Community Health Insurance in India

A COMPILATION OF CASE STUDIES

Friends of Women's World Banking, India

CONTENTS

PREFACE

Health Insurance has hitherto been confined to the four general insurance companies and for them it is a business proposition only. They neither consider it as service nor attach any social norms to connect it to community health care. The concept of community health care and insurance is of recent origin. Community health insurance, in fact, is an alternative form of financing health care.

Community health insurance having its roots in Africa is now slowly coming to Asia. The strength of community health insurance is that it is owned by the community itself and as such there is a strong will to make it a success.

Some of the community health schemes in our country are largely based on European models pioneered in Germany. Some others are co-financed by governments. In Germany, Belgium, Netherlands and Japan it all started with sickness funds. They grew over years and merged with each other to form mutual funds or insurance companies. Thus global experience is in favour of community health insurance. Of the thirty community health schemes in the country, ten are described in detail in this book. The purpose of the book is to discuss the various methods used by NGOs and CBOs to finance the health care via the insurance route. Since community health insurance in our country is in an embryonic stage, it needs technical and financial support. If this publication is successful in enlightening at least a fraction of the population, its purpose is served.

Ahmedabad
7 April 2005

M.V.S. Pasupathinath

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ABBREVIATIONS

AAAHI	Accord-AMS-Ashwini Health Insurance
ACCORD	Action for Community Organization, Rehabilitation and Development
AMS	Adivasi Munnetra Sangam
ANMs	Auxiliary Nurse Midwives
APL	Above the Poverty Line
ASHWINI	Association for Health Welfare in the Nilgiris
BPL	Below the Poverty Line
CBHI	Community-based health insurance
CBO	Community-based Organization
CEO	Chief Executive Officer
CFPD	Centre for Population Dynamics
CHI	Community Health Insurance
FHPL	Family Health Plan Ltd.
ICDS	Integrated Child Development Scheme
IEC	Information Education and Communications
IP	In Patient
ISSS	Integrated Social Security Scheme
KKVS	Kadamalai Kalinjam Vatara Sangam
LFAs	Lay First Aiders
LIC	Life Insurance Corporation of India
MAP	Medical Aid Plan
MGIMS	Mahatma Gandhi Institute of Medical Sciences
MHCs	Mini-Health Centres
MIS	Medical Insurance Scheme
Misereor	A Donor Agency
MOSC	Malankara Orthodox Syrian Church
MPWs	Multi-Purpose Workers
NIAC	The New India Assurance Company Ltd.
NIC	National Insurance Co. Ltd.
OP	Out Patient
OPD	Out Patient Department
PHC	Primary Health Centre
RAHA	Raigarh Ambikapur Health Association
RHCs	Rural Health Centres
RSAIC	Royal Sundaram Alliance Insurance Co. Ltd.
SALDAR	Landless laborer employed on yearly contract
SC	Scheduled Caste
SCUs	Swasraya Credit Unions
SEWA	Self-Employed Women's Association
SHADE	Self-Help Association for Development and Empowerment
SHGs	Self-help Groups
SHH	Student's Health Home
ST	Scheduled Tribe
TPA	Third Party Administrator
UIIC	United India Insurance Co. Ltd.
UNDP	United Nations Development Programme
VHS	Voluntary Health Services
VHV	Village Health Volunteers
VHWs	Village Health Workers

FINANCING HEALTH CARE

INTRODUCTION

Health care is usually considered a service industry and is financed by various means. The most equitable is when the government finances it through general taxes, as in the United Kingdom. The National Health Services are totally funded by general taxation and this implies that everybody contributes towards the health care, according to their capability. Thus the rich pay more (taxes) while the poor pay less. This is also the strategy used in India, where the government becomes both the financer and provider of health care. However in India the amount of government financing (0.9% of GDP) is inadequate. This means that the government health services provide poor quality of health care. Thus most patients (more than 80%) prefer to use the private sector by paying from their pocket.

OUT-OF-POCKET PAYMENT

Out-of-pocket payment is the most common method used to finance health care in India. Current estimates show that about 80% of OP costs and about 50-60% of IP costs are met by OOP. Here the patient pays for services at the time of illness. It is the most inequitable form of financing health care. This is because the poor usually have higher prevalence of morbidity and are more prone to illness. Because of this they have to spend more for health care than the wealthy. Thus the most vulnerable are affected most by this form of payment.

SOCIAL HEALTH INSURANCE

Social Health Insurance is yet another good way of financing the community. Pioneered in Germany and other European countries, the working population contributes to an insurance fund that takes care of the health needs of the entire population (working as well as non-working). Thus there is a sharing of responsibility between the sick and

the healthy, between the wealthy and the poor and between the economically active and the inactive. In India, we have two such examples – the CGHS and the ESIS. Unfortunately, both these schemes limit the beneficiaries to only those who have contributed and their families. Thus these schemes maybe seen as a limited version of SHI.

PRIVATE HEALTH INSURANCE

Private Health Insurance is the most popular way of financing health care in USA. This is the capitalist version of the health insurance concept. Here those who can afford to pay premiums are allowed to join the insurance. Thus usually only the wealthy or the employed are members of this insurance. The benefits are limited only to the members. To protect the weaker sections, the government may subsidize the premium e.g. Medicaid or Medicare (for the elderly). But like all subsidized programmes, this does not cover everybody. It is estimated that about 20% of Americans do not have any form of health insurance cover.

COMMUNITY HEALTH INSURANCE (CHI)

Community-based health insurance (CBHI) is defined as "*any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and the members participate in its management*."

Community Health Insurance is a recent innovation that has taken roots in Africa and is now being introduced in Asia. CHI uses the strategy of health insurance wherein people pay a small contribution at the beginning itself. These contributions are pooled to provide benefits (medical costs) for those who need it. The distinctive feature in CHI is that the community usually initiates and manages it. This difference is very important, as it implies that the CHI is developed to meet local needs. The main strengths of a CHI are that it is owned by the community and there is a strong will to make it a success. The design suits the local needs and requirements. And finally the scheme is usually co-managed

by the people, so the administrative overheads are low. Its main weakness is that it is small and so the risk sharing is low. This makes such schemes vulnerable to bankruptcy in the event of any catastrophe. Also there is limited technical expertise and this may be a major handicap to make the scheme effective and efficient. And CHI like all insurance programmes does not protect the poorest segments of the population.

Currently there are about 30 such schemes in our country and there are three broad models – the provider model, the insurer model and the linked model (see Figure 1). In the provider model, the initiating NGO is both the insurer and the provider of care. In the insurer model, the NGO is the insurer and assumes the financial risk of managing the fund. Independent institutions provide the care. And finally in the linked model, the NGO collects the premium but passes this onto an insurance company. Similarly independent institutions provide health care.

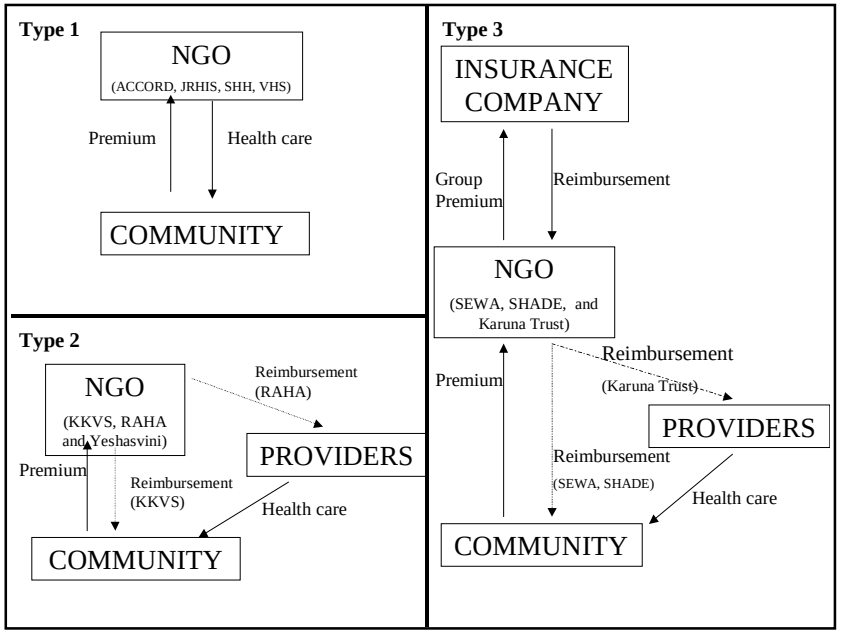
About ten of these CHIs are described in some detail in the following chapters[1]. The main purpose of these case studies is to document the various methods used by the NGOs and CBOs to finance health care through health insurance strategy. CHIs (also called micro-health insurance) are still in an embryonic stage and require technical and financial support. As of date, these micro-health insurance activities are outside the ambit of the IRDA and its regulation. However, this will change over time.

What is the future of these CHIs? Can they meet the insurance needs of one billion Indians? The insurance scenario in India is one of multiple pools. We have the upper class, the middle class, and the poor. In each of these classes, there are different categories, e.g. those in the formal sector, those in the informal sector, those who are self-employed, those who are unemployed etc. Given this state of affairs, it is imperative that

[1] These case studies were conducted in the second half of 2003. Since then the CHIs may have undergone some changes and hence there may be some discrepancy between the written document and field reality.

India will have multiple insurance schemes. And CHI will then be an useful strategy to protect the near poor and the low income groups, especially in the organized sector like cooperatives, trade unions and self-help groups. This potential needs to be exploited to ensure that more Indians are protected against high medical costs.

Figure 1. Models of CHI in India



PROVIDER-BASED MODELS

The ACCORD – AMS – ASHWINI Health Insurance

INTRODUCTION

The ACCORD – AMS – ASHWINI Health Insurance (AAA HI) is managed by three organizations, ACCORD[2] - an NGO; AMS[3] - the tribal union and ASHWINI[4] – an health provider. It was initiated in 1992 to provide health insurance coverage to all the tribal members of the AMS living in Gudalur Taluk.

Its main objectives are:

1. To access health care with dignity by not depending on charity or handouts
2. To encourage health seeking behaviour by offering comprehensive health care with minimal payment at the time of use of the services
3. To enhance the feeling of solidarity among the members of the AMS
4. To protect the AMS members from catastrophic health expenditure
5. To enhance the feeling of ownership of the health programme among the members of the AMS by contributing towards their own health care.
6. To provide a stable income for the ASHWINI hospital.

The AAA health Insurance scheme is a part of a comprehensive development programme. ACCORD, the parent NGO, was started in 1986 and works among the tribals of Gudalur. Its main objective is to empower the tribals to fight for their own rights. ACCORD also provides

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This article has been written by S. Manoharan, N.K. Menon and S. Menon of AMS Team with the guidance of Dr. N. Devadasan

2 Action for Community Organization, Rehabilitation and Development

3 Adivasi Munnetra Sangam

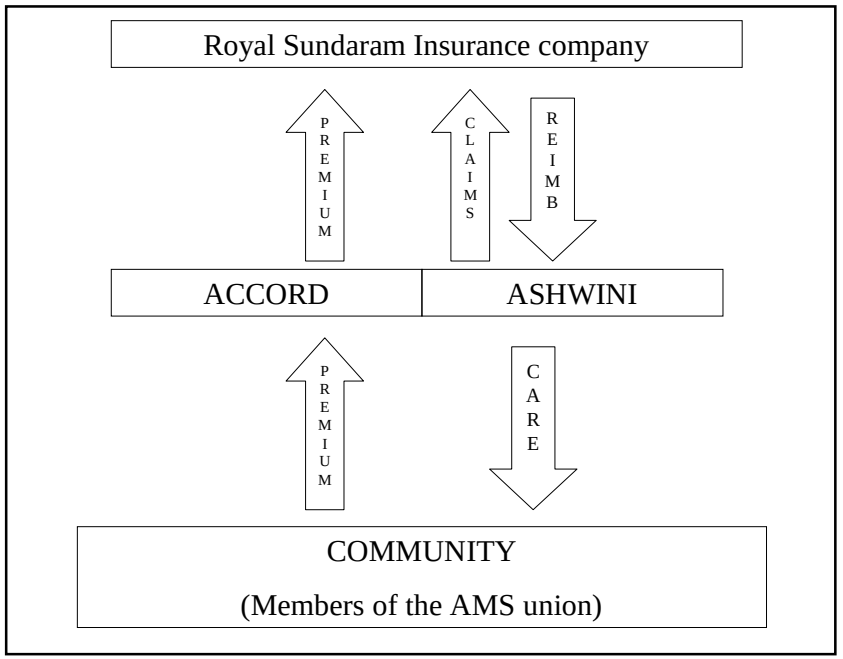
4 Association for Health Welfare in the Nilgiris

services like health, education, agricultural support, housing and animal husbandry. All this is done through the community-based union of tribals called the AMS. ASHWINI, the sister NGO was started in 1990 to take over the health programme. The ACCORD / ASHWINI health programme consists of promotive, preventive and curative care.

Design

The AAA health insurance scheme has to be viewed from two distinct levels. One level is the arrangement between ACCORD / ASHWINI and the insurance company and the other level is the arrangement between the tribal community (AMS) and ACCORD / ASHWINI. The premium, benefit package and administration vary for these two levels.

Figure 1: The design of the AAA Community Health Insurance Programme.



THE COMMUNITY

All the members of the AMS (~12,000), between the age of six months and sixty years and residing in Gudalur Taluk, are eligible to join this scheme. These members are distributed all over the Taluk over a radius of 50 km. Most of the Taluk is heavily forested and the terrain is hilly. The tribals are traditionally hunter-gatherers and also daily wage earners – earning an average of about Rs 1000 pm (~ US$ 22 – Nov 2003). The local economy is a plantation economy, mostly tea and some coffee and pepper. Most of the tribals work as casual labourers in these estates. Some have small land holdings and grow paddy or tea or coffee and pepper.

THE INSURER

The formal insurance company is the prime insurer of this scheme. From 1992 to 2002 it was the New India Assurance Company (NIAC) and then from 2003, it is the Royal Sundaram Alliance Private Limited.

PROVIDER

ASHWINI is the main provider of health care. ASHWINI has a network of village health workers, 7 health centres (manned by nurses and distributed all over the Taluk) and a 20-bedded hospital with all basic facilities. The health centres provide a mixture of curative and preventive care. The hospital provides medical, paediatric, surgical and obstetric care and has a well-equipped laboratory.

PREMIUM

As stated above, the premium has to be seen at two distinct levels.

In 1992, ACCORD / ASHWINI / AMS negotiated with NIAC to insure all the AMS members for a period of five years. This enabled AAA to avail of the long-term discount as well as the group discount. Besides, AAA limited the coverage to Rs 1,500 and reduced the annual premium from Rs 48 to Rs 13 per person per year. ACCORD thus paid the premium

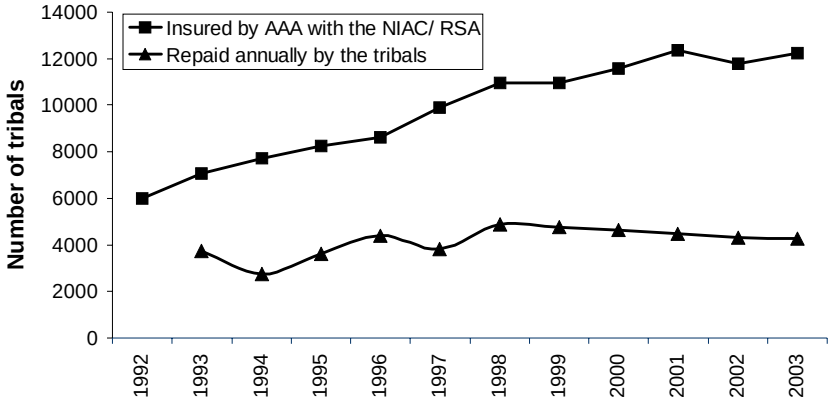
of Rs 65 per tribal (Rs 13 per year for five years) and covered 6000 tribals in the first round. The lump sum amount of Rs 3,86318 was provided by CEBEMO, a Dutch agency. New members who joined subsequently were enrolled on a pro rata basis. The scheme was renewed in 1997 for another five years. The premium remained the same and once again CEBEMO / BILANCE helped AAA meet the lump sum payment of Rs 4,83,000 to insure 9000 tribals for five years.

In 2002, NIAC substantially hiked the premium, and as such ACCORD / ASHWINI / AMS approached Royal Sundaram Alliance Pvt. Ltd. They agreed to provide hospitalisation coverage up to a limit of Rs 1000 for a premium of Rs 20 per tribal per year. The AMS members have been insured for a year from 2003 – 2004.

The tribals were not able to pay the lump sum amount of Rs 65 towards the premium. So it was collected in annual instalments. In the initial years, as insurance was a new concept, the premium was heavily subsidized. In 1992, no premium was collected, but in 1993, the AMS members were asked to pay Rs 4 per person per year. In the next year, this was raised to Rs 6 per person and in 1995, Rs 8 was being collected. Thus by the year 1997, the entire annual premium amount was being paid by the tribals. In the subsequent years, the premium amount was raised and currently they pay Rs 22 per tribal per year.

Thus while the ACCORD / ASHWINI insured tribals *en masse* with the formal insurance company and paid their premiums, upfront; the tribals repaid this premium on an annual basis.

Figure 2: Enrolment into the insurance programme (1992 – 2003) and annual repayment



This is a community rated premium and is collected on an annual basis between December and March. Those who pay are given a receipt and an insurance card with the details of the subscribed members and the unique 8 digit AMS membership number. The premium is collected and handed over to ASHWINI at the end of the collection period. Figure 2 shows the AMS members who have been insured with the insurance company every year as well as the number of tribals who have repaid every year.

BENEFIT PACKAGE

The benefit package also has to be viewed from two levels. A package provided by the insurance company to ASHWINI and another (more comprehensive) provided by ASHWINI to the tribals.

NIAC assures only hospital care with an upper limit of Rs 1500 per patient per year. It also has important exclusions – pre-existing illnesses, diseases due to substance abuse and self-inflicted illnesses. Deliveries and family planning operations were initially excluded, however, while

renewing the policy in 1997, ACCORD managed to include the first two deliveries and family planning operations into the benefit package. The current policy with RSAIC covers hospitalisation up to Rs1000 and the first 2 deliveries up to Rs500. There are no exclusions (except psychiatric illnessses).

