



Framework for developing health insurance programmes

Some suggestions for States

Ministry of Health & Family Welfare

Government of India

New Delhi

Table of contents

NRHM – The Background	3 – 10
The approach to health insurance for vulnerable groups	11
Section 1	
• The framework	12 – 13
• Why health insurance?	14 – 16
• Pre-requisites for a health insurance programme	16 – 17
• Organiser of a health insurance programme	17 – 20
• Communities to be covered	20 – 22
• Defining the benefit package	22 – 24
• The premium	25 – 28
• Empanelling the providers	29 – 32
• Provider payment	32 – 33
• Insurer	33 – 34
• Administration of the programme	34 – 36
• Monitoring	36 – 37
• Managing risks	37
• Values in health insurance	38
Section 2	
• Health insurance programme for BPL families	40 – 43
• Health insurance programmes for SHG families	44 – 46
• Health insurance programmes where there are no hospitals	47 – 49
• Revamping the UHIS	50 – 52
Appendices	
• Some health insurance terms	54 – 55
• Some health insurance programmes in the NGO / Government sector	56 – 59
• Prices of some common conditions	60 – 65
• Utilisation rates of some common conditions	66
• Provider payment mechanisms	67 – 69
• Various Insurance Models	

BACKGROUND:

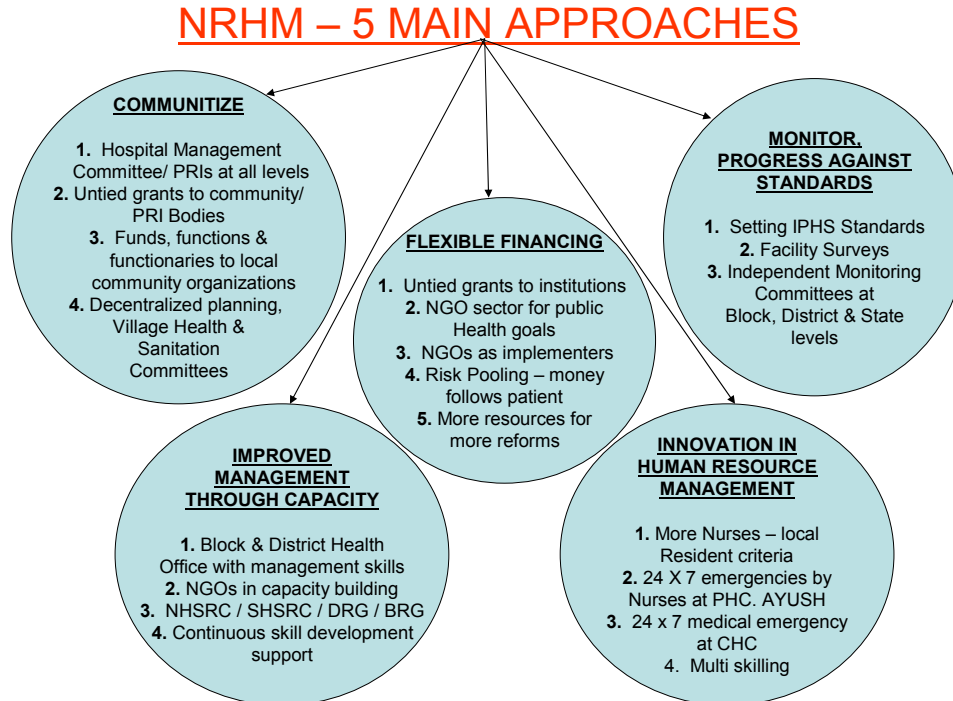
The Hon'ble Prime Minister launched the NRHM on 12th April, 2005 throughout the country with special focus on 18 States, including eight Empowered Action Group (EAG) States, the North-Eastern States, Jammu & Kashmir and Himachal Pradesh.

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality Rate (MMR) in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Rate (IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within the 7 year period of the Mission.

IMPLEMENTATION FRAMEWORK & PLAN OF ACTION FOR NRHM

The key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators.

