | Percent of households insured by a scheme | Number of households insured by a scheme |
|--------------------------|-------------------------------------------|------------------------------------------|
| ESIS                     | 5.2                                       | 10                                       |
| CGHS                     | 5.2                                       | 10                                       |
| SHIS                     | 3.6                                       | 7                                        |
| RSBY                     | 53.6                                      | 102                                      |
| CHIP                     | 1.05                                      | 2                                        |
| OHITE                    | 6.8                                       | 13                                       |
| MRFE                     | 3.1                                       | 6                                        |
| OPPCI                    | 17.8                                      | 34                                       |
| Other                    | 3.1                                       | 6                                        |
| <b>Total</b>             | <b>25.4</b>                               | <b>190</b>                               |

**Source:** Computed from Household data file, NFHS-IV, 2015-16.

According to preliminary examination of NFHS – IV, with 748 sampled households (which includes 375 slum and 373 non-slum households) in Kolkata, only 25.4 per cent of households have at least one usual member covered by a health scheme or health insurance (Table 3). Kolkata city has a higher coverage as compared to many other cities. Nearly fifty% of the insured households are covered by Rastriya Swastha Bima Yojana (RSBY), followed by Privately purchased health insurance scheme (about 18%) and the rest mainly through some form of employment based schemes (ESIS, CGHS, MRTE); all three consisting majority of

**Table 4: Percentage of households covered by health scheme or health insurance, according to background characteristics, Kolkata, 2015-16.**

| Background Characteristics     | Total Percentage of Households Insured |
|--------------------------------|----------------------------------------|
| <b>Highest education level</b> |                                        |
| Illiterate                     | 25.0                                   |
| Primary                        | 20.0                                   |
| Secondary                      | 23.0                                   |
| Higher                         | 31.9                                   |
| <b>Religion</b>                |                                        |
| Hindu                          | 31.8                                   |
| Muslim                         | 14.8                                   |
| Christian                      | 0.0                                    |
| Others                         | 0.0                                    |
| <b>Caste</b>                   |                                        |
| SC                             | 32.7                                   |
| ST                             | 33.3                                   |
| Others                         | 24.8                                   |
| <b>Wealth Index</b>            |                                        |
| Poorest                        | 14.3                                   |
| Poorer                         | 20.2                                   |
| Middle                         | 24.3                                   |
| Richer                         | 23.0                                   |
| Richest                        | 34.2                                   |
| <b>TOTAL</b>                   | 25.4                                   |

*Source: Computed from Household data file, NFHS-IV, 2015-16.*

the health insurance coverage in Kolkata. The State Health Insurance Scheme is currently underperforming and needs to speed up soon. The RSBY coverage rate is interesting however the success rate in terms of care-seeking needs future research attention, since early research evidences across geographies constantly point out to lack of financial protection (Devadasan et al., 2013, Ghosh and Gupta, 2017).

Health insurance coverage is determined by several factors and these vary regionally. Urban determinants are dissimilar with rural as in the former, the main determinants of health insurance coverage are income and employment status (Cunningham and Monheit, 1990; Fronstin, 1999; Jutting, 2000; Gupta, 2002; Gruber, 2008). By socio-economic differentials - education, caste and wealth index does not

**Table 5: Results of Logistic Regression for subscribing to health insurance, Kolkata, 2015-16.**

| Background characteristics    |        | Values |        |
|-------------------------------|--------|--------|--------|
| Highest education level       | B      | Sig.   | Exp(B) |
| Illiterate®                   |        |        |        |
| Primary                       | -.256  | .625   | .774   |
| Secondary                     | -.515  | .227   | .594   |
| Higher                        | -.367  | .138   | .693   |
| <b>Religion</b>               |        |        |        |
| Other®                        |        |        |        |
| Hindu                         | .262   | .367   | 1.236  |
| <b>Caste</b>                  |        |        |        |
| SC®                           |        |        |        |
| ST                            | .238   | .303   | 1.269  |
| Other                         | .333   | .604   | 1.365  |
| <b>Wealth Index</b>           |        |        |        |
| Poorest®                      |        |        |        |
| Poorer                        | -1.349 | .240   | .260   |
| Middle                        | -.719  | .068   | .487   |
| Richer                        | -.335  | .290   | .716   |
| Richest                       | -.540  | .055   | .583   |
| <b>Constant</b>               |        |        | 0.000  |
| <b>Psuedo (R<sup>2</sup>)</b> |        |        | 0.092  |
| <b>N</b>                      |        |        | 748    |