As per the initial policy there was additional coverage for damage to hut and personal accident of the head of the household. However, this was removed in 1997 as AMS felt that this coverage was not very beneficial. While removing this coverage, the company agreed to replace it with the pregnancy cover.

While the above was the benefit package provided by the NIAC to ACCORD, ASHWINI provides a more comprehensive package to the tribal patients. For the insured patient, both OP and hospitalisation is provided for a small copayment of Rs 10 per visit. There are no exclusions and no upper limits. If required they may be referred to a tertiary centre like the Government Medical College at Calicut for further treatment. The patient has to pay only for the food and ambulance expenses.

ASHWINI also provides promotive, preventive and basic curative care through its network of VHWs (Village Health Workers) and Health Centres. This benefit is provided to all the AMS members, irrespective of their insurance status.

While theoretically the patient has to be referred by the Health Centre for admission, in reality this is not adhered to very strictly.

Thus while the formal insurance company provides a hospitalisation package, ASHWINI uses its resources to provide a more holistic cover. External resources as well as from the profits generated from non-tribal patients meet the difference in the benefit package.

As ASHWINI provides comprehensive care, it encourages people to live a healthy life and to seek care at the earliest when ill so that problems

are addressed close to home at the area centre or at the hospital. This cuts down morbidity and expenses - a truly win-win situation. This positive feedback loop is the greatest strength of the programme.

CLAIMS AND REIMBURSEMENTS

At the end of the hospitalization, three copies of the hospital bill are made. One copy is handed over to the patient (but the patient does not pay any amount). One copy is kept for records and the third copy is forwarded by ASHWINI to the insurance company (on a monthly basis). Claims are made to a maximum of Rs 1000 only. Any excess of Rs 1000 is met from ASHWINI's general funds.

The average hospital bill is about Rs 750 per patient per episode of illness. This is a slightly subsidized cost as the doctors and the nurses draw relatively low salaries.

The insurance company in turn reimburses ASHWINI on a regular basis. The lag time with NIAC was around 3 – 6 months, but with RSA it is less than a month. The reimbursement rates have been in the range of 95 – 100%.

REINSURANCE

As stated earlier, the AAA Health Insurance reinsures with the NIAC (and now with the Royal Sundaram Alliance Insurance Company Private Limited) to cover the risks. This has resulted in ASHWINI being able to cover more risks. This is shown clearly in Table 1.

Table 1 – Claims ratio of the AAA Health Insurance scheme

	Premiums paid by AAA to NIAC (INR)	Reimbursements by NIAC (INR)	Claims ratio
1992 – 1997	435,722	594,566	136%
1997 – 2002	594,566	1,268,051	213%
Total	**1,030,288**	**1,862,617**	**181%**

ADMINISTRATION

ACCORD, AMS and ASHWINI do most of the administration of the programme.

Collection of premium

The ASHWINI and ACCORD field staff as well as the AMS leaders collect the premium. The field staff has other work and collecting premium is an additional responsibility that they have undertaken. The AMS leaders do it on a voluntary basis. A system of receipts and strict accounting measures prevents fraud.

Claims and reimbursements

The ASHWINI accountant processes the claims and submits it to the NIAC. The patient does not have to provide any documentation, except to bring along the Insurance card at the time of admission.

RISK MANAGEMENT

Measures to control adverse selection

While the individual is the unit of enrolment, AAA encourages family enrolment. Also for the insurance company, there is very little adverse selection as the entire tribal community is enrolled. There is an initial waiting period of 30 days and a definite collection period. All these help in limiting adverse selection.

Measures to control moral hazard

Provider induced moral hazard is negligible as the medical officers are paid a fixed salary. So there is no incentive for cost escalation. Most of the disease conditions are treated using a standard treatment protocol. Patient moral hazard is minimized by the fact that patients have to incur all indirect costs e.g. transportation, food costs, loss of wages and cost of accompanying relatives. These are an effective deterrent to unnecessary hospitalization.

Measures to control cost escalation

Cost escalation is minimal as there is no incentive for the providers. Also generic drugs, an essential drug list and standard treatment guidelines help in keeping costs low as well as standard. This plus the fact that most of the staff draw very low salaries help in containing costs well below the market rates.

ACHIEVEMENTS

Coverage

The coverage of the AMS members is shown in Figure 2. The average coverage was initially in the range of 50% - 60%, but has now declined to around 35%. Various reasons have been attributed to this fall in coverage. One important reason is the fall in income of the households due to the fall in tea prices. Further analysis needs to be done to understand this fall in coverage.

Utilization

The utilization of the hospital has been high – ranging from 105 to 150 per 1000 insured member. While this is much higher than the national average, it is in keeping with the Kerala's figures (Gudalur Taluk is adjacent to Kerala). This is shown in Fig 3.

Cost recovery

One of the objectives of the AAA CHI was to mobilise resources from within the community. But it was never intended that the insurance programme meet the entire costs as the founders felt that it was not equitable for the poorest to bear the total burden of their health care. Thus throughout the 11 years, efforts were made to supplement the community efforts by raising funds from other sources. The details of the premium recovered from the community are given in Table 2. While the overall recovery is 48%, in the second half, it has reached 67%. This figure could be improved with better coverage. And with larger risk

Figure 3: Hospitalisations among insured and non-insured tribals (1993 – 2002).

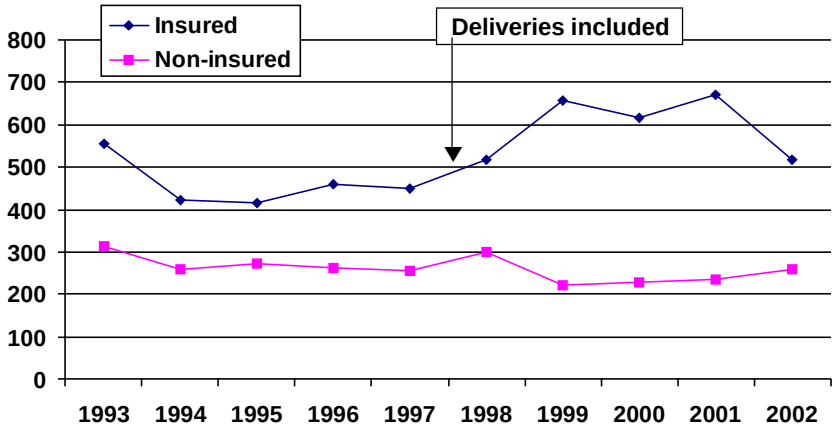


Table 2: Premium paid to insurance company and repaid by tribal community.

	Amount paid to the Insurance companies as lump sum amounts	Amount repaid by the tribals on an annual basis
1992	386,318	
1993	44,296	14,904
1994	20,372	16,464
1995	10,513	28,992
1996	3,904	43,950
TOTAL	**465,403**	**104,310**
1997	523119	45,739
1998	36689	58,784
1999	18236	71,515
2000	11066	78,518
2001	34478	75,895
2002		85,820
Total	**623588**	**416,271**

pooling through the insurance companies, the AAA CHI has been successful in risk sharing between the rich and the poor.

CONCLUSIONS

The AAA CHI is an example of a direct provider model with reinsurance. Some of the unique features of this model are that there is considerable community involvement at all stages, the provider has transferred the risk by reinsurance and a comprehensive package is provided to the patients. A combination of good quality comprehensive care and minimal administration has made the AAA CHI acceptable among one of the poorest sections of Indian society.

The Jawar Health Assurance Scheme

INTRODUCTION

The Jawar Health Assurance Scheme is a unique scheme managed by Dr. Ulhas Jajoo, Professor of Medicine, Mahatma Gandhi Institute of Medical Sciences, Wardha, and his team. It is one of the earliest scheme in which the contribution was collected in kind (Jawar/ Sorghum) to ensure access to timely health care service. The basic principle on which the scheme is based is that everyone must have access to quality health care, irrespective of their ability to pay, but everyone must contribute to it as per their ability. Hence it is known as an assurance scheme.

Though the scheme was initiated by Dr. Jajoo in 1979, the genesis of the scheme runs back to early 50s. Following Gandhiji's assassination in 1948, the management of the hospital was taken over by 'Gandhi Smarak Nidhi', which in due course of time could not manage the hospital finance and wanted the government to take over the hospital administration. The workers were unhappy with this and consulted village leaders, who offered their contribution in the form of Jawar.

Dr. Jajoo resolutely believes that charity corrupts people and people must pay to demand quality service from the providers. He has visited various voluntary health projects of repute in India. From his observation emanated a belief that mere benevolent service will breed a relationship of dole giver and beggar between the provider and the beneficiary. Moreover the schemes were heavily financed thereby posing a threat to their long term sustainability. The tradition of contributing as per one's capacity already prevailed in the villages especially for ceremonial purposes and for construction of temples. The same strategy was agreed

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upon by the villagers and it was therefore decided in consensus with the villagers to create a pool of contribution to meet their health needs.

OBJECTIVES OF THE SCHEME

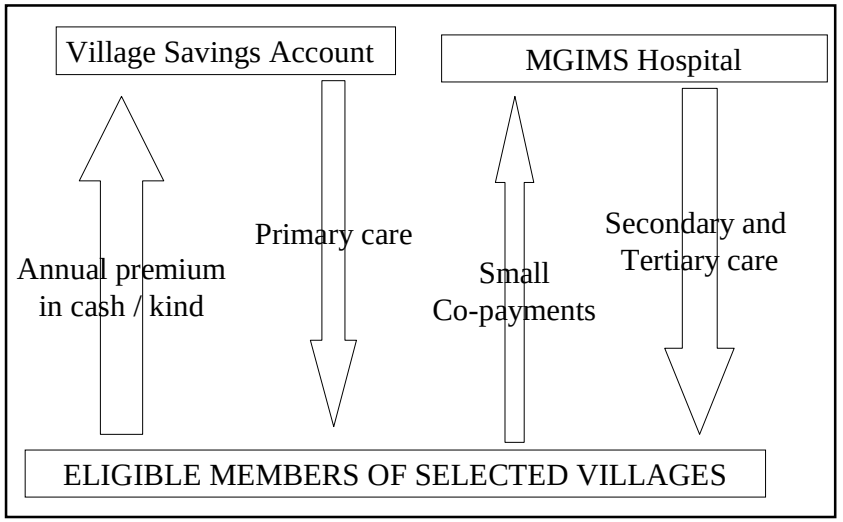
- To generate demand for quality health care to meet health contingencies.
- To make health care services not merely available but accessible to the poorest of the poor.
- Considering village as a social unit, an integral part of the larger society, to make health care services available to more than 75% of the village population with their active participation.
- To create a system to deliver appropriate and prompt health care services to the needy, irrespective of the amount of contribution.

The whole process began with a dream of Gram Swarajya where health was chosen as a medium of entry into the rural life. There has been a paradigm shift in the scheme from an initial focus on curative care to preventive and further to promotive care. It didn't stop there and with perpetual experience and learning shifted the focus on social aspects, which now rests on moral issues.

DESIGN

The contribution from the people, either in cash or kind, is collected by the VHW, which is either in cash or in kind. This amount is deposited in the village fund, which is used only to pay the remuneration of the VHW, manage the drug kit, meet the fuel expenses of the vehicle for the village visit and to arrange village level meetings. The MGIMS supplements the benefit package by providing secondary and tertiary care.

Fig. 1: The design of Jawar Scheme



THE COMMUNITY

The scheme covers all the villages within a radius of 25 km from the hospital. The inhabitants of these villages are either farmers or landless labourers. The process of enrolling a village to the scheme is as follows:

- On requisition from any village, a preliminary visit was made to the village to have a discussion with the villagers.
- The decision of extending the cover was made after an initial assessment of their needs, accessibility, morality of the villagers and extent of co-operation. No more villages are included now as almost all the nearby (accessible) villages are covered and further inclusion will not ensure physical accessibility to the hospital.

Till 1994 all the villagers were eligible to join the scheme; from then on the members were required to satisfy one of the following criteria to be eligible to join the scheme-

- He / She should have initiated the lift irrigation scheme for the entire village.
- He / She should have availed of the 'One house one latrine' scheme with 100% participation.
- Member of the family must be a member of the diary co-operative.
- He / She should have elected village panchayat by consensus.

These conditions were further amended as follows from 2002 onwards. The eligible candidate should:

- Be a member of Self Help group.
- Has assumed organic farming.
- Be an organizer or participant in Prabhodan (educative lecture series)
- Has taken a vow for Vastra Swavlamban(spinning charkha).

CONTRIBUTIONS

The contributions to the scheme are income rated. The villagers are expected to contribute as per their ability. Dr. Jajoo decided a tariff in consultation with the villagers depending on their income and assets. The villagers unanimously agreed to contribute 2 payali (2.5 kg) of Jawar per acre of landholding[5]. Landless labourers contribute a flat rate of 4 payali per family of five. Families with more than five members contributed 2 payali per additional member. Those having additional sources of income would contribute 4 payali more. For the salaried class, contribution was decided in proportion to the SALDAR's (landless labourer on yearly contract) income. The collected jawar was sold to the market and converted into cash for utilization. Members may also contribute the equivalent in cash.

The contribution is deposited in the village account. This amount is then transferred to the 'Kasturba Health Society' corpus and utilized for

5 One kilo of Jawar costs Rs 4 (2004).

various village level activities. It does not reimburse the hospitalization expenses of the beneficiaries.

PROVIDER

Mahatma Gandhi Institute of Medical Sciences is the provider of medical care. It is a 648 bedded hospital with 23 teaching and research departments. The hospital being a medical college hospital and a research institute, provides all the diagnostic and curative facilities. The preventive and promotive care is provided to the select villages through other community development projects. It is an autonomous institute but receives grants from the Government of India.

BENEFIT PACKAGE

The insured members are eligible to receive free primary health care from the VHWs with the aid of the village drug kit. This is funded from the Village Savings Account. The latter also reimburses the expenses for the doctor's visit.

Other than this, the members receive secondary and tertiary care at the MGIMS hospital. This includes out patient and inpatient services. There are no upper limits for the services and no exclusions. However the insured is required to bear 50% of the hospital expenses for elective admissions.

Also the insured patient is required to meet the cost of referral services as well as purchase of medicines that are not available in the hospital pharmacy.

Preventive and promotive care is provided through various developmental initiatives.

PAYMENT TO PROVIDER

The cost of the drug kit for the villages and the VHW's remuneration are met with from the insurance contributions. Besides this, the expenses

of arranging the village level meetings and the fuel charges of the vehicle for village meetings are also reimbursed from the contributions.

The hospital expenses on insured patients are usually met by the hospital funds. Moreover, the doctors in the hospital are paid fixed salaries, and so there is no incentive to over treat the insured patients.

ADMINISTRATION

Collection of premium

The collection of the premium is managed by the VHW and community representatives. They collect the cash or the jowar and handle the accounts. These accounts are presented to the community at village meetings, so there is transparency at all levels.

Claims and reimbursements

Each beneficiary is given a card at the time of enrolment. When the patient seeks treatment in the OPD (Out patient department) he/she has to just show the card, while in case of admission he/she has to produce a note in the prescribed format (which is given to every VHW in advance) from the village health worker. A staff member appointed for management of the scheme enters the details in a register and endorses the note following which the patient is admitted in the ward. At the time of discharge, the patient may have to pay the co-payment (in the event of elective conditions) or the cost of medicines purchased outside the hospital pharmacy. No other costs are charged to the patient.

RISK MANAGEMENT

Measures to control adverse selection:

The family is the enrolment unit. Also there are very stringent conditions for enrolment. Thus there are very little chances of adverse selection at the time of enrolment. However there are no waiting periods, upper age limit or exclusions in the scheme.

Measures to control moral hazard

The providers have no incentive in treating the patients as the scheme does not reimburse the cost of the treatment. Hence provider induced moral hazard is negligible.

The patients have to incur all the additional charges like that of medicines prescribed from outside, besides indirect cost like transportation, food, loss of wages, and cost of accompanying relatives. Thus patient induced moral hazard is also minimized. Also there is a referral system and without the VHWs' note, the patient cannot get admitted to the hospital.

ACHIEVEMENTS

Coverage

With one village in 1979 the number of villages increased to 15 in 1986 and currently 40 villages are covered under the scheme. Around 9628 villagers were covered under the scheme in 2003.

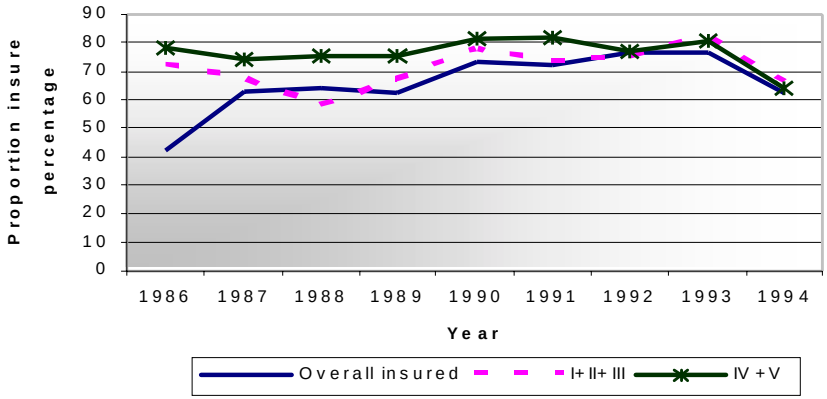
The insurance scheme was conceived in 1979, which went through a phase of evolution till 1985. From 1986 to 1994 the entire village was offered the scheme i.e. all the villagers from the selected villages, were eligible for the scheme. From 1995 onwards more than one scheme was offered to the villagers and from 2000 onwards the scheme was open to selected families satisfying the eligibility criteria. As the scheme was in evolutionary phase till 1986, and as it is difficult to separate the data of Jawar scheme from the pooled data from 1995 to 1999, the data from 1986 to 1994 is analyzed.

From Fig. 2, the overall coverage shows an initial increase till 1992, which then falls. Though there was a high demand for the scheme from the people, their inability to satisfy the stipulated conditions made them ineligible for the scheme.

It is interesting to study the coverage in different classes of people, which also reflects on their acceptance for the scheme. The graph below shows

the trend in enrolment over the years, under different categories based on the socio-economic status.

Fig 2: Line diagram showing the trend in enrolment under the jawar scheme.



Category I – Families who employ labourer on yearly contract (Saldar) for agricultural work.

Category II – Families who own irrigated land and a pair of bullocks, but do not employ saldar.

Category III – Family who own unirrigated land and a pair of bullocks but do not employ saldars.