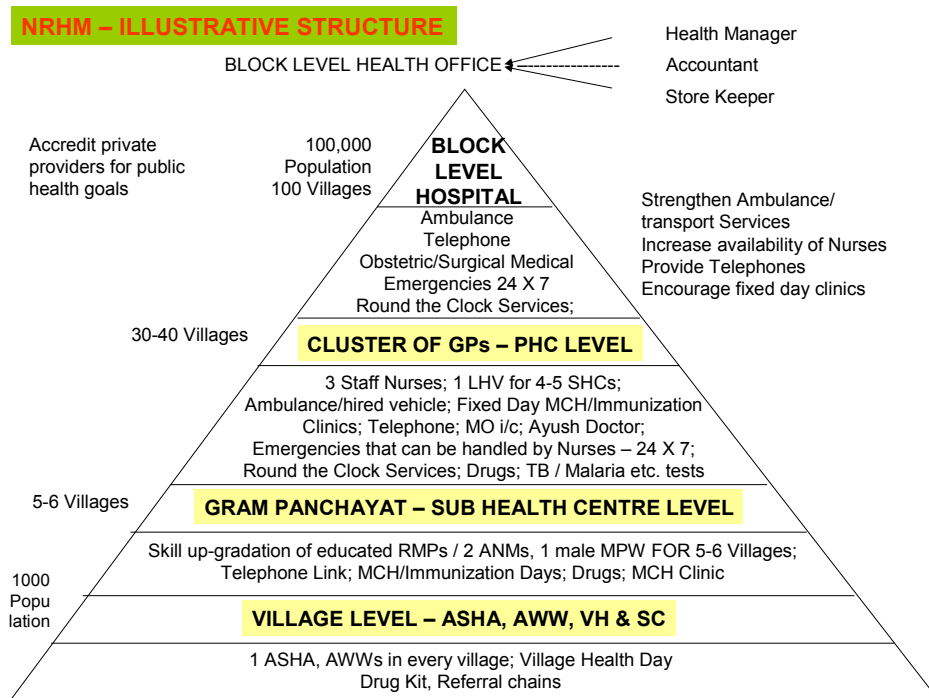
The Diagrammatic Representation of the 5 Main approaches of NRHM is illustrated below:



IMPROVING THE PUBLIC HEALTH DELIVERY SYSTEM

Given the status of public health infrastructure in the country, particularly in the EAG and the North Eastern States, it will not be possible to provide the desired services till the infrastructure is sufficiently upgraded. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning as well as infrastructure strengthening. The Mission would provide priority to both these aspects.

A generic Public Health Delivery System envisioned under NRHM from the Village to the Block Level is illustrated below:



PUBLIC HEALTH INFRASTRUCTURE

The Central Govt. has so far supported only the construction/up gradation of sub-centres. Because of their difficult financial conditions, the States have usually not provided sufficient funds for construction / up-gradation of Primary Health Centre [PHC]/Community Health Centre [CHC]/District Hospitals etc. As a result, health infrastructure is in poor condition in most of the states. NRHM allows the expenditure for construction subject to the condition that it should not be more than 33% of the total NRHM outlay in the case of high focus States, and, 25% in the case of non-high focus States. NRHM also provides for upgradation of District Hospitals.

In the first Cabinet approval, provision had been made for setting up of Indian Public Health Standards (IPHS) only for Community Health Centres (CHCs)/PHCs. The Mission now provides for IPHS at all levels i.e., sub-centres PHC/CHC and district hospitals.

As per the original Cabinet approval, untied grants were to be made available only to sub-centres. However, the Mission now proposes provisions for untied funds at PHC/CHC/district levels. A provision for funds for taking up innovative schemes at district/State/Central level has also been made.

Having Rogi Kalyan Samitis for managing health facilities has already been approved by the Cabinet. Now funds would be released as corpus grants to these Samitis as 100% grant by GOI during 2006-07, while it would be in the ratio 2 : 2 : 6 with regard to State / Internal / GOI from 11th Plan onwards.

The Mission also seeks to ensure the availability of requisite equipments and drugs at all the public health care facilities. Procurement of equipments/ drugs would be progressively decentralized and a road map prepared.

It is proposed to improve outreach activities in un-served and underserved areas specially inhabited by vulnerable sections through provision of Mobile Medical Units [MMU] in every district under this proposal. The MMUs would also cover Anganwadi centres.