**Note:** ®Reference category.

**Source:** Computed from Household data file, NFHS-IV, 2015-16.

show wide disparity in coverage rates. Religion-wise disparities are higher; Hindus tend to be more covered by insurance than other religious groups. (Table 4). By caste group, coverage among the Scheduled Castes and Scheduled Tribes is higher than the city average (25.4%). Similarly, households with higher educational achievement, Hindu and richest quintile households show coverage rate higher than city average. This is further tested through the multivariate logistic regression which shows that the relationship between socio-economic variables and health insurance is not significant (Table 5).

### **Reasons for not joining any market-based health insurance scheme: Findings from Primary Data**

In this part of analysis the focus is mainly on the buying constraints of market-based schemes. This is important to tap the potential beneficiaries. Bundorf and Pauly's (2006) proposed that there are many 'insured unafforders' who buy insurance and there are 'uninsured afforders' who do not. It is widely known that employer provided insurance is generally meant for the people who have regular paid jobs and provision to it. It segregates many households who have self-employed jobs. Any loss in employment or switching of jobs or retirement results in losing of already enrolled employer provided health plan. Moreover, the current employer plan may not have sufficient coverage. These factors may lead to household's decision in covering themselves with an additional plan. In addition, uninsured households who have potential to buy are also out of coverage. To be optimistic about future coverage growth rates some study concludes that increased income and health consciousness can rule out buying decisions (Anita, 2008 cited in Chaudhuri et al, 2015 and Mathur and Ujjwal, 2015).

Since market-based schemes are available voluntarily, and many potential buyers can buy insurance are still out of coverage, thus this part of the study emphasizes on the reasons for not enrolling. For the analysis, the sample size taken is 250 households. This includes households who have no coverage at all (145) and those who have coverage only from employer based schemes (105), as the later is more likely to lose coverage once they switch job or retire. Only some government sector jobs offer post retirement health plans with several clauses attached.

The primary reason stated by uninsured households for not enrolling in any health plan is that they cannot afford premium amount. Low income is the main reason for unaffordability status. Nearly one-fourth of the households reported that they earn a living below Rs 30,000, with moderate to high monthly household expenses. Moreover, households do not take the benefits of insurance seriously as they have not seriously thought about the importance of health insurance and do not need or do not want insurance (Table 6). Thus income and perceived need influence buying decisions.

Other than the uninsured households, many employer covered households have opted out of private health insurance coverage (Table 6). The main reason for not enrolling is their present coverage due to which they do not feel the need for enrolling in any other policy, followed by not thought about other insurance option seriously. Moreover, these populations are least worried about losing employer-based insurance in case of change or loss of current job. This indicates how coverage by one scheme reduces the scope of other and increases the risk of losing current coverage in future. The proportion of households who can continue their employer based scheme even after retirement is very less, but this is another reason associated with not enrolling in any health plan from the market.

**Table 6: Reasons for not joining any market-based health insurance scheme by insurance status, Field Study, Kolkata, 2012-13.**

| Reasons                                              | Employer-based Insured | Uninsured  | Total      |
|------------------------------------------------------|------------------------|------------|------------|
| Already covered by employer                          | 41.9                   | 0.0        | 17.6       |
| Cannot afford premium amount                         | 11.4                   | 25.5       | 19.6       |
| Do not need or do not want insurance                 | 8.5                    | 17.2       | 13.6       |
| Not seriously thought about it                       | 24.7                   | 18.6       | 21.2       |
| Can continue health scheme (EBI) after retirement    | 3.8                    | 0.0        | 1.6        |
| Do not know how to enroll/Do not know about programs | 4.7                    | 18.6       | 12.8       |
| Others                                               | 4.7                    | 20.0       | 13.6       |
| <b>Total number of households</b>                    | <b>105</b>             | <b>145</b> | <b>250</b> |

*Source: Computed from Primary data.*

Quantifying some of the responses is not possible. The reasons given by the respondents for not joining any health scheme that are available from the market have been recorded and presented here.