Category IV – Families who own dry land but neither employ saldar nor have bullocks.

Category V – Landless labourer.

Any other additional occupation raises the economic grade by one.

Thus the villagers from category I, II & III can be considered from comparatively higher socio-economic status as compared to those from category IV & V.

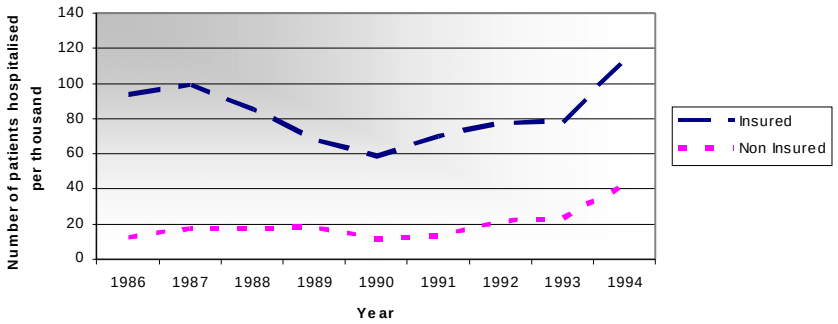
The increase in the overall enrolment shows increased acceptance of the scheme. However a few villages were dropped out intermittently due to non-adherence to the conditions laid. The level of enrolment from the lower economic strata has always remained more than that from the upper strata, till 1992, after which both categories became equal.

Utilization

Though the insured members are eligible for both out patient and inpatient care, as no separate register is maintained of insured and non insured patients in the OPD, the utility of the out patient service cannot be assessed.

The utilization of indoor services has been high from 93 to 115 per thousand insured members (Figure 3)

Figure 3: Hospitalization rates among insured patients over time.



Cost recovery

The objective of this scheme is to generate demand for health services by the poor and make these services available to them at the time of need irrespective of their affordability to pay. Hence it does not aim at meeting the cost of care from the contributions.

The collected amount is not pumped back into the hospital and is utilized to cover the cost of providing outreach services. However, if this amount was to be used for the provision of hospital services, the probable cost recovery would be 2.2% in 1986 of the total hospital recurring expenditure, which remained constant at 2.4% in 1994.

CONCLUSIONS

The scheme, therefore, reimburses only the cost of the outreach services while creating a demand for even out patient and in patient services in the medical college hospital.

Some of the unique features of the scheme are : it has been able to generate demand for the services and has created a sense of ownership. Tertiary care services are available to the poor at minimal expense. As only two staff members at the hospital manage the scheme, the administrative cost is also kept minimal and above all it has served as a nodal point of entry for other developmental programmes in the village.

Medical Aid Plan of Voluntary Health Services – Chennai

INTRODUCTION

The Voluntary Health Services (VHS) is a noted NGO established by the legendary Dr Sanjivi in 1958 to provide comprehensive care to the underprivileged in rural and slum areas in a cooperative manner. Currently it provides health care through a referral hospital (VHS Hospital and Medical Centre) and a network of 14 Mini-Health Centers (MHCs). The VHS Hospital is a multi-speciality hospital with 405 beds and manned by doctors, many of them work on an honorary basis. The MHCs are manned by 2 Multi-purpose workers (MPWs) and provide curative and preventive care to the 6000 – 10000 population in their catchment area. The MPWs work closely with Lay First Aiders (LFAs) who are equivalent to VHWs and provide promotive health care in their villages. A single MO visits these MHCs on a weekly basis. The VHS also provides training (for MOs, Nurses and other para-medicals), conducts research and implements projects (ranging from AIDS care to de-addiction clinics).

The VHS hospital is located in Adyar, once the outskirts of Chennai. Today many important institutions surround it and it is in the midst of the booming IT industry. Most of the villages have access to facilities in Chennai through a very efficient bus service and a network of good quality roads. Of the 14 MHCs, 10 are within 10 km of the VHS hospital. The farthest village is about 45 km from the VHS hospital. Most of the villagers are casual labourers, working in the fields or industries in and around Chennai. There are about 104247 villagers in the catchment area of the MHCs. There is a good network of government and private doctors in this area.

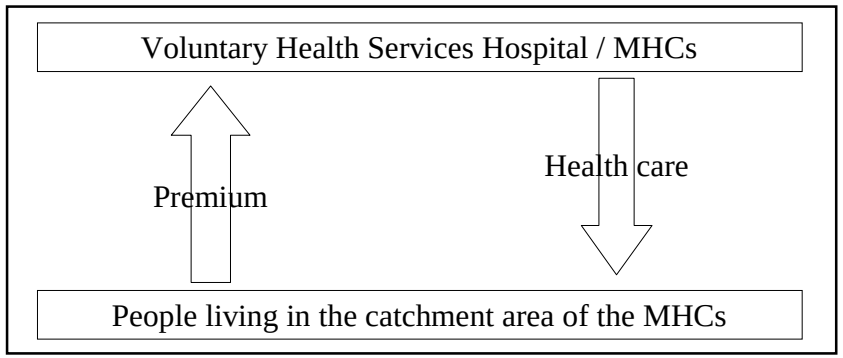
THE MEDICAL AID PLAN (MAP)

The Medical Aid Plan (MAP) is the health insurance component of the VHS services. It was started in 1972 to protect the poor families from impoverishment. The main objective was to develop a health financing mechanism for the poor in a cooperative manner based on their ability to pay. The scheme was designed and implemented by Dr Sanjivi.

DESIGN

The MAP is basically a provider model wherein the NGO (VHS) is both the provider of health care as well as the insurer of the scheme. They collect insurance premiums from the community and in turn provide health care. The details are given in Figure 1.

Figure 1: The design features of the Medical Aid Plan



COMMUNITY

The community eligible to enrol are basically the people living in the catchment areas around the MHCs. This is predominantly a rural area. The poorer sections of society tend to enrol in the MAP scheme. The average daily wage is about Rs 50 to Rs 80 for men.

It is noticed that residents from other areas (and predominantly around the VHS hospital) also enrol at the hospital by paying the premium.

PREMIUM

The premium is income rated i.e. the amount depends on the reported monthly income of the family. The tariff rates are as follows:

Monthly Income slab (Rs)	Category	Premium (Rs) per year			
		For families	For individuals	Donations	Total for family
< 500	C 1	75	30	175	250
501 – 1000	C 2	120	40	130	250
1001 – 2000	C 3	140	50	110	250
2001 – 3000	C 4	250	60	0	250
> 3000	C 5	450	80	0	450

It appears that the VHS staff officially collects donation especially from those who are enrolling as a family. However, there appears to be some flexibility and the staff can reduce or even waive this donation, depending on the socio-economic status of the subscriber.

While the VHS encourages family as the enrolment unit, it is possible for individuals to enrol also. This is done predominantly at the hospital level. Once paid, the premium is valid for one year. However, there is neither a definite collection period nor a waiting period. It is not that patients approach the MHC / Hospital at the time of illness and purchase insurance and avail of the services immediately.

The premium is mostly collected at the MHCs by the MPWs. However, some patients also pay the premium directly at the hospital. A receipt is given to the subscriber which ensures insurance status. The money that is collected at the MHCs is submitted to the VHS hospital on a fortnightly basis alongwith the details of the subscribers. The staff are given an incentive to collect the premium – Rs 50 for collecting Rs1000 per month.

BENEFIT PACKAGE

The MAP provides a comprehensive benefit package for its subscribers. This ranges from primary care at the MHCs to OP and IP care at the VHS hospital.

At the MHCs all subscribers get totally free care, including medicines. Non-subscribers have to pay a flat rate of Rs 15 per visit. At the VHS hospital, the patient receives subsidized OP as well as hospitalization benefits. Both secondary and some tertiary health services are provided to the patients at the hospital. Co-payments are charged depending on the income status (and hence the category of enrolment). This is summarised in Table 2

Level	Items of service	For subscribers	For Non subscribers
MHC	Consulting fees	Nil	Nil
	Medicines	Nil	Rs 15
	Laboratory (only at one MHC)	Cost	Cost
VHS OP	General Consultation fees	Nil	Cost
	Specialist Consultation	Subsidized (Rs 12 – 88, depending on category)	Rs 100 per consultation.
	Medicines	110% of costs	110% of costs
	Laboratory	Subsidized (depending on category)	As per tariff rate
VHS IP	General ward	Subsidized (Rs 0 to Rs 85 per day, depending on category)	Rs 85 per day
	Special wards	As per tariff rate	
	Theatre charges	Subsidized (Rs 50 to Rs 600 depending on category)	Rs 1500

While earlier there was a strict referral system, currently this does not exist and patients can approach the hospital directly. Generics are used at the MHC level.

PROVIDER

The provider is the VHS hospital and its 14 MHCs. The staff at the MHCs and the hospital receives a fixed salary. Many of the doctors at the hospital also provide honorary services and thus the costs are lower compared to other hospitals of similar size and capacity.

FORMAL INSURANCE COMPANY

There is no linkage with any insurance company

CLAIMS AND REIMBURSEMENTS

As the scheme is a direct provider model, there are no claims or reimbursements. The bills of the insured patients are settled by the hospital accounts department from the insurance fund.

ADMINISTRATION

The administration is minimal and is mainly handled by the MPWs at the MHCs. They create awareness about the MAP and sell the product. Collection of the premium and filling the necessary receipts and registers are all done by them. At the hospital level, the accounts department handles the claims and reimbursements. There is a manual system of MIS, that is not very user friendly.

CHANGES OVER TIME

The MAP has been flexible and has changed with the times. The main changes are in the premium amount and in the co-payment schedules. Unfortunately some of the initial measures like collection period, referrals and targeting the catchment population were modified, thus diluting some of the strengths of this scheme.

RISK MANAGEMENT

VHS's MAP seems to be weak in managing risks, especially adverse selection and moral hazard. As there are no waiting or collection period, patients can enrol at the time of illness. This has severe implications on the health of the insurance fund. While family as the unit of enrolment is promoted, it is possible for individuals to join, again promoting adverse selection. And finally by removing the referral system, the demand side moral hazard is not controlled adequately. Only co-payments are used to control unnecessary use. And this is not a good measure as there are no fixed scales. Thus the patient is left with some uncertainty at the time of hospitalization. This goes against the insurance principles.

Generics do promote better quality of care and fixed salaries do control on supply side moral hazard. Fraud is controlled to a certain extent by receipts.

ACHIEVEMENTS

About 2214 families (9573 individuals) enrolled during 2002. Usually most of them (77% in 2001) subscribe to the lowest tariff. This indicates that the enrolment rate is only 9%. In 2001 another 3821 individuals enrolled directly at the VHS hospital, indicating that about 45% of patients are subscribing directly and probably out of the catchment area.

The utilization rate at the MHCs and the VHS hospital is much higher for the insured as compared to the non-insured. However, these figures should be taken with precautions, as the denominator is not satisfactorily demarcated. The utilization rates are given in Table 3.

Cost recovery data was not available and so this was not attempted. But from interviews with the key informants, it is clear that the MAP was never planned as a financially viable programme. It was meant to meet the needs of the poor.

1999	2000	2001	2002	
Utilization of MHC OP	18466	21649	30031	38191
Utilization of MHC OP by members				31015
VHS admissions	8038	8226	7628	NA
Utilization of IP facilities by members	4935	3701	3087	NA
%age of VHS admissions who are members	61%	45%	40%	NA
Utilization rate of IP by members (admissions per 100 members)	33	34	24	NA
Utilization rate of IP by non members (admissions per 100 non members)	4	5	5	NA

CONCLUSIONS

The MAP is one of the older CBHIs in the country and started with philanthropic motives. It has made health care services affordable for many of the poor around the MHCs. Providing a comprehensive package makes it acceptable and people enrol in spite of other options. However with time, some changes have weakened it. Unless measures to control adverse selection and moral hazard are not taken now, there is a danger of the scheme becoming bankrupt.

The Student's Health Home – Kolkata

INTRODUCTION

The Student's Health Home (SHH) is the oldest community based health insurance programme in our country. It was initiated in 1952 by students. The main objectives are:

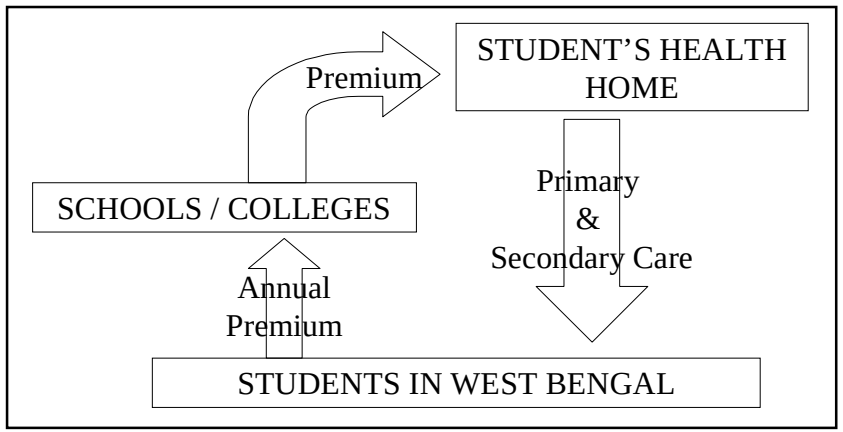
- To organize the students …… for health awareness and to ensure both preventative and curative health care for the student community.

It is seen more as a self-help movement of the students focused mainly on the broad definition of health i.e. physical, social and mental well-being. Today the SHH is owned by a body of volunteers and managed on a day-to-day basis by a management committee headed by the General Secretary of the SHH.

DESIGN

The SHH is a provider model of CBHI, with the SHH taking on the responsibility of both providing health care as well as managing the insurance fund.

Figure 1: The design of the Student's Health Home CBHI.



COMMUNITY

The target community are all the students from Class V to University level. The unit of enrolment is the school / college. Once an institution joins the SHH, then all the students in that institution are mandatorily enrolled as members of the SHH. This is one of the only mandatory CBHIs in the country.

Other than institutional membership, individual students can join independently as a member (in case their institution has not enrolled), especially if the student is from the weaker sections of society. They have to submit an application that includes their family income. A committee screens these applications and decides on whether to accept or reject the application. However, these instances are rare and not encouraged.

As all schools and colleges are targeted, this is an excellent example of risk pooling – wherein the wealthy and the poor share the risks.

PREMIUM

The premium is Rs 4 per student collected annually at the beginning of the academic year (July). The premium is collected through the schools and submitted to the SHH. It is mandatory for all the students in an enrolled institution to pay the premium.

There is no waiting period, but there is a definite collection period.

Marketing activities are limited as most of the institutions are aware of the SHH and its benefits.

Each student from an enrolled institution can avail of the services of the SHH through his / her student id card.

Individuals who join have to pay a premium of Rs 60 per person and is given a photo id card.

Universities also pay a lump sum of Rs 7500 per year to the SHH.

Institutions that default for two consecutive years are removed from the SHH membership.

PROVIDER

The SHH has its own network of health care institutions. The main centre is at Kolkata and is a 70-bed hospital with various speciality services. However the specialists come on specific days, and not all the days. Thus a particular specialist (and hence the speciality service) will be available only once a week. The Kolkata centre also has adequate equipment including ECG, Echocardiogram etc.

Other than this, the SHH has 32 regional centres at the district headquarters. These regional centres vary in capacity. Some have a few beds, but most of the others mainly have only OP services. For IP services, the regional centres refer the patients to the government hospitals.

The doctors work mainly on a voluntary basis. This helps to keep the costs down.

BENEFIT PACKAGE

The benefit package consists of OP and IP services. The OP services include general and specialist OP. IP services include surgerical and medical specialities. All the OP services at both the Kolkata and the regional centres are free. The insured patients have to pay a nominal co-payment for IP services. This ranges from Rs 2 per day for all medicines to Rs 25 a day for admissions and Rs 75 for surgeries

While most conditions, including chronic diseases and HIV are included in the benefit package, pregnancy and emergencies are excluded from the purview of the insurance programme.

If the patient requires any service that is not provided by the SHH, then s/he is referred to the government hospital. Any expenses incurred by the patient there is reimbursed by the SHH.

INSURER

The SHH takes the responsibility of managing the insurance funds. They receive a token grant from the Government of West Bengal. This plus the voluntary services of the doctors help them meet their expenses with the premium collected. There is no linkage with any insurance company.

ADMINISTRATION

Collection of premium is minimal and is done by the educational institutions.

Claims and reimbursements are limited to managing the accounts at the Kolkata centre as well as the regional centres.

RISK MANAGEMENT

Control of adverse selection has been well developed through the mechanism of mandatory subscription, the institution as the unit of enrolment and a definite collection period.

Measures to control moral hazard

As most of the doctors are employed on a voluntary basis, there is no incentive for supply side moral hazard. On the other hand, because of a strict referral mechanism from the regional centre to the main centre, the demand side moral hazard is also kept to a minimum. However, there seems to be anecdotal evidence to suggest that because of the voluntary nature of the service providers, the efficiency of the Kolkata centre leaves much to be desired. The average length of stay is very long as doctors come only once a week. And because there is hardly any charges, the patients also prefer to remain admitted in the hospital.

Measures to control cost escalation

Co-payments are the only measure used. While the management tries to purchase generic medicines, many of the doctors prescribe branded drugs.

ACHIEVEMENTS

Coverage

As per reports in 2003, there were about 5 lakh students enrolled in the scheme.

Utilization

Figures are not available for recent years. Data from 1993 indicate that the admission rates is about 1 to 2 per 1000 insured.

Cost recovery

Data on this aspect is not available. Apparently they manage with the premium collected and the co-payments and a Rs 3.5 lakh donation from the government of West Bengal

CONCLUSIONS

The SHH is one of the oldest CBHI schemes and has insured the student community against medical costs. By collecting a low premium and using the voluntary services of the doctors, they have been able to establish a low cost and equitable CBHI scheme that covers about 5 lakh students. However, there is considerable room for improvement – especially in the depth of the benefit package, the efficiency of the services and the awareness among students. Of course this requires more resources.

INSURER MODEL

Medical Insurance Scheme (MIS) – RAHA

THE LOCAL CONTEXT

The Medical Insurance Scheme (MIS) is one of the older community-based health insurance (CBHI) programmes in India. Started in 1980, it offers health insurance coverage to poor in the four districts of Chattisgarh – Raigarh, Surguja, Jashpur and Korba (Figure 1). These districts, with a total population of four and a half million (2001 Census), are typically rural. Forested and crisscrossed by small streams, this area is sparsely populated. The largest group is the Oraon tribals (70% of the population) who live in the valleys and survive on subsistence farming, cultivating one crop of rice every year. The rest of the time, they collect minor forest produce. Literacy rates are high, because of the efforts of Christian missionaries and both men and women are well educated.