IMPROVING AVAILABILITY OF CRITICAL MANPOWER

The issue of availability of critical manpower in the rural areas is proposed to be addressed through initiatives like introduction of a trained voluntary community Health Worker (**ASHA**) in every village of the 18 high focus states, additional ANM at each sub-centre, three staff nurses at the Primary Health Centres (PHC) to make them operational round the clock and additional specialists and paramedical staff at the Community Health Centres (CHC). The condition of local residency is proposed to ensure that the staffs stay at their place of posting. In the North-east, keeping in view the difficulty in availing services of doctors and specialists, the emphasis is on recruitment, training and skill upgradation of locally recruited ANMs/nurses/midwives/ para medics. It is also proposed to supplement the availability of critical manpower across the States through contractual appointment/local level engagement of medical and paramedical manpower upgrading and multi-skilling of the existing medical personnel. Innovations in Public private participation for service provision, franchising of service providers, licensing and training of Rural Medical Practitioners (RMP), rationalization of existing manpower are few of the innovations/options being explored. Stringent monitoring at all levels, involvement of the PRIs and monitoring by the Rogi Kalyan Samits should ensure presence of doctors & paramedicals in the rural areas. Besides compulsory posting of doctors in the rural areas, better cadre management & personnel policies would also help to improve manpower availability.

CAPACITY BUILDING

In order to provide managerial support, for tracking funds and monitoring activities under the Mission, provision has been made for setting up Programme Management Units at the State/District level. Over 500 professionals have already been recruited. The successful implementation of the Mission would require health sector reforms and development of human resources. Capacity building at all levels is a huge challenge under NRHM. In order to provide technical support to the Mission for achieving this objective, it is proposed to set up National Health System Resource Centre [NHSRC] at the Central and State levels (SHSRC) with an annual corpus support of Rs. 15 crore and Rs. one Crore at the Central and State levels respectively. The NRHM also emphasizes the setting up of fully functional Block and District level Health Management systems, as under NRHM 70% of the resources would be utilized at Block and below Block levels and 20% at the district level. Given the large army of ASHAs, ANMs, Nurses, Rural Medical Practitioners continuous skill development is needed. Strengthening nursing institutions, linking medical colleges for providing skill development support to rural health workers, involving the voluntary sector in skill development are few key interventions to be taken up.

To make the health facilities more accountable, their control would be gradually shifted to the PRIs and civil society. The Sub-centres are proposed to be placed exclusively under the control of the Panchayat. The PHCs and CHCs are also to be managed by the Panchayat Block Samitis (PBS) and Rogi Kalyan Samitis (RKS).

COMMUNITY HEALTH WORKERS

As per the approval of the Cabinet dated 4.1.2005, one female Accredited Social Health Activist (ASHA) is to be provided for every village with a population of 1000 (with provision for relaxation in the eight EAG States, Jammu and Kashmir and Assam) in each of the high focus states. She would be the link between the community and the health facility and would be the first port of call for any health related demand. Now under the Mission, it is proposed to have an ASHA in all the 18 high focus States. Besides, based on the recommendations of the Committee of Secretaries (COS) in its meeting held on 20.10.2005, it is also proposed to support ASHAs in tribal districts of all the remaining States. In case the other States would like to extend the scheme in remaining districts as well, it would be possible for them to do so under the RCH II. ASHA along with Anganwadi workers (AWW) & the Auxiliary Nurse Midwife (ANM), Self Help Groups & community based organizations, preraks of continuing education centres through their coordinated action at the village level & through combined organization of monthly Village Health, Nutrition & Sanitation day at the Anganwadi centres would be expected to bring about perceptible changes in the health status of the community.

CONVERGENT ACTION ON OTHER DETERMINANTS OF HEALTH

The PRIs and a large range of community based organizations like Self Help Groups, School, water, health Nutrition & Sanitation Committees, Mahila Samakhya Groups, Zila Saksharta Samitis provide an opportunity for seeking local levels accountability in the delivery of social sector programmes. Schools and Anganwadis would form the base of these activities. NRHM provides for School Health Check-ups and School Health Education to be worked out in consultation with the States. Convergence of programmes would be at the village and facility levels.