One of the uninsured respondents said, “At the time my parents planned to enroll in a policy, the provider was not offering the benefits they wanted. There were number of exclusions (due to old age and pre-existing diseases). And the benefits were lesser than the cost of insurance. This made my parents to stay out of coverage. And I am young so I do not want to enroll now, but surely after some years. Any plan that would cover the benefits my parents want can change their mind to join. Otherwise, my parents will have no option other than staying uninsured”.

Other uninsured respondents who also evaluated health insurance on lack of benefits think, *“Benefits are less than the cost of insurance”*.

Some retired or unemployed respondents said, *“Paying premium for health will be an extra expense now. Meeting daily need is difficult, so how can one pay for health”* uninsured respondent.

Many uninsured respondents said, *“Not thought seriously about subscribing to insurance and now due to old age, no eligibility. If given opportunity and feasible premium cost is offered, then can think of joining”*.

*“Until the time of retirement I and my family were covered by medical insurance through employer. But after retirement I lost coverage and subsequently my family. Did not have any idea about losing coverage after retirement. Private health insurance was a new concept then and I was not aware of it”* uninsured respondent.

*“Paying premium every year without any utilization of healthcare services seemed to be loss of money, since there is no return of money. That is why thought of staying out of coverage and instead save money personally for medical expenses”* uninsured respondent.

*“My relatives have experienced monetary loss after being insured, and hassle during claim period. Seeing their turmoil, I donot feel like joining any health plan. If these things are improved in the health insurance sector then I can think of joining”* uninsured respondent.

Uninsured households with aged individuals replied saying that, *“not aware about any programs which can cover aged people”*. *“Cannot pay high premium amount”*.

*“I have savings. My family and I will manage with our savings”* uninsured respondent.

*“I already have coverage from employer, and I still have time to enroll later”* employer-based Insured respondent.

*“I am covered by employer until retirement time. At the age of 50 years I would like to enroll myself and my family. As for now, it seems to me paying for another health plan is wastage of money because occurrence of hospitalization cases is usually low. And yes I am aware of the high premium charges at that age, but I am ready to pay yearly Rs 10, 000 or a little more at that time”* employer-based Insured respondent.

*“Why do I purchase insurance when it only covers hospitalization costs? And how many times does a person gets hospitalized? If there are chances, I would still not think of purchasing. Whatever happens I am ready to take the risk”* uninsured respondent.

*“I am not aware of the policy details and never took interest in knowing more about them”* uninsured respondent.

The above responses reveal that, those households who have expressed unwillingness to enroll in market based insurance schemes did so mainly due to low utility returns (illnesses or diseases coverage and low amount covered for hospitalization). It also seems that the households have prioritized other things over health and are also confident enough to avert health risk followed by some cases of limited knowledge about right time to enroll for paying low premium amount. However, the above statements also clearly indicate that, there is willingness among some of the households to enroll. Those who want insurance don't have the ability to pay so they have remained uninsured and some have left on time. Post retirement it becomes difficult for people to enroll in market based policies because of the high cost of insurance against age related health risks. Many families have put their savings at risk to pay for health care out-of-pocket since they think paying premium amount yearly without any healthcare utilization will generate zero return (value for money).

Besides income, age has been found to influence health insurance purchasing decision. Young adults have a tendency to stay uninsured as long as they feel they can avert risk. For the older adults however, income, age and level of awareness about the details of the schemes available to them are the constraint factors to pay for insurance premium. When to enroll and how to enroll continues to affect many families in making purchasing decision. People who have been ignorant of details about health plans and did not take health insurance seriously, also continue to remain deprived of health care benefits.