Wage labour is rare and the average wages (2003) were between Rs 35 and Rs 40 per day. There are some coal mines in this region and a large steel factory at Raigarh. These offer additional employment opportunities for the local people. Also because of this industrial activity, the roads are better developed compared to other rural districts. However, the geographically unfriendly terrain makes travel a difficult proposition. The distance from a village to a Government PHC (Primary Health Centre) ranges from two to twenty kilometres.

Each of the districts has a government district hospital and a network of PHCs. However, most of these PHCs are unmanned and do not appear to be operational. The only government health staff who appeared to be working in the field were the Auxiliary Nurse Midwives (ANMs) providing routine immunisation to the infants. Other than the government infrastructure, there is a network of 92 Rural health centres (RHCs) and three hospitals managed by the Catholic Church. The RHCs are small dispensaries with a nurse and with facilities to treat minor ailments and a few beds for emergency admissions. The hospitals are

well equipped and well staffed and are able to provide most of the basic hospital services. There are also a few private practitioners in the towns.

Then of course there is the ubiquitous "jhola doctor" – an informal medical practitioner who visits the villages and treats all illnesses with injections and sometimes intravenous fluids. He is very popular among the community and is probably the most accessible health care provider. However, people complained about the costs involved – ranging from Rs 50 to Rs 200 per visit.

RAHA

The Medical Insurance Scheme is a CBHI organized and managed by the Raigarh Ambikapur Health Association (RAHA). Started in 1969, RAHA is a federation of the Catholic dispensaries (92) and hospitals (3) working in the four districts mentioned earlier. It is more a coordinating body and provides technical and logistical support for the staff of the dispensaries and hospitals. This ranges from continuing medical education sessions to training sessions on social development. RAHA also supports micro-credit groups, and implements the Chattisgarh government's Mitanin programme and the Government of India's Integrated Child Development scheme (ICDS) in one Taluk. At Pathalgaon, RAHA has a centre for rehabilitation of physically challenged patients. There is a close link between RAHA and all the Catholic institutions in the region, especially the village level priests. An Executive director[6] and her small field and administrative staff manage the RAHA programme.

6 Sr. Elizabeth, RAHA, Pathalgaon, Jashpur District, Chattisgarh, India – 496118, Tel: 07765 233384, Email id - Nil

THE MEDICAL INSURANCE SCHEME

The MIS was started with the following objectives:

- To subsidize the cost of medical care of the members at primary, secondary and tertiary level.
- To encourage people's participation in health services
- To encourage people to be a "caring community" and contribute towards the medical care of their fellow beings through membership fees.
- To reduce exploitation from money lenders

It is a typical insurer model, where RAHA collects the premium from the community and purchases health care on their behalf from the NGO providers. The design is figuratively represented in Figure 2

COMMUNITY

Tribals (Oraons) are the main inhabitants in these four districts. The MIS is targeted at this group as well as other people from low socio-economic background. The better off population e.g. government servants, businessmen etc are not eligible for enrolment. All the family members are eligible to enrol in the insurance programme, and there is no age bar. Family enrolment is encouraged, however the premium is calculated and collected on an individual basis.

RAHA also mandatorily insures all the tribal students staying at the church-run hostels.

PREMIUM

The community pays an annual premium of Rs 20 per person. This is collected by the village health volunteer and handed over to the nurse at the RHC during the collection period (October to January). The premium can also be paid in kind (2 – 3 kg of rice, equivalent to Rs 20). A card is given to the insured person who is then eligible for care at the health institutions from April to March. The hostel students pay the

premium (cash) in July, when they enrol at the hostel. The warden then transfers this to the nearest RHC.

While officially the premium has to be paid in one instalment, in practice, the Village Health Volunteer (VHV) collects the premium in instalments (especially for large families) and hands it over to the nurse when the full amount is collected. Occasionally, if the patient is poor and has not paid the premium, the RHC nurse will waive the premium amount and exempt the family. But this is done on an ad hoc basis and there are no formal guidelines for this.

75% of the premium is retained at the RHC for treating the insured patients. 25% is sent to RAHA as the central fund. This fund is used to reimburse the hospital bills of the insured patients. RAHA reimburses the hospitals directly, thus ensuring a cashless system for the insured patients. To supplement the RHC income and to encourage the RHCs to enrol families, RAHA pays a matching grant of Rs 20 per family insured to the RHCs. This is paid from external donations.

INSURER

The insurer of the MIS is RAHA. RAHA receives 25% of the premium and uses this to purchase hospital care for the insured patients from the three hospitals. If this is not enough, it is usually supplemented by funds from an external donor (Misereor).

RAHA's role currently is limited to monitoring the financial transactions. So it has records of the amount of money collected at the RHCs and the hostels, the number of insured patients admitted in the hospitals and their bills. The hospital bills are sent on a monthly basis to RAHA, who then reimburses the hospitals.

RAHA has not been very successful in improving the quality of care for the insured patients. Thus referred patients have to still wait in queues in hospitals. Similarly, in spite of directives, the doctors at the hospitals continue to dispense branded and non-essential medicines.

PROVIDER AND BENEFIT PACKAGE

There are three levels of providers in the insurance programme. At the village level, there are VHVs who provide basic preventive and curative care for the village community. This is provided free to all the villages.

At the next level is the Rural Health Centre (RHC). This is a dispensary with usually 2 – 4 beds and a labour room. A nurse (usually a nun belonging to a Catholic denomination) and some assistants provide the services. Each RHC is an autonomous institution and is controlled by the individual denomination's management. Insured patients are eligible for free OP treatment at the RHC (except for injections and tonics). Patients pay 50% of the hospital bill at the time of admission in the RHC. Insured women delivering at the RHC have to pay Rs 50. All non-insured patients pay the actual cost of treatment which usually ranges from Rs 50 to Rs 100.

The referral level includes the 3 Mission Hospitals, one at each of the district HQs of Raipur, Jashpur and Ambikapur and each belonging to a different Catholic denomination. These 150 – 250 bedded hospitals are equipped to provide effective secondary care. Many of the staff in the hospital are Catholic nuns who do not charge for their professional services. The rest of the providers are salaried employees.

Insured patients can avail of OP services at these hospitals by paying 50% of the OP bill. Insured patients referred by the RHC pay a co-payment (ranging from Rs 100 to Rs 250 and inversely correlated to the distance from the hospital) at the time of admission. Hostel students pay a flat co-payment rate of Rs 50 per admission. Admitted patients then can avail of hospitalisation services upto Rs 1250 per episode. The patient pays the excess amount in case the bill exceeds Rs 1250. But this is not a routine as the average cost of treatment is about Rs 1000. Insured patients not referred by the RHC or non-insured patients have to pay the full cost of treatment.

CLAIMS AND REIMBURSEMENTS

The hospitals send a monthly statement to RAHA, indicating the number of insured patients admitted during the month and the costs incurred. RAHA then reimburses them from the Central fund. As this is inadequate to meet the hospital costs of all the patients, this fund is topped up by donations from an external donor – Miserior. This donation is about Rs. 5 lakhs per year.

ADMINISTRATION

Administration is kept to the minimum, to the extent that some important information is not available.

Collection of premium

The VHVs and the RHC nurses visit the villages during the collection period and motivate the community members. Community members pay the premium either to the VHV or to the nurse at the RHC. Each member is given an insurance card with details like name, age, sex and address. The only records kept at the RHCs are the number of individuals and families enrolled.

Claims and reimbursements

The regular RHC and hospital staff collects the co-payments and deductibles. They send a monthly report to RAHA with the number of outpatients and inpatients seen by them. The hospitals generate a monthly list of insured hospitalized patients. This is sent to the RAHA office, which then reimburses the hospitals. This validity of the bills is never in doubt as Catholic nuns manage the hospitals and there is implicit trust.

Managing the funds

RAHA manages the funds and is responsible for ensuring that the Central fund reaches RAHA in time. It also reimburses the hospital on a monthly basis. It also is responsible for raising external donations for the MIS.

The administrative work here is limited to a few days every month. Chartered accountants audit RAHA's accounts annually. The individual Churches monitor the RHC accounts and RAHA does not have any say in this matter.

Contracting with the providers

This is one of the weak areas of RAHA – they have not been able to influence the functioning of the RHCs or the hospitals in favour of the insured patient. Some improvements include introducing rational therapy, use of generics, direct access to the referred insured patients etc. Though all the stakeholders belong to the Catholic church, individual denominations control the RHCs and hospitals. RAHA has very little influence over them. Also because of the monopoly situation (the RHCs and the three hospitals are the only ones in this region that can provide this care); the providers are in the driver's seat.

RISK MANAGEMENT

Measures to control adverse selection

There are various measures to control adverse selection – mandatory enrolment of students; definite collection period (October to January) and waiting period (February and March); preference to family enrolment etc.

Measures to control moral hazard

Co-payments and deductibles reduce the unnecessary hospitalisation by patients. An effective referral system also helps. As the providers are salaried employees, there is less tendency on their part to intervene unnecessarily.

Measures to control cost escalation

No specific measures against cost escalation were noticed.

Measures to control fraud

Most of the RHC staff know the patients and their families, and so fraud by patients is practically impossible. This is especially so as the patients have to produce their card at the RHC and their card and the referral letter at the hospital. Fraud by the providers is also nil as all the providers belong to the Catholic church.

ACHIEVEMENTS

As stated earlier, raw data was not easy to come by. So the quantitative achievements were not easily measurable. The fact that it has been functional for the past 23 years, itself is a major achievement. The decentralised collection of premium, an accessible and comprehensive benefit package and third party payment means that people get good care with the minimum of trouble.

Coverage

Of the 4.5 million population, 53,598 were enrolled during the year 2003. However, in reality, the staffs of the dispensaries are most active in the two to three villages around the RHC (approximately 1000 – 1500 population). And most of the members of the MIS are from these villages. If we consider that the main target population are those living in these 2 – 3 villages surrounding the RHCs, then the population covered by insurance is about 52%. Of this, 48% are students. This is a good coverage, given the hilly terrain and the scattered population. This coverage has remained stable for the past few years.

Utilization

Of the 53,598 members, about 476 patients were admitted for various reasons in the 3 hospitals. This gives an admission rate of about 9 per 1000 insured per year and is similar to admission rates in other CHIs.

There were also about 227180 illness episodes among the insured, warranting OP treatment at the RHCs or the Hospital OP. This gives an

utilization rate of 4 per capita per year, which is high for domiciliary care.

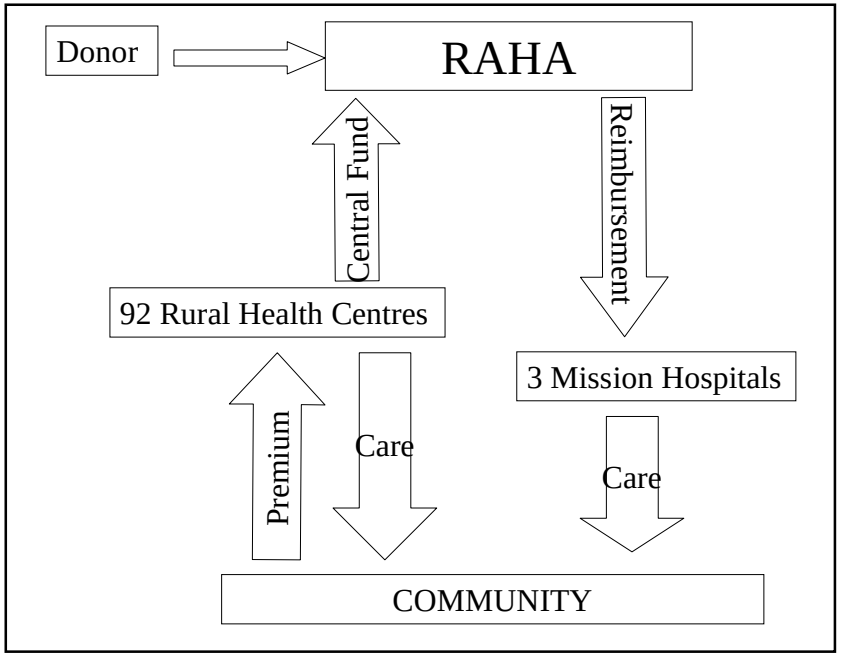
Cost recovery

No adequate data is available on this. The scanty data shows that about Rs 10 lakhs were collected during the year 2003 as premium and that about Rs 5 lakhs were donated by Miserior. This was adequate for meeting the costs of treating the insured patients (hospital and RHCs). However, this does not take into account the subsidy of the nurses and assistants' services.

CONCLUSIONS

This is an effective programme that meets the needs of the poor tribals in Chattisgarh. RAHA has cleverly used the existing network of providers in these districts and by keeping administration minimal it has been successful in offering an affordable CBHI product to this poor community. The fact that 50% of the main target population has enrolled is a major achievement. Also the fact that there is good utilization of services implies that financial barriers may have been reduced. However, geographical distances and difficult terrain hamper further access and RAHA would need to consider expanding their benefit package to include ambulance services. Also RAHA should explore mechanisms to improve the quality of care provided.

Figure 1: The Medical Insurance Scheme - RAHA



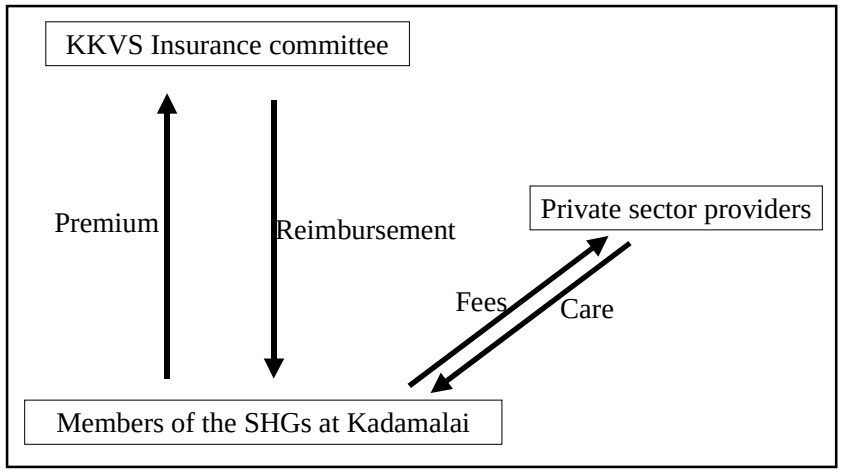
The KKVS Community-Based Health Insurance Programme

INTRODUCTION

The DHAN Foundation is a professional developmental NGO that has various activities in the four South Indian states. One of its important activities is the promotion of community banking through women's self-help groups (SHGs). These SHGs over time have federated to form block level organizations that run independent of the DHAN Foundation. One such SHG federation – the Kadamalai Kalinjam Vatara Sangam (KKVS) - instituted health insurance activities in April 2000. The main reasons for starting a CBHI was to plug the leakages from the women's savings due to medical expenses. The main objectives of the scheme are:

- Protection of households from costs of health care
- Fulfilment of the needs of the community

DESIGN



COMMUNITY

The KKVS is a federation of the SHGs at Kadamalai block of Theni district, Tamil Nadu. This is a remote forested area in the rain shadow of the western ghats. The population is 69,278 (1991 census) and most of the people are engaged in subsistence agriculture, cultivating kambu and chollam. Female literacy is about 24%.

Only women of the SHGs in Kadamalai and their families are eligible to join the KKVS CBHI. Most of the women in the SHGs are landless labourers, earning about Rs 25 – 30 per day. Only a member who has been a SHG member for at least two years can join the health insurance programme.

INSURER

The health insurance programme is run by KKVS itself. It collects premium from the members and reimburses the patients if and when they incur hospitalization expenses. A committee has been elected from the Federation that meets monthly to look into the insurance programme.

PROVIDER

The providers are mainly private hospitals in Theni. The list is as follows:

- Meenakshi Mission Hospital at Kadamalai Kundu for general cases
- Arvind Eye Hospital – Theni for cataract surgeries
- AL Raja Hospital – Theni for surgeries
- Holy Cross Hospital – Theni for general cases
- Chandrasekhar Hospital – Theni.
- Christian Fellowship Hospital – Oddanchatram for Further referrals

While in theory a referral service exists and all patients are expected to be referred by the KKVS nurse to the hospitals, in practice, this does not function. Most of the patients inform the KKVS after admission.

FORMAL INSURANCE COMPANY

There is no linkage with a formal insurance company

PREMIUM

The premium is Rs 100 for an individual member and Rs 150 for a family. The premium is paid in cash annually in April. It is collected by the SHG leaders who then pass it onto the cluster and then from there, to the federation.

The annual enrolment to the insurance scheme is as follows:

Year	No: of SHG members	No of Medical Insured members	Premium collected	No: of claims	Amt of reimbursement
2000	3217	1500	222,500	51	126,755
2001	4419	2222	326,650	64	236,593
2002	4560	1893	277,550	47	190,179
2003	4514	? 2600 +			

Insured members = only SHG members. The number of family members are not included.

About 40 – 50% of the members are covered by the health insurance programme every year.

BENEFIT PACKAGE

The benefit package has been decided by the women and has undergone some changes over the years. Currently it is

- Hospitalization benefits up to a maximum of Rs 10,000 for the entire family. Only 75% of the hospitalization bills are reimbursed.
- All common illnesses, including pre-existing illnesses and cataract are covered.
- Only 50% of charges are reimbursed for hysterectomies, up to a maximum of Rs 5000.

- Up to a maximum of Rs 2500 for Caesarian sections
- Has to be a hospitalization of > 24 hours and a bill more than Rs 1000. Any bill less than 1000 has to be met by the patient.
- Free OP care by a nurse at the Kalinjam Hospital

Patients pay a co-insurance of 25% of the hospital bill to limit moral hazard.

HIV, TB and normal deliveries are excluded from the list of diseases.

The hospitalization rate is about 6 – 8 per 1000 insured.

In 2002 the top reason for reimbursement was hysterectomy.