DECENTRALIZATION

As the indicators of health depend as much on drinking water, nutrition, sanitation, female literacy, women's empowerment as they do on functional health facilities, NRHM seeks to adopt a convergent approach for interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block and district levels. The **District Health Action Plan would be the main instrument for planning, Inter-sectoral convergence, implementation and monitoring of the activities under the Mission.** Rather than funds being allocated to the states for implementing programmes designed and approved at the GOI level, the States would be encouraged to prepare their perspective and annual plan which in turn would be based on the District Plans. Even though village is envisaged as the primary unit for planning, looking at the extensive capacity building required before it would be in a position to take up the exercise, the Mission would not insist on the village plans at least during the first two years. The District Health Mission under the Zilla Parishad would get the district plan prepared covering health as well as the other determinants of health. Household and Facility Surveys would define the baseline. Periodic surveys would thereafter be taken up on an annual basis to track the improvements in the facilities as well as in the reduction in health indicators. The District Plans would be collated into a State Plan which would be appraised and approved by the Mission at the national level. As far as the other determinants of health are concerned, the funds for them would continue to flow through the existing channels but the District Plan would clearly bring out the convergent action being taken at the district level. NRHM recognizes that delegation of financial and administrative powers at various levels would be necessary for the successful implementation of the decentralized plans.

MAINSTREAMING OF AYUSH

Provision has been made for State specific proposals for mainstreaming AYUSH, including appointment of AYUSH doctors/paramedics on contractual basis, providing AYUSH Wings in PHCs and CHCs. As envisaged under NRHM vision and goals, efforts will be made to integrate AYUSH in primary health delivery.

FLEXIBLE FINANCING

The programmes under the erstwhile Departments of Health and Family Welfare and Department of AYUSH were not being run in an integrated manner. As a result the transfer of funds to the states under different budget heads at different points of time vertically hampered flexibility. It also led to duplication of efforts, and, thereby, wastage of scarce resources. For improved delivery, the Mission attempts to bring the schemes of the Ministry of Health & Family Welfare within the overarching umbrella of NRHM as approved earlier by the Cabinet. Therefore, under the Implementation Framework, from the Eleventh Plan onwards, it is proposed to have a single budget head for the activities under the Mission. This would provide the States much needed flexibility to direct the funds to those areas where they are needed the most. However, a minimum amount would be earmarked for various disease control programmes to ensure that the national objectives and commitments are met. The funds under the NRHM budget head would flow through the integrated health society at the State and the District levels. The norms under which the funds would be allocated by the Centre to the States and by the States

to districts on the basis of Integrated State/District Health Activity Plans have been clearly spelt out in the Implementation Framework.

NORMATIVE FRAMEWORK

The District Health Action Plans would be prepared based on a normative framework. The cost norms have been derived from three sources. First, existing norms of the schemes brought under the umbrella of the NRHM. Secondly, norms developed by the NCMH. Thirdly, norms developed and approved as new interventions under NRHM.

MONITORING AND ACCOUNTABILITY FRAMEWORK

The NRHM Framework is based on a rights based approach. The Framework proposes accountability at every level through a three pronged process of community based monitoring, external surveys (SRS, DLHS household surveys by ASHA, facility surveys in the district level) and stringent internal monitoring. The process of community involvement of the health institutions itself would enhance accountability and the NRHM would facilitate this process by wide dissemination of the results. For effective monitoring a strong MIS is being put in place. The Citizen Charter would help the public to know their rights and entitlements at each facility. The setting up of IPHS at each level of health delivery system would be instrumental in provision of minimum service guarantees at those levels. Monitoring also would be in terms of service guarantees provided by each facility, utilization of such services by the community {especially weaker sections} changes in their health seeking behavior, etc. The Facilities Survey is expected to create a baseline for each health facility and assist in monitoring annual progress against the baseline in terms of services guaranteed. The MOUs signed with the States would enable monitoring of progress under NRHM in terms of the agreed milestones. Independent evaluation would ensure midcourse corrections.

PRO-PEOPLE PARTNERSHIPS WITH THE VOLUNTARY SECTOR

Investments by voluntary Organizations are critical for the success of NRHM. The Mission provides for partnerships with the voluntary groups/ organisations for advocacy, building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services and working together with community organizations. It is proposed to provide people friendly regulatory framework that promotes ethical practice through accreditation, standard treatment protocols and training and upgradation of skills of non-government health providers. 5% of the total NRHM outlay is proposed to be the resource allocation to voluntary organizations on the basis of approved guidelines & norms.