## **Discussions**

As revealed from secondary data, overall health insurance coverage in India has improved over a decade (2005-06 to 2015-16), indicating better enrollment rates. The health insurance providers are many; employer, market-based and publicly funded. Higher coverage households are however by public funded schemes that is, by State Health Scheme and RSBY as revealed by the recent round of NFHS-IV. This comes as a surprise as constant review of underperformance in meeting the targeted population and low enrollment rates since RSBY's launch in 2008 has been demanding government intervention. The findings also highlight the fact that many potential buyers are still out of coverage. This includes both the working class in the organized sector and self-employed jobs and their families.

The regional level Kolkata city analysis is partially consistent with earlier studies (Cunningham and Monheit, 1990; Fronstin, 1999; Jutting, 2000; Gupta, 2002; Gruber, 2008), who have pointed out that better income and employment are found to be the main influencing factors to stay insured in many developed and developing countries like India. Though Kolkata show highest coverage by RSBY but it has significant number of households with privately or voluntarily purchased scheme

indicating market based schemes has the potential to grow and become a significant provider of health insurance. The other major insurance provider found is through the employer in the organized sector. This is also a high potential provider but lacks satisfactory coverage mainly firms which work with limited human resources.

Lastly, the primary survey findings reveal buying constraints can be categorized as low income and lack of need. In addition to these a number of households reported they have not seriously thought about enrolling and also lack information on how to enroll who could be future potential buyers. It is also clearly evident that, there is inadequate association of income with the current status of “market-based uninsurance” among the employer-based enrollees. Many of them prioritize other consumption goods over health insurance and do not value the importance of health insurance. Moreover, the amount of confidence in taking financial risks is also evident from the anecdotes. This is seen both in case of uninsured households as well as the already insured households who are in a risk of losing current coverage. Misinformation along or rather lack of information about the benefits of insurance is another factor evolved from the qualitative enquiry. Chaudhuri et al, (2015) observes similar controlling factors such as lack of awareness and affordability for low enrollment rates in private insurance, but suggests that right information could raise the enrollment rates among other income groups.

Further, age has been a significant factor in determining enrollment status. Young adults are tender in their decisions and show high risk takers, in contrast, the old do not have much choice as prior illness and high premium amount charged for old enrollees act as a barrier. Thus, considering Bundorf and Pauly's (2006) theory on non-coverage of potential buyers who can afford market-based health schemes, there is a need for intervention through proper channels to stimulate coverage growth rate among the uninsured as well as the employer-insured who are likely to be uninsured.

State-funded or public funded schemes may continue to enroll the non-targeted population as long as universal health coverage is not introduced, but to cut short the wait, these non-targeted afforders population can seek the market available option to avoid catastrophic health expenditure.

## **Conclusions**

The discourse of the results has ruled out that health coverage is still low in our country and the financial risk across populations is tremendous. The government needs to raise the bar to accommodate many households who fall above the poverty line but fall into the poverty trap due to various episodes of illness and subsequent loan burden debts. In addition, understanding the cause of un-insurance is very important to build our knowledge on whether better income groups can be secured through private health insurance until government launches universal coverage schemes. This part of analysis has focused on a small regional context with an expectation that human behavior pertaining to this issue may remain nearly

same across geographies as also evident from limited studies (Chaudhuri et al, 2015 and Mathur and Ujjwal, 2015).

Understanding un-insurance or underinsurance is a necessary step to be taken forward in a time when medical discoveries have allowed people to live much longer than before, and the growing concern is still on the changing morbidity and mortality patterns. New emerging diseases and related threat to life immediately challenge health policy makers and medical experts to identify the problems in eradicating or reducing illness impact on human life and consequent financial burden. It is well perceived that attitude of people do not change over time but many reluctant potential buyers may buy insurance under the present pandemic situation.

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