PAYMENT OF PROVIDER

The patient pays the hospital bill directly and submits the bills and other relevant documents to the local SHG. After the SHG clears it, it is forwarded to the federation. An insurance associate verifies the amounts with the hospital and submits his report to the federation. If everything is in order, the federation reimburses the amount to the SHG who in turn hands it over to the patient. The average lead time between discharge and payment to the patient is about 1 – 2 months.

CLAIMS AND REIMBURSEMENTS

The process is outlined above. About 8% of the claims have been rejected by the federation for various reasons, ranging from claiming for excluded diseases to fraud.

REINSURANCE

No reinsurance is in effect.

RISK MANAGEMENT

Measures to control adverse selection

- Family as the enrolment unit
- Waiting period
- Definite collection period

Measures to control moral hazard

- Co-payment
- Fixed indemnity

Measures to control cost escalation

- Co-payment
- Maximum limit

CONCLUSIONS

The KKVS CBHI is an example of a direct model of CBHI. Here the CBO takes the risk of insurance and manages it by itself. While the women have managed to build in measures to protect the fund and have changed the conditions every year to suit the requirements of its members, one should realise that it is at a precarious stage. Any adverse event can wipe out the reserves and cause bankruptcy. This needs to be discussed by the women.

The Yeshasvini Co-operative Farmers' Health Care Scheme

INTRODUCTION

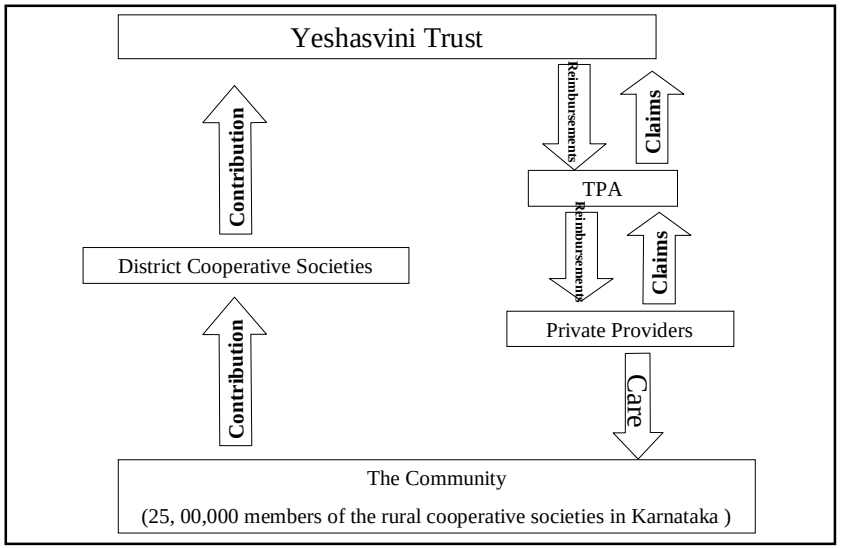
The Yeshasvini scheme is an initiative by the department of Cooperation, Government of Karnataka. Initiated on November 14th 2002, it became operational from the 1st of June 2003.

Its main objectives are

- To provide protection against catastrophic health expenditure
- To involve the private health sector in the provision of health care and thereby improve their utilization
- To expand the role of cooperatives by involving them in the health sector.

DESIGN

Figure 1: The design of the Yeshasvini Co-operative Farmers' scheme



THE COMMUNITY

This scheme is targeted at the members of the cooperative societies. There are more than 30,562 societies with a membership of about 1,87,00,000. Of these about a third are dairy cooperatives where the members are mainly women. Most of the members are either farmers or involved with agricultural products.

In the first phase only the rural societies are targeted. This amounts to about 25,00,000 individuals. Only the members and their families are eligible for enrolment. The scheme is limited to the member, spouse and two children. Elderly dependents are not usually enrolled with their children. The age limit for eligibility is 1 year to 75 years. Also only those who have been society members for at least 6 months are eligible to join the scheme.

THE INSURER

The body that takes the risk is the Governing body of the Yeshasvini Trust. This is a trust registered under the Indian Trust Act 1871. The Hon'ble Chief Minister of Karnataka is the chief patron. Members include representatives from the Government of Karnataka, private health care providers and the Principal Secretary, Dept. of Cooperation. This trust formulated in 2003 administers the scheme. The corpus fund is deposited in a bank and a working committee of the trust meets fortnightly to monitor the scheme.

PROVIDER

The providers are 114 private sector hospitals that have enrolled in the scheme on a voluntary basis in 26 districts. The eligibility criteria to be enrolled into the scheme as an empanelled hospital are

- Easily accessible – e.g. near the District HQs
- 25 beds at least
- Minor and major Operation Theatres

- ICU
- Surgeon and anaesthetist
- Dedicated telephone line

Dr Devi Shetty – an eminent and altruistic cardio-thoracic surgeon - conducted the initial negotiations with the private health care providers. Currently this role has been taken over by the Third Party Administrator (TPA), the Family Health Plan Limited (FHPL).

CONTRIBUTION

The contribution for the individual member is Rs 60 per year. The government of Karnataka has provided a matching grant of Rs 30 per member per year for the **first** year. Thus the money collected is Rs 90 (US$2) per member per year.

The co-operative societies' leaders collect the member's contribution at the village level and then deposit it into the taluk level bank. The money then is transferred to the District Central Cooperative Banks and from there to the Apex Bank in Bangalore. At the end of the collection period, the Apex bank hands over the money to the Yeshasvini Trust. The government's contribution is handed over directly to the trust. In return, the insured member receives a photo id insurance card (one per member) with details. This has to be produced for accessing the benefits. While in the first year, this collection and card was managed by the District Societies, now it is being centralised and standardised.

BENEFIT PACKAGE

The benefit package is as follows

- Free out patient consultation for any illness if the consultation leads to surgery. Else the patient pays the cost of the out patient consultation.
- Subsidized diagnostics for any illness

- Free hospitalization for any surgery (1600 surgeries have been identified, including cardiac surgeries); up to a maximum limit of Rs 1,00,000 per hospitalization or Rs 2,00,000 per person per year. Rates have been fixed for each surgery e.g. for hysterectomy it is a maximum of Rs 8,000 while for cardiac bypass surgery it is a maximum of Rs.75,000/-.
- Non-surgical admissions are not covered. Similarly, any replacement surgeries e.g. joint replacements are not included.

ADMINISTRATION

The collection of contributions has been channelled through the District Cooperative Societies (as detailed above). Members who wish to join fill in an application form and their premium is deducted at source at the village level itself.

The entire administration for claims and reimbursements has been outsourced to a TPA – Family Health Plan Limited. They receive 5.5% of the total sum assured as implementing fees. This organization is responsible for the following

- Providing identity cards for the members
- Negotiating with the private sector providers for enrolling into the scheme
- Assist in managing Yeshasvini help desks in every hospital
- Pre- authorising and verifying the claims
- Monitoring the reimbursements through a MIS
- Conducting regular meetings at the district level with the representatives of the private medical providers.
- 24/7 call centre to guide and assist the members

CLAIMS AND REIMBURSEMENTS

If a member needs surgery, the empanelled health facility sends a "Pre-authorisation" form to the TPA. The TPA clears this within 24 hours and in which case the patient can undergo the surgery.

After the surgery, the patient walks out without any payment, while the hospital submits a claim to the TPA. After scrutiny and verification, the TPA recommends for reimbursement to the Y. Trust. The trust pays the amount to the TPA, who in turn directly reimburses the hospital.

PROCESS FLOW OF PATIENTS AVAILING TREATMENT IN THE NETWORK HOSPITAL:

Beneficiary approaches nearest Network Hospital with ID card for availing the Surgical benefits under the scheme

⬇

Network hospital examines ID card of the beneficiary of the scheme and forwards the pre-authorization form to FHPL only if the required treatment is covered under the scheme

⬇

The FHPL after scrutiny issues pre-authorization to the Network Hospital to perform the surgery

⬇

Network Hospital extends cashless facility to the beneficiary.

⬇

Network Hospital after performing the surgery forwards the bill along with the relevant documents to the FHPL for the settlement of the claim

⬇

FHPL scrutinizes the bill and presents it to the Trust for sanction

⬇

Trust accords approval for sanction of the bill.

RISK MANAGEMENT

Measures to control adverse selection

The strategy of insuring large numbers of existing society members minimizes adverse selection considerably. Also there is an eligibility criteria for membership.

Measures to control moral hazard

The providers are paid a fee on service basis, so there is a potential for moral hazard. Similarly as there is no referral system, patient moral hazard is also a possibility.

Measures to control cost escalation

The costs for most of the common surgeries (60) have been fixed (albeit arbitrarily[7]) and this minimizes cost escalation.

Measures to control fraud

The TPA monitors all the claims and verifies whether there is any fraud. It has employed more than 10 field workers for this, each covering 3 districts. They review major surgeries only.

ACHIEVEMENTS

Coverage

Of the 25 lakhs target population, 16,10,000 have enrolled, giving an enrolment rate of 64%.

20.29 lakh members are enrolled under the scheme for 2004 – 2005.

7 The providers were requested to provide their price list for each surgery. The average of the maximum and minimum was calculated per surgery and fixed as the cost per surgery.

Utilization

As the utilization started only in June 2003, it is still too early. But in the first year 9039 surgeries were performed – giving an approximate utilization rate of 5.61 admissions per 1000 insured per year.

35814 patients availed of free OP services (value of Rs 6.6 million).

As on 23-10-04, 15148 farmers availed of free out patient benefits.

As on 23-10-04, 2806 farmers availed surgical treatment under the scheme

CONCLUSIONS

This has been a novel venture to cover the informal sector. Using existing platforms of the cooperative sector, large numbers of members were covered in a short period of time. This coupled with the use of existing private providers has made this scheme acceptable to the community.

However, there are some criticisms of this scheme, the main one being that the benefit package is too narrow, just surgical admissions. Also it is a pity that quality assurance mechanisms have not been introduced. This could have improved the performance of the private sector providers.

The Yeshasvini scheme has attracted global attention with two major US bodies, Harvard and the Rockefeller Foundation, planning to study it closely and replicate it elsewhere, especially in African countries. The World Bank too has shown interest in the functioning of this health programme with the intention of finding more pragmatic solutions to low-cost, high-quality healthcare in the developing world.

LINKED MODELS

Self Help Association for Development and Empowerment (SHADE)

INTRODUCTION

Five small self-help groups called Swasraya Credit Unions (SCUs) in Ernakulam district of Kerala have been implementing a community health insurance programme since December 1993. Their programme was coordinated by Self-Help Association for Development and Empowerment (SHADE). SHADE is a registered society under the guardianship of the Community Medicine Department of the Malankara Orthodox Syrian Church (MOSC) Medical College Kolenchery.

THE COMMUNITY

The total population in the 4 blocks is about 5 lakhs. The community health project of the Medical College covers only selected areas around their health centres with about 100, 000 population. 30-40% of the community is middle class, 30% labour class, 30% poor, 2-5% very poor and 2-5% rich people. The average family size is four. The community health insurance programme operates only in this project area. There are currently over 9000 members in the five SCUs. Anybody willing to pay Rs 10 as registration and contribute any multiple of Rs 5 as a weekly contribution to the group is eligible to join a SCU.

THE COMMUNITY HEALTH INSURANCE PROGRAMME

Only members of the SCUs and their families are eligible to join the health insurance programme.

There are basically two parallel schemes.

- The oldest scheme (started in 1993) was organized by the women themselves. They collected an annual premium of Rs 33 per person

This article has been written by Dr. Marina Rajan, MD

per year and purchased a Mediclaim policy from the National Insurance company (NIC). This was tailor made to suit the local women and covered hospitalization for a maximum of Rs 5000 per year. However, over the years, the premium started increasing because of high claims ratio. In 1998, the SCUs switched over to the Jan Arogya Policy which was popular. Then in 2003, they switched over to the Viswaragya policy. Now the premium is Rs 356 for an individual per year, Rs 530 for a family of 5 and Rs 720 for a family of 7. For BPL families there is a subsidy of Rs 100 on the premium. The BPL families are identified by the ration card.

This premium is collected by the SCU representatives annually over a two-month period and handed over to the NIC. The benefit package covers hospitalization in any hospital for an annual limit of Rs 15000 per individual or Rs 30,000 per family. There is a waiting period of one month for new members. At the time of hospitalization, the patient has to pay the hospital bills. S / he then submits the necessary documents to the local SCU who scrutinizes it to ensure completeness. If the claim is complete, it is handed over to the NIC. They reimburse the patient through the SCU. The SCU collects a 15% administrative charge on the reimbursement, which is used to meet the administrative costs of the insurance scheme as well as to subsidize the premiums of the poorest.

There are about 200 people who are still enrolled in the original scheme because the upper limits are higher.

- The second scheme was started in 2003 for the people around the Medical College Hospital. Most of the members in this scheme are members of the SCUs living within a 10 km radius of the hospital. This is also a Viswarogya policy, but here the MOSC Medical College further subsidizes the premiums for the BPL families. They pay a token of Rs 10 per family and the rest is paid by the hospital on their behalf. APL families are requested to pay as much as possible – this

usually ranges from 25 – 100% of the actual premium. The insured family gets an insurance card, which they need to present at the hospital for receiving benefits. There is a special desk at the hospital for the insured patients.

The benefit package is the same as in the first scheme. Difference is that here there is only a single provider – the MOSC Medical College. Patients get admitted at the hospital and do not have to pay any money at the time of discharge (unless their bills exceed the upper limits). Their claims are processed by the hospital and sent to UIIC who in turn reimburses the hospital directly.

Other than this, all the insured members have access to the free OPDs conducted in their villages by the community medicine dept on a weekly / fortnightly basis.

SHADE helps now with the negotiation of the scheme with the insurance companies. Its workers also help out in the collection of the premium, especially in the second scheme. It also helps in the management and administration of the scheme. All accounts are audited annually.

Other than this, SHADE also provides a personal accident policy for which about 7000 members have joined.

PERFORMANCE OF THE COMMUNITY HEALTH INSURANCE PROGRAMME

- Scheme 1 – 850 families out of a potential of 2000 have joined the scheme in 2003 – 2004. There were about 100 claims amounting to about Rs 250,000. The claims rate = 30 / 1000 insured and the claims ratio is 55%.
- Scheme 2 – 1226 BPL families and 257 APL families out of a potential of 7000 have joined the scheme in 2003 – 04. There were 261 claims in the same year amounting to about Rs 550,000. The claims rate = 66 / 1000 insured and the claims ratio is 65%.

Community Health Insurance – Karuna Trust

INTRODUCTION

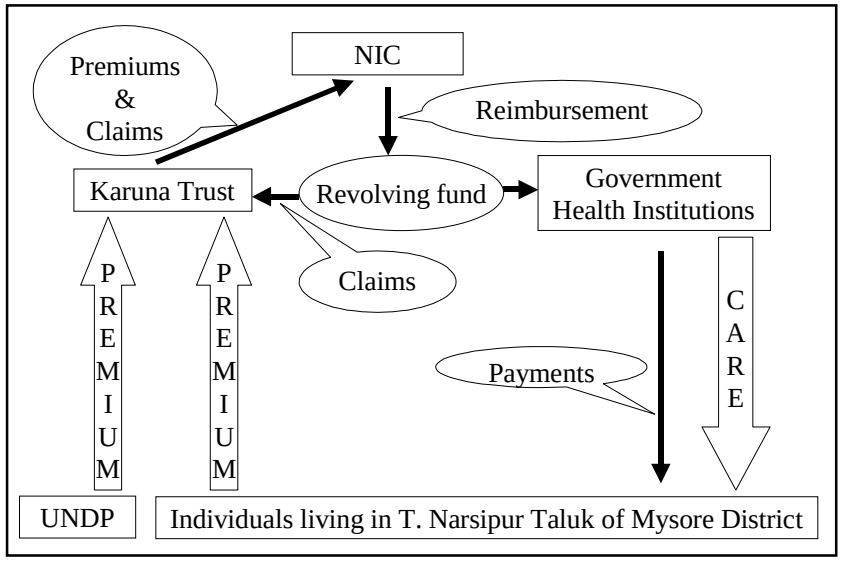
The CHI – Karnataka (1) is managed by Karuna Trust. It was initiated in September 2002 by a partnership between Karuna Trust, the Govt. of Karnataka, the Govt. of India, the United Nations Development Programme (UNDP), the National Insurance Company (NIC) and the Centre for Population Dynamics (CFPD). Initially operational in T. Narsipur Taluk, it has been subsequently expanded to Yelandur Taluk also. It is one of the few CBHIs where the government health services are intimately involved.

The main objectives of the scheme are:

- To increase the access to medical care for the poor
- To empower communities to manage their health care through partnerships with the providers
- To develop a model for the country
- To assess the impact of involving the insurance sector

DESIGN

Fig 1: Community Health Insurance – Karuna Trust.



COMMUNITY

All the residents of T. Narsipura Taluk are eligible for the insurance coverage. Most of them are farmers or labourers. The total population is 278,156 of which 245,036 live in 132 revenue villages and 76 hamlet villages.

INSURER

Karuna Trust is an NGO working mainly with the poor at Yelandur Taluk and T. Narsipur Taluk, of Mysore district. Its main objectives are integrated development of the poor and marginalized sections of society through health, education, vocational training and socio-economic programmes.

Karuna Trust organizes the collection of premium and reinsures with the National Insurance Company (NIC). The NIC (a para-statal insurance company) reimburses the claims submitted by Karuna Trust.

PROVIDER

The providers are any government health institution with more than 6 beds. Patients can use the services of the Community Health Centres, the Taluk and District Hospitals and are even referred to the Mysore Medical College. There is a clear-cut referral system, with a wireless connectivity for ambulance services.

PREMIUM

The premium varies according to the socio-economic status.

The premium for the households below the poverty line is Rs 30 per individual per year.

UNDP fully subsidizes the premium for the households that are below the poverty line (BPL) and belong to the SC / ST category. So in reality, for these families, it is free.

UNDP partially subsidizes the premium for those households that are below the poverty line and do not belong to the SC / ST category. These families pay Rs 20 per individual per year.

Those households that are above the poverty line have to pay Rs 60 per individual per year, but was not covered in the first year.

The first round of premium collection was in July 2002.

Karuna Trust forwards the collected premium (as well as UNDP's subsidy) to the NIC on a regular basis.

All those who pay the premium receive an identity card (in a plastic folder), which has the names, ages, gender and addresses of the insured household members.