REDUCING IMR/MMR/TFR AND THE DISEASE BURDEN

Reproductive and Child Health Programme (RCH-II) was launched in 2005 as a part of the Mission as the principal vehicle for reducing IMR, MMR and TFR as envisaged in the original Cabinet Note. Upgradation of Community Health Centres as First Referral Units (FRUs) for dealing with Emergency Obstetric Care, 24x7 delivery services at the PHCs, operationalising of Sub-Centres multi-skilling of doctors, contractual appointments of MOs and AMOs, training medical officers in Anesthetic skills, training doctors/ANMs/Nurses as Skilled Birth Attendants (SBA) permitting ANMs

to administer certain drugs in emergency, partnerships with voluntary organizations, RCH camps accreditation of non profit organizations, IEC activities are the major interventions in reducing MMR. For reducing neo natal mortality programme for Integrated Management of Childhood illnesses (IMNCI) is being extended at the community and facility levels. Activities of ASHAs, Anganwadi workers and ANMs, preraks of continuing Education Centres and SHG groups at the village level with focus on both preventive and promotional aspects of health care accelerated immunization programme, advocacy on age of marriage/ against sex selection, spacing of births, institutional delivery, breast feeding, meeting unmet demands for contraception, besides providing a range of RCH services are to have impact on reducing the health indicators. Efforts are being made to integrate HIV AIDS programme with the RCH at the district and sub-district levels. Convergence of disease control programmes, integration of services, combined awareness generation, education and the advocacy at community and facility levels, taking care of preventive, promotive and curative health care are expected to bring down IMR/MMR/TFR and the disease burden as stated in the proposal.

RISK POOLING AND THE POOR

The Mission recognizes that in order to reduce the out of pocket expenditure of the rural poor, there is an imperative need for setting up effective risk pooling systems as already envisaged. State specific, community oriented innovative and flexible insurance policies need to be developed and disseminated. While the first priority of the Mission is to put the enabling public health infrastructure in place, various innovative models would be pilot tested to assess their utility.

FINANCING OF NRHM

The National Commission on Macroeconomics and Health (NCMH) has worked out an additional requirement of non recurring expenditure of Rs. 33811/- crores per annum and additional recurring expenses of Rs. 41006 crores at current prices for delivering functional health care in the public domain. This outlay, which would be shared by the Centre and the States would push the expenditure on Public Health care to nearly 3% of GDP. As some of the elements included in this computation of fund requirement relate to activities which are not strictly covered under the NRHM (like setting up of medical colleges etc) and if allocations to be made on such activities are excluded, then the additional capital and recurring requirements come to Rs. 30,000 crores and Rs. 36,000 crores per annum respectively over and above the current allocations. It may, however, be mentioned that with growth in GDP, in order to maintain the same percentage level of health expenditure vis-à-vis GDP, the expenditure would have to go up in the same proportion.

Given the absorptive capacities of the States and the time it may take up to build their capacities, it is projected in the implementation framework that there would be a 30 % annual increase in the central allocation for health till 2007-08, which, thereafter is envisaged to grow at the rate of 40 %. If the projected funds, become available, the public health expenditure is likely to reach 2% of the GDP from the current level of 0.9%.

In order to step up the expenditure on public health over the next 5 years, the states also have to very significantly increase the allocation for the health sector in their budgets, since they contribute almost 4/5th of the current total expenditure. The EFC has agreed that under the NRHM, 100 % grant be provided to the states during the 10th Plan which could be phased downwards to 85% in the 11th and 75% in the 12th Plan.

The approach to health insurance for vulnerable groups

NRHM is a serious effort to provide quality health care in rural areas that is accessible, affordable and accountable. The principal thrust of NRHM is to make the public system fully functional at all levels. Along side the efforts at strengthening the public system, NRHM also envisages partnerships with non – governmental providers for public health goals. Health insurance, under the over all NRHM framework is largely an effort to reduce the distress and duress of households in seeking health care, by reducing out of pocket expenditures through risk pooling. As NSSO 60th Round data reveals, there are out of pocket expenditures that households incur even when they go to a public hospital. The effort of the NRHM is primarily to improve the services of the public hospital but even then there would be out of pocket expenditures. It is on this count that NRHM strategy for health insurance for vulnerable groups is primarily to reduce out of pocket burden of poor families when they go to a government hospital. This will also improve the utilization of government hospitals. The intent of health insurance under NRHM is not to weaken the public system in any manner. It also tries to address the issue of non availability of services in the public sector in many areas. While NRHM will make all efforts to make publicly funded health services accessible, there may still be a need to seek partnerships with non governmental sectors as service providers as per mutually agreed standard of services, procedures and costs. Service guarantee to the poor households is the prime objective of NRHM and all efforts will be made to use the instrument of community health insurance to reduce the duress of households on account of high out of pocket expenditures.