BENEFIT PACKAGE

The benefit package is a comprehensive hospitalization package. All insured patients admitted to a government hospital receive total care. At the end of the hospitalization period, the BPL patient is also paid @ Rs 50 per day towards loss of wages. And the institution receives Rs 50 per patient day towards providing better services in whatever form; e.g. external purchase of any drugs that are necessary, ambulance services. What is noteworthy is that there are no exclusions for any illnesses. The maximum benefit that can be availed of is Rs 2500 per patient per year. This implies that an individual can avail of 25 days of hospitalization in a year.

This money is paid from a revolving fund managed by representatives of the health institution, the Karuna Trust and the CEO of the Zilla Parishad.

Other than this, Karuna Trust also provides preventive services and financial support for OP services through other resources.

PAYMENT TO PROVIDER

The providers are government medical officers who receive regular salary.

CLAIMS AND REIMBURSEMENTS

Karuna Trust has social workers posted in each of the health institutions. They process the claims and submit it to the NIC. The NIC in turn reimburses the revolving fund.

ADMINISTRATION

Collection of premium

Karuna Trust has conducted a door-to-door census to identify the BPL SC/ST households.

Village staff of Karuna Trust, the field staff of the Health Dept. and the ICDS dept. and the Panchayat leaders, collect the premiums of other households. These are collected and handed over to Karuna Trust on a periodic basis. Strict records are maintained at all levels.

It also conducted intensive IEC activities to make the community aware about insurance.

Claims and reimbursements

Karuna Trust social workers manage the claims and monitor the reimbursements. The administrative medical officer in each health institution is responsible for verifying the validity of the claims.

NIC has provided computer software to monitor the claims and reimbursements.

RISK MANAGEMENT

Measures to control adverse selection

Mandatory coverage of all BPL, SC/ST households.
Family is the unit of enrolment.

Measures to control moral hazard

Providers do not have any direct benefit and so the danger of moral hazard is minimized.

Measures to control cost escalation

Not applicable.

ACHIEVEMENTS

Coverage

During the year 2002 – 2003, the following numbers of individuals were enrolled in the insurance programme.

Category	Number	%age
BPL SC/ST	82546	
BPL non SC / ST	2546	
Total	**85092**	**31%**

Utilization

During the period September 2002 to August 2003, the following number of claims were made.

	Number	Utilization rate
Total	**540**	**6.3 / 1000 insured**

The total claims made during the period 09 / 2002 to 08 / 2003 amounted to Rs 457400 / -. The average claim was Rs 847 / -

Cost recovery

Karuna trust paid Rs 2,566,900 to NIC for insuring 85,092 individuals. Of this, Rs 2,501,840 (97.5%) was paid by UNDP and the rest was collected from the community. For the period September 2002 to August 2003, a total of Rs 457,400 was claimed and reimbursed. Thus the claims: premium ratio is 18%. The administrative costs have not been factored in.

CONCLUSIONS

This is an example of an intermediary model of CBHI with the NGO reinsuring with a formal insurance company and negotiating with suitable providers. What is unique about this scheme is the fact that it is a cashless benefit, and in fact the patient gets some money in lieu of loss of wages. This helps the patient meet some of the indirect costs incurred.

This pilot project is an attempt at introducing CBHI by involving both the public and the voluntary sector. Each stakeholder has worked on their strength – the voluntary sector in mobilising the community, raising resources and negotiating with the stakeholders. The public sector has

played the role of a provider and has incorporated some amount of flexibility in its operations to accommodate the increasing demands of administering an insurance programme. The NIC also has shown flexibility in developing an appropriate scheme and finally the donor has been very supportive. Karuna Trust is trying to mobilize existing panchayat funds to continue the programme in the coming years. This will ensure sustainability of the programme. An area that would need improvement is the quality of care provided. Karuna Trust needs to negotiate with the government providers on behalf of the community.

Vimo SEWA

INTRODUCTION

Vimo SEWA is one of the oldest member-based organizations (along with ACCORD) to link up with formal insurance companies to provide insurance cover for its population. Started in 1992, the main objectives were to protect women from indebtedness resulting from:

- sickness requiring hospitalization.
- the death of a spouse; or
- loss of working assets.

Vimo SEWA is an integrated micro insurance scheme protecting the health, life and assets of its members and their families. Vimo SEWA is a part of the SEWA family, which is a labour union of self-employed women workers in Gujarat and other parts of India. The combined strength of the SEWA movement is 700,000 (530,000 in Gujarat itself). Other than insurance, SEWA provides the following services:

- SEWA Bank – a women-led micro finance institution with about 200,000 depositors and about Rs 1 billion working capital.
- Child care – for the children of members
- Health care – for the members and their families
- Housing - for the members and their families

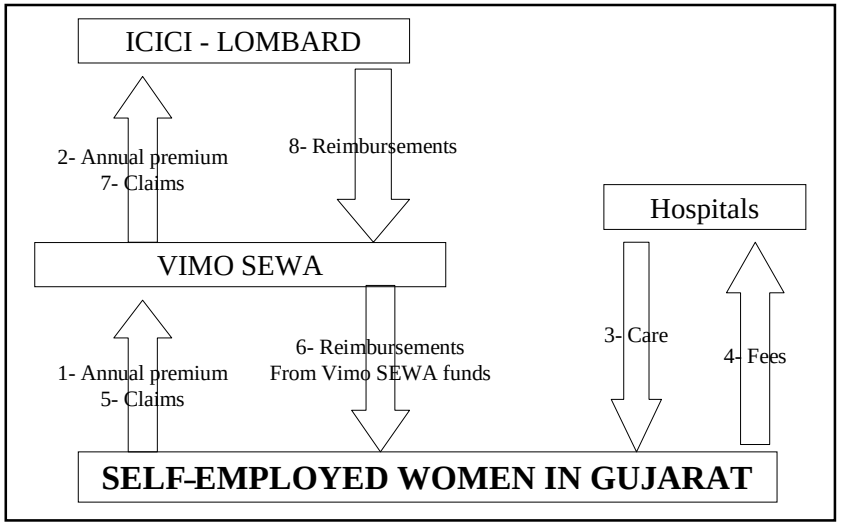
The Integrated Social Security Scheme (ISSS) was initiated in 1992. The main components of the ISSS currently are life, health and asset insurance. For a large part, SEWA has linked up with existing insurance companies to develop the products. However, for a few years between 1994 and 2000, SEWA de-linked from the insurance companies for health and asset insurance. The linkages over time are given in the table below.

Vimo SEWA – the linkages over time

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Life Insurance	L I C													Aviva Life
Health Insurance	UIIC		SEWA							NIC			ICICI Lombard	
Assets	UIIC						SEWA			ICICI Lombard				
Accidental deaths	UIIC						NIAC			ICICI Lombard				

The design of the Vimo SEWA integrated social security scheme is given in Figure 1.

Figure 1: The Vimo SEWA CHI



Note: In the figure above, the numbers represent the sequence in the chain of events, with 1 being the first step and 8 being the last step in the chain.

DESIGN

Vimo SEWA is one of the first linked models of CBHI. Vimo SEWA collects the premium and hands it over to the formal insurance company. When patients fall sick, they seek care from any provider. After discharge, the patient submits the necessary documents to the Vimo

SEWA staff that checks the document and verifies its authenticity. Once this is cleared, the patient receives the cheque, from the insurance fund. In the meantime, the claim documents are sent to the insurance company for reimbursement and they reimburse Vimo SEWA. This insurance fund is created by a floater fund from ICICI – Lombard.

COMMUNITY

The target community is mainly the SEWA union members, though the scheme is not limited to them only. These are mainly self-employed women, their spouses and children from 3 months to 18 years of age. While initially women between 18 and 58 were the only ones who were eligible to enrol in the insurance programmes, other members of the family were included in stages.

Table 2 compares the general rural Gujarati households with Vimo SEWA members, in the 16 sub-districts where Vimo SEWA has the most members, based on select indicators of socio-economic status. By most indicators, the Vimo SEWA members appear slightly "poorer" than the general population – and significantly so for indicators of food security.

Table 2. Comparison of rural Vimo SEWA members in 16 sub-districts with the general rural population by key socio-economic characteristics

SES characteristics	Vimo SEWA members Mean /Frequency	General population Mean / Frequency
Number of observations	(n = 967)	(n = 780)
If wall brick or stone with plaster (%)	41.8	42.9
If oil store for >= 1 mo., during last 12 mos. (%)	15.5	27.8
If millet store for =12 mo (%)	8.9	17.7
If wheat store for >=1 mo., during last 12 mos. (%)	34.2	55.0
If electrical connection, own or shared (%)	62.9	62.9
Number of rooms	1.8	1.9
Adults literate (%)	47.6	49.6
Adults attended college or univ. (%)	2.1	4.0
Number of wrist watches	0.48	0.57

PREMIUM

There are two schemes. Currently the premium for Scheme 1 is Rs 100 for a woman, Rs 170 for woman and her husband and Rs 250 for the entire family. This premium covers life, health and asset insurance.

The breakdown of the premium for the woman under Scheme 1 is as follows:

Rs 20 for natural death cover;
Rs 7 for accidental death cover
Rs. 33 for health insurance
Rs 10 for asset insurance
Rs 30 for administrative expenses

The premium is usually collected annually (Oct – Dec) by Aagewans (community-based leaders). These Aagewans are responsible for collecting premiums, processing claims and helping with any other related matter. They are paid for each day of work put in. They collect the premium and hand it over to the district insurance coordinator, who in turn hands it over to the Vimo SEWA office in Ahmedabad. Each insured family receives a receipt to acknowledge its insurance status and payment of premium.

Yet another mechanism for paying the premium is through the fixed deposit. A deposit in the SEWA Bank of Rs 2100 will ensure that her premium is paid on an annual basis from the interest on the deposit. This saves tremendously on administrative expenses.

Much effort goes into the community before the collection period. Meetings are held at the village level, information-education-communication (IEC) material is distributed and even door-to-door campaigns are conducted.

BENEFIT PACKAGE

The insured family receives a comprehensive cover. The benefits under Scheme 1 are as follows:

Natural death of insured member – the nominee receives Rs 5,000
Accidental death of insured member – the nominee receives Rs 40,000
Accidental death of husband of insured woman – the wife receives Rs 15,000
Illness of insured member – hospital expenses up to Rs 2,000 per year
Damage to house and its belongings – Up to a maximum of Rs 10,000

The details are given below

SCHEME 1			
	Individual woman	**Woman + husband**	**Woman + husband + children (3months to 18 years)**
Premium	Rs 100	Rs 170	Rs 250
Fixed deposit	Rs 2100	Rs 3600	—
Benefit in case of death	Rs 5000	Rs 5000 / Rs 5000	Rs 5000 / Rs 5000
Benefit in case of illness	Rs 2000	Rs 2000 / Rs 2000	Rs 2000 / Rs 2000 / Rs 2000
Benefit in case of damage to house	Rs 10,000	—	—
Benefit in case of accidental death	Rs 40,000	Rs 40,000 / 25,000	Rs 40,000 / Rs 25,000
Benefit in case of accidental death of spouse	Rs 15,000	—	—
SCHEME 2			
	Individual woman	Woman + husband	Woman + husband + children (3months to 18 years)
Premium	Rs 225	Rs 400	Rs 480
Fixed deposit	Rs 5000	Rs 9000	—
Benefit in case of death	Rs 20,000	Rs 20,000 / Rs 20,000	Rs 20,000 / Rs 20,000
Benefit in case of illness	Rs 6000	Rs 6000 / Rs 6000	Rs 6000 / Rs 6000 / Rs 2000
Benefit in case of damage to house	Rs 20,000	—	—
Benefit in case of accidental death	Rs 65,000	Rs 65,000 / 50,000	—
Benefit in case of accidental death of spouse	Rs 15,000	—	—

All of this is reimbursed. The process is detailed in the claims section. Vimo SEWA is experimenting with a system of prospective reimbursement to hospitalized members, wherein Vimo SEWA pays the patients in the hospital itself within 24-48 hours of hospitalization.

PROVIDER

Currently Vimo SEWA allows the patient to go to any hospital for care. While they do encourage public hospitals, the ultimate choice is with the patient. After discharge, the patient is supposed to collect the relevant documents and hand it over to the Aagewan or to the insurance coordinator at the district SEWA office.

Vimo SEWA has not negotiated with the providers for either cost control measures or quality of care. In fact, most of the providers are not aware of the insurance status of the patients, until discharge, when the patient requests for the documents.

One of the drawbacks of a "free choice" is that at times the patient receives poor quality of care or the documentation is inappropriate. So Vimo SEWA is experimenting with 'preferred providers'. Using specific criteria, they are trying to identify hospitals with good track record. As a first step, they identify hospitals that have been used fairly regularly by our members for a period of years. From among these, they then try to select facilities that fulfil certain requirements pertaining to quality of facilities, availability of doctors and nurses, cost, etc. Members are visited individually in their homes and given information about these preferred providers. Also the prospective reimbursement is operational in these preferred provider's hospitals only.

CLAIMS AND REIMBURSEMENTS

The process of claims and reimbursements is clearly well organized and run professionally. The patient is expected to provide the following documents for filing a health claim:

- Insurance receipt
- A discharge summary
- Bills from the hospital, pharmacy and laboratory
- Prescriptions
- Laboratory results

This is handed over to the insurance coordinator at the district level, who then visits the patient at his / her house and confirms the details of the admission. If necessary, the coordinator also visits the admitting hospital to get further information. The documents are then handed over to an empanelled doctor who checks whether the treatment received was appropriate or not. Finally all this is presented to the insurance committee (at the district level in some districts, but at Ahmedabad in others) that meets every week. The insurance committee, comprising of representatives from the member community and one to three staff members of SEWA (including somebody from Vimo SEWA's central office in Ahmedabad), is the final decision maker. It decides on whether the patient should be reimbursed or not, and if yes, how much should be the reimbursement. Some of the criteria for arriving at the decision are:

- Are all the documents in place?
- Is the admission warranted?
- Is the treatment provided appropriate?
- Do the documents reflect the treatment provided?
- How long has this patient been insured? Patients who have a very short track record of insurance and submit claims for seemingly chronic conditions are subjected to extra scrutiny.

Once this is decided, the patient is informed and the cash / cheque is sent to the village for disbursement in front of a group of people. This has two advantages – it creates a transparent system and increases the visibility of the insurance programme in the community.

INSURER

Currently Vimo SEWA is linked up only with private insurers. They are Aviva Life Insurance for life insurance and ICICI Lombard for health, asset and accidental death insurance. The reason why they shifted to private health insurers is that they received better offers in terms of benefit package as well as better service in terms of faster claims processing and providing a floater fund.

While there were periods when Vimo SEWA took the financial risk of managing the insurance funds, they found it too risky. Some events, like the 2000 floods and 2001 earthquake, made them realise that without reinsurance and spreading the risk in a larger pool, they would be exposing themselves to high risks. Hence they decided to link up with insurance companies, though they had problems with the insurance companies like inflexible products, long lead times between claims and reimbursements and partial reimbursements. However, now with a longer track record in the business and strong relationships with insurance companies, they are finding it much easier as compared to earlier.

ADMINISTRATION

A large part of the administration is through paid staff of Vimo SEWA. This is possibly one of the contributing factors to the relatively high administrative costs in Vimo SEWA as compared to other Community Health Insurances, where most of the administrative burden is shared by community-volunteers. However, given the size of the ISSS of Vimo SEWA, it may not be possible to rely on volunteers to cover the target population. The various administrative tasks are:

CREATING AWARENESS

Awareness in the community about Vimo is created primarily through community meetings and gram sabhas (village level meetings). House-to-house visits to educate members about Vimo are being carried out in a few talukas on a pilot basis.

COLLECTION OF PREMIUM

The Aagewans have been given specific zones and they market the insurance product with great zeal. They are paid on a daily wage basis. They are provided with all the necessary support in terms of information material; receipt books and stationery. They are also trusted by Vimo SEWA to handle the money.

CLAIMS AND REIMBURSEMENTS

The Aagewans often help the patients in submitting the claims; in other instances, members are able to put together the required documents themselves. There are occasional gaps in the system when neither the member nor the Aagewan is able to put together the required documents. Once the claims are submitted, the rest of the process is the responsibility of Vimo SEWA. As seen above, there is a lot of work involved to prevent fraud and ensure that the patient receives the appropriate amount. The insurance companies' role is limited to disbursing the money to Vimo SEWA.

MONITORING THE SCHEME

Vimo SEWA probably has one of the most detailed management information systems among the CHIs in India. It is fully computerised and up to date. Middle management also uses this data regularly to monitor trends in utilization and enrolment.

RISK MANAGEMENT

Risk management is one of the essentials of any CHI. Vimo SEWA with its experience of many years and the inputs received from various quarters has managed to put in systems to minimize various risks.

Measures to control adverse selection

Vimo SEWA has used a collection period and a waiting period to minimize adverse selection. While earlier, the individual was the enrolling unit, today they are encouraging family as the unit of

enrolment. This also has a positive control on adverse selection. Yet another measure is the exclusion, during the initial six months of membership, of coverage of chronic and pre-existing illnesses.

Measures to control moral hazard

Co-payments in terms of fees paid over the upper limit are the only measure used to control either supply side or demand side moral hazard. Also a medical doctor checks all claims to ensure that admissions are appropriate. Other mechanisms like cost control or a referral system (through Arogya SEWA) could have been used.

Measures to control cost escalation in claim amounts

No specific measures or incentives have been instituted yet. But given the low ceiling of Rs. 2,000 the members have a strong, personal interest in keeping the costs down.

ACHIEVEMENTS

Vimo SEWA started as a small CHI, but has been growing over the past few years. This is clearly reflected in their enrolment rate.

Year	Numbers enrolled	Number of health claims	Claims rate / 1000 insured
2002	92928	1921	20.67
2003	112112	2726	24.31
2004	106479	3728	35.01

COST RECOVERY

In the year 2004, the total amount of premium collected was Rs 89,19,600 while the total amount reimbursed to the community was Rs 95,24,341.

CONCLUSIONS

Vimo SEWA is one of the most famous CHIs in India. However, it cannot be said to be representative of CHIs in India for various reasons. For

one, it is much larger than most of the CHIs in India. Secondly it is more professionally managed as compared to other CHIs that are dependent on volunteers. Due to the large size of its membership, direct participation of the members in the management of the scheme is not possible. However, Vimo SEWA is committed to ensuring that the needs and interests of members guide the scheme design and implementation.

Community participation in Vimo SEWA governance occurs in two ways. First, the governing body is made up of representatives of the member community (including insurance members). Major decisions such as premium and coverage amounts, and expansion of the scheme to new geographic areas are taken in consultation with, and after approval by, the elected representatives. Second, members of the insurance programme actively express their feedback and their needs *vis à vis* the scheme to the workers who market and service the scheme. These inputs are incorporated into the design of the scheme to the extent possible.

Yet another mechanism for community participation in the scheme is the Claims Committee which scrutinizes and approves claims that are submitted. The mediclaim committee, which scrutinizes and decides on each health insurance claim submitted, is made up of SEWA Aagewans representing different trades practiced by SEWA members. This mechanism ensures community participation and transparency in the claims decisions.[8]

Vimo SEWA has been offering an integrated insurance package to its members since 1992. The primary aim of the insurance, viz, to protect SEWA's members from risky events and associated financial losses, has stayed the same over the years. The operational aspects of the scheme

[8] Another benefit of a having community members on the claims committee is that it reduces the information asymmetry that occurs when insurers and insured belong to different socio-economic backgrounds.

have changed with time, always in response to the needs of the members. For instance, Vimo SEWA de-linked from the insurance companies for a few years because members were not being satisfactorily served by the insurance companies. However, once it was able to negotiate better servicing, it linked up again with the insurance companies, thus shifting the risk from the member-based union to the insurance company.

In terms of risks covered, the package has enlarged its coverage to the husbands and children of members because that is what the member demanded. Coverage amounts have also been increased to offer better protection to SEWA's members; this has been possible in part due to the improvement of SEWA's negotiating power *vis a vis* the insurance companies.

Vimo SEWA current efforts are focused on improving its services to its members by improving its internal efficiency. Vimo SEWA is also strengthening its links with health care providers, with the twin objective of ensuring better quality services to its members and cost-containment of health claims.

COMMUNITY HEALTH INSURANCES IN INDIA – LESSONS LEARNT

INTRODUCTION

We see from the earlier chapters that community health insurance is emerging as an alternative form of financing health care. Conservative estimates indicate that about 3.5 million Indians are covered by community health insurance. In the Indian context of one billion population, this may look small (0.35%), but as totally only 30 million Indians are insured, this is a sizable percentage. Considering the fact that it is more equitable (as compared to out-of-pocket expenditure), this form of health financing should be encouraged.

Historically one learns that other countries, especially those with predominantly social health insurance (Germany, Belgium, Netherlands, Japan), all started with small 'sickness funds' that grew over time and merged with each other to form the current "Mutual funds" or health insurance companies. Today these are the shining examples of equitable and comprehensive health insurance programmes globally. Thus history and international experience is on the side of community health insurance.

But before we rush off and start a community health insurance programme, can we learn from the existing ones? There are many lessons that we can learn and need to keep in mind as we embark on unchartered waters.

WHY CHI?

This is one of the most important questions that one needs to ask before starting a health insurance programme. What is the imperative to shift to a health insurance programme? One has to remember that a health

insurance programme is administratively more complicated as compared to an out of pocket scheme.

When one reviews the ten schemes, one notes that the predominant reason for introducing health insurance is to **improve access** to health care by removing the financial barriers. Some organizations (especially the recently started CHIs) also felt that health care costs were high and were impoverishing their communities. So they started CHIs to **protect the patients from these catastrophic health expenditures**. Some of the older CHIs started health insurance as a measure to **increase solidarity** among their community, to enhance the feeling of 'oneness' and mutual support during distress. And finally some of the CHIs hoped to use health insurance as a tool to increase the involvement of the community in their own health care. They felt that when people contribute, they will have more stakes in improving the system and will **participate in decision making**. Though this was the stated objective, we did not find evidence of this in many of the CHIs.

Table 1: Reasons for initiating community health insurance by the NGOs

	Access	Protection	Solidarity	CP
ACCORD	Y		Y	Y
DHAN	Y	Y		
SEWA	Y	Y		
BAIF		Y		
YESHASVINI	Y	Y		
RAHA	Y	Y	Y	Y
SHH	Y			Y
MGIMS	Y		Y	Y
KARUNA	Y	Y		
VHS	Y	Y		Y

Health insurance seems to be the flavour of the month and one sees many organizations trying to jump into the bandwagon without

understanding the real implications. Many of them seem to think that health insurance is the panacea for all evils in the health system. One forgets that health insurance is just a health financing mechanism. It has some specific roles. One should not expect miracles by changing over to a health insurance system.

Be clear why you are starting health insurance in your region.

- *Are there financial barriers to health care?*
- *Are the medical expenses very high?*
- *Do you want to build on existing solidarity mechanisms?*

COMMUNITIES

It is clear from the Indian CHIs that they have specifically targeted the poorer sections of society and that too within a definite geographical limit. Only Yeshasvini and SHH appear to have some degree of risk sharing across income groups. This is not surprising given the fact that all these schemes were initiated by NGOs / CBOs who were working with specific communities. Health insurance was a response to a need and not an end in itself.

Table 2: The target populations of the ten Indian CHIs

	Target population
ACCORD	Scheduled tribes in Gudalur taluk
DHAN	Women belonging to SHGs in Kadamalai taluk
SEWA	Self-employed women in 9 districts in Gujarat
BAIF	Women belonging to SHGs in Uruli Kanchan
YESHASVINI	Members of the district farmers' cooperative societies in Karnataka
RAHA	Poor tribals in 3 districts of Chattisgarh
SHH	Students in West Bengal
MGIMS	Farmers in the 30 villages around SEWA
KARUNA	BPL population in T Narsipura
VHS	People living in the catchment area of their MHCs

Thus the risk pooling is only limited to sharing of risks between the healthy and the sick. This low level of risk pooling has theoretical implications for long-term sustainability. However given the fact that these are more homogeneous societies, administration and management of health insurance becomes easier. Hence one needs to keep a balance between risk sharing and administrative convenience. Is it possible to introduce the same scheme across income groups? This is the challenge for the CHIs.

Most of the CHIs, were however, not able to cover the poorest sections of society. Thus this important section of society invariably falls through the safety net. Some of the CHIs have initiated informal mechanisms to cover this vulnerable section. RAHA staff pay the premiums of the poorest from their own pocket. At ACCORD, some people pay extra and this is used to pay the premiums of the destitutes in the village. At DHAN, the SHG pays the premium on behalf of the poorest members of their group. As stated above, these are ad hoc arrangements and very few have formal methods to include the weakest sections. This is yet another challenge.

Most of the CHIs have used existing community organizations to implement the health insurance schemes, be it self-help groups, unions or cooperatives. This is an effective and efficient way to develop a CHI and the potential is enormous e.g. hospitals / NGOs could piggy back insurance programmes on existing local trade unions, cooperatives, self-help groups or NGO groups.

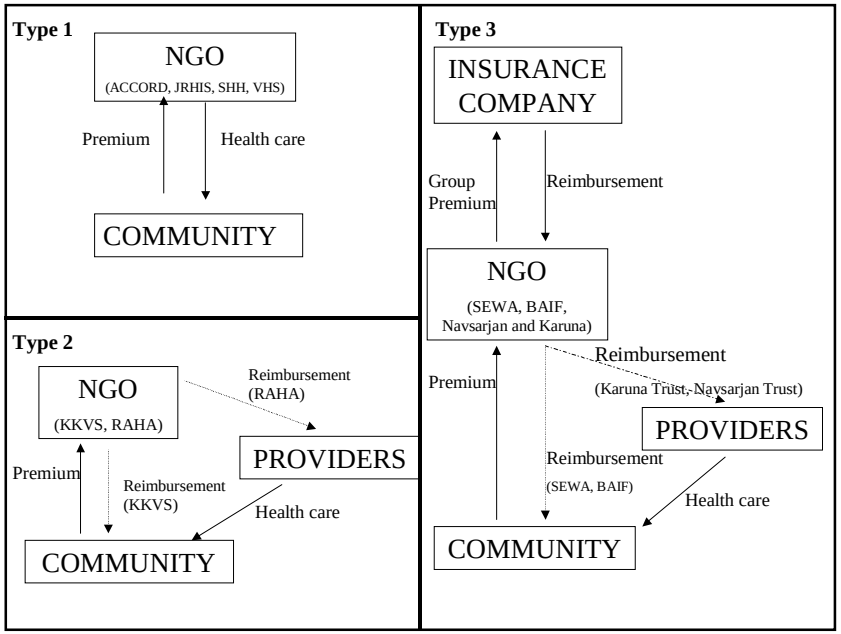
And lastly while many CHIs cover all the family, there are some CHIs which limit membership to only members of the SHGs or only to adult members etc. This is contrary to insurance principles and ideally one should insure all members from birth to death. Also by promoting family as the unit of enrolment, one reduces adverse selection. And by using the floater principle, the premium can also be lowered.

- *An insurance pool of poor and not poor is more sustainable in the long run.*
- *Remember that the poorest fall through the safety net, so specific measures are required to protect them.*
- *Use existing community organizations to develop CHIs.*
- *Keep family as the enrolment unit.*

DESIGNS

Indian CHIs can be broadly divided into three types – the provider model, the insurer model and the linked model. In the provider model, usually the NGO is both the provider of care as well as the insurer, taking charge of the funds collected. In the insurer model, the NGO / CBO takes the responsibility of the funds and the associated financial risks. They either purchase care from other providers or reimburse the patients who have gone to other providers. And finally in the linked model, the NGO / CBO collects premium and hands it to over to a formal insurance company. So there is minimal financial risk with the NGO / CBO and their role is mainly in managing the scheme.

Figure 1: The three models of community health insurance in India.



The design of the CHI will of course depend on the technical and financial capacity of the NGO / CBO. The main advantage and disadvantages of these three models are provided in Table 3. The main difference is that in the linked model, the product is more rigid as compared to the other models.

Design the scheme depending on your strengths e.g. if you have a hospital, then definitely try out the provider model. If you have skills in negotiating with the insurance company, go for the linked model.

Table 3: The advantages and disadvantages of the three models of Indian CHIs.

	Provider model	Insurer model	Linked model
Freedom to suit the local needs	Very free		Depends on the insurance company's products
Premium	Set by the NGO / CBO and usually based on affordability		Set by the insurance company and usually based on actuarial calculations
Benefit package	Usually comprehensive and meets the local needs		Traditional mediclaim policy with its exclusions and limitations
Financial risk	With the NGO / CBO		With the insurance company
Quality of care	Better because the NGO / CBO has a relationship with the provider	No difference in the quality of care between insured and non insured patients	
Community involvement	Minimal as the hospital is in charge and usually too technocratic	Varies, depends on the NGO / CBO	

PREMIUMS

Premium setting in the Indian CHIs depends on the model. While in all the three models, the final premium is a balance between actuarial calculations and affordability, in the linked model, the preponderance is towards the former, while in the provider and the insurer model, the emphasis is on the latter.

The premiums range between Rs 20 and Rs 60 per person per year and this appears to be the affordable limit among the poorer sections of rural Indian society. Two of the CHIs have tried collecting the premium in kind, but admit that it is difficult as compared to cash because of storage

and quality issues. Nowhere do they collect it in instalments, probably because of the administrative load involved. However, at SEWA, a fixed deposit acts as a perpetual source for renewing the insurance.

Collection mechanisms are varied, but the predominant feature is the use of existing staff / volunteers to collect the premium. This reduces administrative costs considerably. Only at SEWA do they use separate staff to collect premiums.

Practically all the CHIs have a specific collection period for collecting the premium. This usually coincides with a period when the disposable income in the community is maximum. This is an excellent method to reduce adverse selection.

- *Remember to maintain a balance between affordability and financial sustainability while calculating the premium.*
- *Use existing community structures to collect the premium. This will reduce the administrative costs further.*
- *Make the collection as simple as possible and minimize paper work.*
- *Discuss with the community to identify acceptable mechanisms for premium collection e.g. instalments, collection periods etc.*

BENEFIT PACKAGES

All the CHIs studied provided hospitalization benefits. The comprehensiveness of this also depends on the model of CHI. What is interesting to note is that all the CHIs have also provided primary care (preventive plus basic curative care) through other resources. This is an obvious step to make the insurance package more attractive to the community. Thus the community receives a comprehensive health care package of primary and secondary care, the latter being funded through an insurance mechanism.

Some (notably SEWA) have also added other insurance products like life insurance and asset insurance, but this does not seem to be very popular in other schemes. In fact ACCORD removed this from their integrated package because of the negligible demand from the community.

All the benefit packages had an upper limit, ranging from Rs 1000 to Rs 15000. Only Yeshasvini has an upper limit up to Rs 1,00,000 per person per year. Anecdotal evidence suggests that an upper limit of Rs 5000 to Rs 8000 will cover most of the patients' expenses. This is a reasonable package while keeping the premium still affordable.

The provider model has the least exclusions, while the linked model has the most. Only Karuna Trust has been able to negotiate with the insurance company and remove the exclusions. The common argument of the insurance companies are that exclusions protects against adverse selection. However, since one is talking about community health insurance, where large numbers of people enrol *en masse*, adverse selection is minimized. This plus other measures like family unit of enrolment, specific collection period, waiting period etc are effective measures to reduce adverse selection. Hence exclusions should be minimized or removed from the benefit package.

While quality of care is an issue in health insurance, this does not seem to be addressed in any of the CHIs. Anecdotal evidence suggests that there is no difference in the care provided to insured patients; and this is a lacunae that needs to be looked into. Similarly cost containment measures are sorely lacking in all the CHIs. Only at ACCORD is there some attempt at cost containment through the use of generic medicines and standard treatment guidelines. And Yeshasvini is the only CHI that was able to fix costs after negotiating with the providers.

- *Hospitalisation should be the core benefit for any health insurance. Others like primary health care enhances the acceptability of the scheme.*
- *Exclusions are not usually acceptable and are against public health logic. So it should be minimized as much as possible.*
- *Remember the dynamic link between the benefit package and the premium. So keep this within acceptable and affordable limits*
- *Negotiate with the providers to introduce quality of care and cost containment measures.*

CLAIMS AND REIMBURSEMENTS

Claims and reimbursements are usually handled by the NGO / CBO staff. This is admirable in that administrative costs are kept to a minimum. In the linked model, and in keeping with the insurance company requirements, the hospital bills are reimbursed. In all the other schemes (except at DHAN), there is a third party payment (cashless system), enabling the patient to leave the hospital without any burden. This is a major boon for the patients and need to be explored in other CHIs also.

In many of the CHIs the community volunteers were used to check on fraud. So committees comprising leaders / volunteers met to clear claims. Reimbursements were made in meetings, so that everybody knew the amount reimbursed and any objections could be raised even at this point.

As almost all the CHIs had an upper limit to the benefits, even in the third party payment; some patients may have had to pay the extra charges. Some of the CHIs had in addition introduced co-payments to raise revenues and reduce unnecessary utilization. Given the poor status of the patients and the multiple barriers to health care, co-payments should not be used to limit unnecessary utilization.

- *Use existing community structures to manage claims and reimbursements.*
- *Community control of fraud is very effective and efficient.*
- *Regular feedback to the community about reimbursements helps in enhancing acceptability.*
- *Cashless system of reimbursement should be promoted.*
- *Keep co-payments to a minimum.*

PROVIDERS

Almost all the providers for the CHIs were either the private-for-profit hospitals or private-not-for-profit hospitals. While the provider model used their own hospitals as the providers of health care, the others used the existing private sector. Only Karuna Trust used the government hospital as their sole provider.

One of the issues about using the private provider was that there was very little discussion or negotiation with the provider regarding quality of care or cost containment. Thus costs varied depending on the provider. Also there was even less discussion with the community about empanelling providers. Only DHAN had a list of 6 providers. SEWA was experimenting with shortlisting some hospitals as preferred providers.

- *Empanelling providers ensures some form of checks on the patients and the providers*
- *Negotiate with the providers for better quality of care and for cost controls (get technical support for this if necessary).*

MANAGEMENT

Most of the management functions in these CHIs is performed by the local NGO / CBO staff / volunteers. This ranged from creating awareness among the community, selling the insurance products, processing claims and reimbursements, managing fraud to redressing grievances. Thus it appears that the NGOs have the ability to manage a health insurance programme and would probably require some help in technical aspects like premium setting, negotiating with the providers and the insurance companies.

Table 4: Distribution of management functions in the Indian CHIs

Functions	Provider model	Insurer model	Linked model
Creating awareness in the community	NGO staff	NGO staff and community	
Fixing the premium	NGO staff	NGO and community	NGO & Insurance company
Collection of premium	NGO staff	NGO and community	NGO and community
Managing the insurance fund	NGO staff	NGO / Community	NGO
Negotiations with providers	Inherent	Nil	
Negotiations with insurance company	Not applicable	NGO	
Providing care	NGO	Purchasing care from other providers	
Managing claims	NGO	NGO / Community	NGO & Insurance company
Managing reimbursement	NGO	NGO / Community	NGO & Insurance company
Managing the risk	NGO	NGO	Insurance company
Monitoring	Financial monitoring by NGO	Financial monitoring by NGO	Minimal monitoring by NGO.
Feedback to the community	NGO	NGO	NGO

However, it is clear that many of the NGOs do not have an effective management information system and so are not able to assess their effectiveness in terms of their objectives. Very few NGOs could give figures on accessibility; on financial protection and even on financial sustainability. There is very little information on why people insure, or not insure; what are the renewal rates. This is one of the greatest weaknesses of the CHIs. Anecdotal evidence suggests that most of the CHIs required infusion of extra funds to manage it sustainably. Studies at ACCORD indicate that there is an increase in accessibility and financial protection, but it is still too premature to extend these findings to the entire sample of CHIs.

- *NGOs / CBOs do many of the management functions*
- *However, they require technical support to negotiate with insurance companies, with providers, and to set up MIS*
- *Effectiveness of CHIs need to be monitored regularly.*

RISK MANAGEMENT

Almost all the CHIs have various measures to control for financial risk. These measures are given in Table 5. While more can be done, especially in terms of cost containment, it would probably require technical expertise at the NGO level.

Table 5: Managing risks – the Indian CHI way

Risk	The method used to mitigate risk	The method that could have also been used
Adverse selection	Definite collection period	Family as the enrolment unit
	Definite waiting period	
	Exclusions of pre-existing diseases	
Patient induced moral hazard	Co-payments	Referral system
	Upper limits	
Provider induced moral hazard		Case based billing, rather than a fee for service billing
Fraud	Community checks	
	Identity cards for insured	

CONCLUSIONS

From these case studies, it is clear that NGOs in India have been organizing and managing health insurance schemes successfully. And they have been able to provide coverage to the weaker sections of Indian society. These models illustrated in this book should provide inspiration for others to start similar programmes in their areas. What is noteworthy is that many of the institutions already exist in most of the regions of the country, ranging from uninsured communities; NGOs and CBOs (unions, associations, self-help groups); health care providers (private or trust hospitals) and insurance companies. What is needed is the catalyst to bring these together to develop an effective CHI. This is the challenge for the reader and it is hoped that through these case studies, some of the issues in developing a CHI have been demystified.

GLOSSARY

Actuary: A mathematician who specializes in estimating risks, rates, premiums, and other factors for insurance companies.

Actuarial analysis: The technique of calculating the insurance premium and the reserves required; using actuarial methods. This involves mathematical modeling using the life expectancy of the population, the frequency of hospitalization, the costs of health care etc. *All insurance company premiums are usually based on actuarial analysis, but in India, because of the lack of adequate data, this analysis is based on a weak foundation.*

Administrative costs: Costs related to the operations of the health insurance. This included costs incurred in marketing the scheme, in premium collection, in claims processing, in quality assurance and underwriting fees. *In India, the insurance companies load the premium by about 20% to cover these costs.*

Adverse selection: It occurs when those who anticipate needing health care choose to buy insurance more often than others. It is because insurance suppliers lack full information about the risk of individual insured persons. Adverse selection may result from the tendency among patients to seek or continue insurance coverage to a greater extent than healthy people. An example of adverse selection is when only the baby in a family is insured. This is done because the family knows that the chances of the baby falling ill are higher. Adverse selection needs to be prevented, else it affects the financial sustainability of the insurance programme. *It can be controlled to a certain degree by making the insurance mandatory and/or by enlarging the subscription unit, e.g. if the entire family is insured rather than an individual.*

Age Limits: Stipulated minimum and maximum ages below and above which the insurance company will not accept applications or may not renew policies. *Most Mediclaim policies in India have age limits of 3 months to 70 years.*

Agent: An insurance company representative, licensed by the regulator, who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Ambulatory Care: Medical services that are provided on an outpatient (non-hospitalized) basis, services may include diagnosis, treatment, and rehabilitation.

Association Group: A group formed by members of a trade or a professional association for group insurance under one master health insurance contract.

Asymmetry of information: The situation where two people in a transaction have different amounts of relevant information. For example, in a health insurance transaction, the insured knows best about his health status. Asymmetry may allow the agent with more information to practise opportunistic behaviour, e.g. a patient with diabetes will suppress the information, so that he can avail of a lower premium.

Beneficiary: A person who is eligible to receive, or is receiving benefits from an insurance policy. Beneficiaries usually include both people who have contracted for benefits for both themselves and their eligible dependents. (See also *subscriber)*

Benefits: Benefits are the sum of money received by an insured or an assignee (e.g. a hospital) as reimbursement for medical costs incurred due to illness. Benefits may also be in the form of health services received. These benefits are in lieu of a premium paid to an insurance provider.

Blanket Medical Expense: A provision that entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Brochure (also **called Certificate of** Coverage): The booklet showing the complete details of a plan's benefits, limitations (or limited

benefits), exclusions, and definitions. The brochure is a plan's contractual statement of benefits.

Cap: A limit of the benefit amount that an insurance company will pay. The cap may be an overall maximum, such as a maximum of Rs 10,000 per patient per year, or may apply to specific services, such as a cap of Rs 500 per year for outpatient services.

Capitation: A method of payment for health services in which an individual or institutional provider is paid a fixed per capita amount for each person treated, regardless of the actual cost of the services provided, e.g. Rs 2000 for normal delivery.

Catastrophic insurance: A "top-up" insurance (or re-insurance) to cover individual cases with severe or prolonged illnesses resulting in very high costs. See also co-payments.

Catastrophic Limit: A benefit feature to limit the amount you would have to pay in a calendar year if you or your family incurred large and unusual medical bills. This is the opposite of the 'cap'. Here the beneficiary pays a certain amount of the bill. The insurance company pays any amount above that.

Cherry picking: A practice by private insurance companies of offering medical insurance to individuals they believe to be healthy while denying coverage to those they believe to be unhealthy (see also cream skimming).

Claim: A request to an insurer by an insured person (or by the provider of goods or services on behalf of the insured individual) for payment of benefits according to the terms of an insurance policy.

Claim Amount: It is the amount / benefit payable by the insurer under a policy on a claim occurrence.

Co-insurance: A cost-sharing provision of a health insurance policy that requires the insured beneficiary to pay a percentage of the cost of covered services. The rest is then paid by the insurance company. e.g. the beneficiary pays 10% of the bill, the rest 90% is reimbursed

by the insurer. (See also co-payments, cost sharing and deductibles)

Collection period: A definite period during which the insurance premium is collected.

Community financing: Ways of raising money that are organized and controlled by communities themselves. Contributions may also be provided in the form of materials and community or individual labour.

Community rating: A method of establishing premiums for health insurance based on the average cost of actual or anticipated health care used by all the subscribers in a specific geographic area or industry. Community ratings do not vary for different groups or subgroups of subscribers or according to such variables as the particular group's claims experience, age, sex, or health status. It is usually a flat rate applicable to all the members of the insurance programme.

Compulsory insurance: An insurance programme in which legislation defines the population covered, benefits, the conditions of eligibility, and the sources of funds. An insurance plan may be compulsory only for an employer or for individuals as well. Any universal public plan is necessarily compulsory regarding the payment of taxes (which support the plan), and thus not optional for the individual.

Contributory: A group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan.

Co-payment: A type of cost-sharing arrangement whereby insured or covered persons pay a specific, flat amount per unit of service or time and the insurer pays the rest. The co-payment is incurred at the time that the service is rendered. Unlike co-insurance (see above), which involves payment of some percentage of the total cost, the co-payment paid does not vary according to the cost of a

service. e.g. the insured beneficiary pays the first Rs 100, the rest of the bill is reimbursed by the insurer. (See also co-insurance, cost sharing and deductibles)

Cost-sharing: Sharing the costs of providing a particular type of health care between the patient and agencies such as the provider of care and the employer of the patient. The main aim of this is to reduce frivolous / small claims.

Coverage: The guarantee against specific losses provided under the terms of an insurance policy. Frequently used interchangeably with benefits or protection, coverage is the extent of insurance afforded by a policy. It also often means *insurance* or an insurance *contract.*

Cream-skimming: A process whereby an insurer tries to insure the most healthy individuals in order to increase profits. Cream-skimming can make it difficult or impossible for individuals with high risks e.g. children, elderly, etc. to purchase private insurance.

Declination: The insurer's refusal to insure an individual after careful evaluation of the application for insurance and any other pertinent factors.

Deductible: The amount of money an insured person must pay "at the front end" before the insurer will pay. In health insurance with a Rs 1,000 deductible, the insured must pay any medical bill under Rs 1,000 in its entirety, and the first Rs 1,000 when the total is over that amount. The reason for introducing this concept into health care coverage is primarily to discourage "unnecessary" use of services, and also to reduce insurance premiums, since all claims have a minimum amount, which the insurer will be spared on every claim. (See also co-insurance, cost sharing and co-payments)

Diagnosis-Related Groups (DRGs): System that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories.

Dread (or Specified) Disease Insurance: Insurance providing an unallocated benefit, subject to a maximum amount, for expenses

incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis, and spinal meningitis.

Eligibility conditions: Conditions that insured persons must meet in order to be entitled to the benefits of the scheme. These include a maximum duration of benefits (the time during which the insured may receive benefits); a qualifying period (a minimum period of contributions before the insured person or dependents can qualify for benefits); and a waiting period (the time an insured person has to wait before qualifying for specific benefits).

Eligibility Period: A specified length of time, frequently ninety days up to one year, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Evidence of Insurability: Any statement of proof of a person's physical condition and / or other factual information affecting his / her acceptance for insurance.

Exclusions: Specific conditions listed in an insurance or medical care policy that are not covered by benefit payments. Common exclusions include pre-existing conditions, such as heart disease, diabetes, hypertension, or asthma which began before the policy was in effect. Because of exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage either for a particular disease or in general. Sometimes conditions are excluded only for a defined period after coverage begins, such as nine months for pregnancy or one year for illnesses. Exclusions are often permanent in health insurance coverage for individuals and temporary (e.g., one year) for small group insurance. They are uncommon in large group plans that are capable of absorbing extra risk.

Experience Rating: The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Ex Gratia: A payment made where there is no legal liability

Family Policy: A policy that insures both the policyholder and his or her immediate dependents (usually spouse and children).

Fee schedule: A listing of accepted charges or established allowances for specific medical or dental procedures. It usually represents either a physician's or a third party's standard or maximum charges for the listed procedures.

Fee-for-service: A method of charging whereby a physician or other practitioner bills each encounter or service rendered. e.g. separate fees for consultation, medicines, laboratory, procedures etc. This is the usual method of billing by the majority of India's private physicians. Under a fee-for-service payment system, expenditures increase not only if fees go up, but also if charges are made for more units of service or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or prepayment systems, where by payments do not change according to the number of services actually used or if none are used.

Grace Period: A specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues. (The premium can be paid without any late fees).

Group Contract: A contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity. .

Group insurance: Any insurance plan under which a group of employees (and their dependents), or members of a similar homogeneous group, are insured under a single policy that is issued to an employer or the group itself. Group health insurance is usually rated based on experience (except for small groups, all of which are given the same rate by an insurance company). Group coverage is less expensive than comparable individual insurance, in part because an employed population tends to be healthier than the

general population, and in part because of lower administrative costs, particularly in marketing and billing costs). Note, that a policyholder or insured is the employer or group, not the individual employees or group members.

Health Insurance: A financial instrument that, in return for payment of a contribution (or premium), provides members with a guarantee of financial compensation or service on the occurrence of specified events. The members renounce ownership of their contributions. These are primarily used to meet the costs of the benefits.

Health Maintenance Organization (HMO): An organization that provides a wide range of health care services for a specified group at a fixed periodic payment (akin to a premium). The main advantage of a HMO is that it has an inherent interest in keeping costs low.

Health sector: The part of the economy which is involved in activities intended to improve health. The term may be used to mean health services but it is often used synonymously with the term health system, to cover both health services and health-related activities.

Home Nursing Care: Skilled care in the home provided by a nurse. The care generally ordered by a physician is usually limited to a specified number of hours per day and visits per year, and does not include homemaking services of any kind.

Hospice Care: A coordinated programme at home and/ or on an inpatient basis, offering easing of the patient's pain and discomfort, and providing supportive care, for a terminally ill patient and the patient's family, provided by a medically supervised specialized team under the direction of a licensed or certified hospice care facility or agency.

Hospital Indemnity: A form of health insurance that provides a stipulated daily, weekly, or monthly indemnity during hospital confinement. The indemnity is payable without regard to the actual expense of hospital confinement.

Indemnity: Benefits in the form of cash payments rather than services. In most cases, after the provider of a service has billed the patient in the usual way, the insured person submits to the insurance company proof that he / she has paid the necessary bills. He / she is then reimbursed by the company for the amount of covered costs and makes up the difference him / herself. In some instances, the service provider may complete the necessary forms and submit them to the insurance company directly for reimbursement, thereafter billing the patient for costs that are not covered.

Individual Insurance: Policies that provide protection to the policyholder and / or his or her family. Sometimes called "personal insurance," as distinct from group and blanket insurance.

Inpatient Services: The care provided to a patient while occupying a bed in the hospital or in a covered facility.

Insurance Company: Any company primarily engaged in the business of furnishing insurance protection to the public.

Insurance: The contractual relationship that exists when one party (the insurer) agrees to reimburse another (the insured) for loss caused by designated contingencies. The contract refers to insurance policy, the consideration is a premium, the loss is the risk, and the contingency is a hazard or peril. Insurance is a formal social device for reducing the risk of losses to individuals by spreading the risk among groups.

Insuring Clause: The clause that sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Insured: A person covered by an insurance policy, to whom protection is provided under the policy terms.

Lapse: Termination of a policy upon the policyholder's failure to pay the premium within the time required.

Limitations (or Limited Benefits): Statements in a brochure showing services or supplies that are not fully covered, only partially paid

by a plan, or covered only if the service or supply provided meets certain specified criteria, e.g., pre-authorization for surgery.

Limited Policy: A contract that covers only certain specified diseases or accidents.

Loading costs: Administrative and other costs associated with underwriting an insurance policy. See also loading factor.

Loading factor (or load): The percentage of total premiums used for administrative costs, profits, and all items other than medical benefits.

Long-Term Care: The range of maintenance and health services to the chronically ill or physically or mentally disabled. Services may be provided on an inpatient (for example, rehabilitation facility, nursing etc)

Managed Care: Health care systems that integrate the financing and delivery of appropriate health care services to cover individuals by arrangements with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of health care providers, formal programmes for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

Manual Rate: The premium developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Maternity Care: Prenatal and postnatal care and delivery by a covered hospital, physician, or other covered practitioner, including, in many cases, nurse midwives.

Minimum Group: The least number of employees permitted to effect a group for insurance purposes. The purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Moral hazard: The tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have insured. Moral hazard can be classified into 'supply side Moral Hazard' (when the doctor provides unnecessary care because the patient is insured) or 'demand side Moral Hazard' (when the patient demands unnecessary care because he is insured).

Morbidity: The incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

No Claims Bonus: A reduction in the premium of an insurance policy effected through an increase in risk cover offered, because no claims have been made on it in the past years.

Non-contributory: A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. All eligible employees must be insured.

Out-of-pocket payments or costs: Costs borne directly by a patient who lacks insurance benefits; sometimes called *direct costs.* Unless covered by insurance, they include patient payments under cost-sharing provisions.

Outpatient Services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Overheads: The costs pertaining to general services (e.g. administration) which do not necessarily arise from the operation of a given programme.

Payroll deduction: A specific amount withheld from the earnings of an employee to finance a benefit. Payroll deductions may come in the form of a set payroll tax or a required payment for a benefit, such as a group health insurance premium.

Policy: The legal document issued to the policyholder that outlines the conditions and terms of the insurance; also called the "policy contract" or the "contract."

Policyholder: A person who pays a premium to an insurance company in exchange for the insurance protection provided by a policy of insurance.

Pre-admission Certification: A procedure whereby the insured or his doctor is required to contact the insurance company before admission to a hospital, and get the latter's permission.

Pre-existing condition: 'An injury that occurs, a disease that is contracted, or a physical condition which existed prior to the issuance of a health insurance policy. Such conditions usually result in an exclusion from coverage under an insurance policy due to costs of care for the condition.

Premium: The amount of money or consideration paid by an insured person or policyholder (or on his or her behalf) to an insurer or third party for coverage under an insurance policy. Premiums are related to the actuarial value of the benefits provided by the policy, plus a loading fee to cover administrative costs, profit, etc. Premiums are paid for coverage whether or not benefits are actually used. They should not be confused with cost sharing mechanisms, such as co-payments and deductibles, which are paid only if benefits are actually used.

Private health insurance: Health insurance that is sold by either commercial firms or not-for-profit organizations to individuals or groups. Such insurance is voluntary for the individual or group as a whole (though it may be compulsory for members of the group).

Provider: A person or institution which physically delivers health care goods and services. e.g. a hospital or a doctor.

Referral: The practice of sending a patient to another practitioner or to another programme for services or consultation, which the referring source is not prepared or qualified to provide.

Regulation: The intervention of government in the health care or health insurance market in order to control entry into or change / monitor

the behaviour of participants in that marketplace through specific rules.

Reimbursement: Payment by an insurance scheme to a health care provider, or to insured persons, as a refund for all or part of fees for services.

Reinsurance: The acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Renewal: Continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Rider: A document that amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage, or in any other way amend the original contract.

Risk: Any chance of loss.

Schedule: A list of coverages or amounts concerning things or persons insured

Self-Insurance (Self-Insured Plan): A programme for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial insurers.

Skimming: The practice in health programmes and insurance companies that are paid for on a prepayment or capitation basis of seeking to enroll only the healthiest people as a way of controlling programme costs. This is possible since the income of a programme or company is constant whether or not services are actually used. Skimming is also called creaming and contrasts sharply with *adverse selection* (see above).

Social health insurance: An insurance scheme set up and controlled by government or public agencies to provide protection against sickness. Social insurance is usually compulsory for the whole population or for a certain group. The contributions are usually

from payroll deductions of employed citizens, but the benefits are usually for the entire population.

Stop loss: The quantitative level up to which an insurer is liable for costs, beyond which risk is passed on to a re-insurer. Stop-loss clauses usually cover either overly large single claims or excessively high aggregate claims of any one member within a defined period.

Substandard Risk: An individual who, because of a health history or physical limitations, does not measure up to the qualifications of a standard risk.

Third-Party Administration: Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Third-Party Payer: Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. The individual generally pays a premium for such coverage in all private and in some public programmes and the organization then pays bills on his/her behalf. Such payments are called third-party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (the third party). (See also service *benefits* and *indemnity benefits.)*

Time Limit: The period of time during which a notice of claim or proof of loss must be filed.

Underwriter: The term as generally used applies to either (a) a company that receives the premiums and accepts the responsibility for the fulfillment of the policy contract, or (b) the company employee who decides whether or not the company should assume a particular risk.

Underwriting: The process by which an insurer determines whether or not to accept an insurance application and on what basis/terms it will be accepted.

Uninsurable Risk: One not acceptable for insurance due to excessive risk.

Universal coverage: Coverage of all the citizens of a country under a particular insurance scheme or variety of schemes.

Utmost Good Faith: A duty imposed on both parties to an insurance contract. The legal duty implies full disclosure of all facts material to the contract during negotiations of the contract.

Waiting period: The period of time that an individual must wait either to become eligible for insurance coverage or to become eligible for a given benefit after overall coverage has commenced (see exclusions). Some Policies will not pay maternity benefits, for example, until nine months after the policy has been in force. Another common waiting period occurs in group insurance that is offered through a place of employment, whereby coverage may not start until an employee has been with a firm for more than 30 days.

Waiver of Premium: A provision included in some policies that exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract,

Waiver: An agreement attached to a policy that exempts from coverage certain disabilities or injuries that are normally covered by the policy.

APPENDIX

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