This document is aimed primarily at the government officers who are planning a health insurance programme in their state - the Health secretary, the Director of Health services etc. It gives a step by step approach to introducing health insurance in their state / districts, within the overall framework of strengthening the public health system and improving the utilization of services from them. Starting from the rationale for introducing health insurance, it explores the communities that need to be covered, the packages that can be offered, the premium that should be collected and finally the administrative details. While the first section is more generic and gives guidelines for the framework, the second section is more prescriptive.

Some of the key messages are

- Be clear why you want to start health insurance
- Appoint a body that will take the responsibility of organising the health insurance programme. It may be an independent Health Insurance Corporation, or a cell in the Dept. of H & FW, or a separate trust, or a NGO.
- Start with covering 'organised' sections of the informal sector first. BPL families would be another option, but as they are poor, it would not be equitable to make

them pay. We have not tackled the option of involving the formal sector in this paper.

- The basic package should be a hospitalisation cover (upto a maximum of Rs 15,000) with no exclusions. For the BPL families, transport and wage loss compensation could also be included.
- The premium for this package is about Rs 250 for a family of five. A subsidy of Rs.150 - 200/- from the NRHM could be admissible with balance coming from State/beneficiary.
- An independent body should be appointed to administer the scheme. This could be a TPA or a NGO with the necessary technical and administrative skills.
- A monitoring cell should monitor specific indicators to ensure that the programme is on track.

There is currently a lot of interest in rural health insurance as it is realized that this is necessary to provide for basic health needs of the poor. Planners and policy makers in the Centre and States, all are interested in health insurance programmes. Although there has been a governing body of literature on this subject and several projects across the country, unfortunately, due to various reasons, including the fact that it is a new and complex subject, there is very little clarity on how to go about it. This document presents a framework which highlights some of the main steps and elements in developing a health insurance programme which will hopefully help in designing effective health insurance programmes. This document is aimed at the planner at the state level who wants to start a health insurance programme. However, it can also be used by district level staff or by national level planners who want to introduce health insurance schemes for their target group. The emphasis is on the **process** rather than on a product.

The document is divided into 2 broad sections. In the first section, each element is taken and developed in detail, keeping in mind the diversity in our country. This section gives the rationale to choose a particular option for each of the elements. In the second section, we outline some of the products suited for specific segments of population. This will help the planner who wants a readymade programme.

Some years ago the Ministry of Finance had started the Universal Health Insurance Scheme (UHIS) which was to be implemented by Public Sector Insurance Companies. This had a defined package of inclusions and exclusions, high premium and substantial subsidy for BPL families. However, this has had poor response for a variety of reasons – no ownership of States; high premium; many exclusions; criteria about providers; absence of TPA mechanisms; no marketing. Clearly, all these issues need to be examined and addressed. Lessons need also to be learnt from many successful but small social insurance schemes. Costs, and consequently premium and subsidy, need to be reduced to ensure sustainability while addressing minimum but basic needs. Health seeking behaviour and savings habit needs to be encouraged but costs of provision and administration need to be driven down. This requires decentralization of basic functions and the existence of structures for spread, trust and management. The State must also share the subsidy burden to impart ownership and accountability.

A meeting of State Health Secretaries had been called on 28th April, 2006 to discuss these issues. Some reading material was also provided. States have since been showing interest and taking initiatives. This document is a further steps to facilitate the work of States.

The Ministry of Health and Family Welfare would like to thank Dr. N. Devadasan of the Institute of Public Health, Bangalore and Dr. S.P. Goswamy, Consultant (Health Insurance) for their efforts in putting this volume together.

New Delhi
August 2007

Section 1

The framework

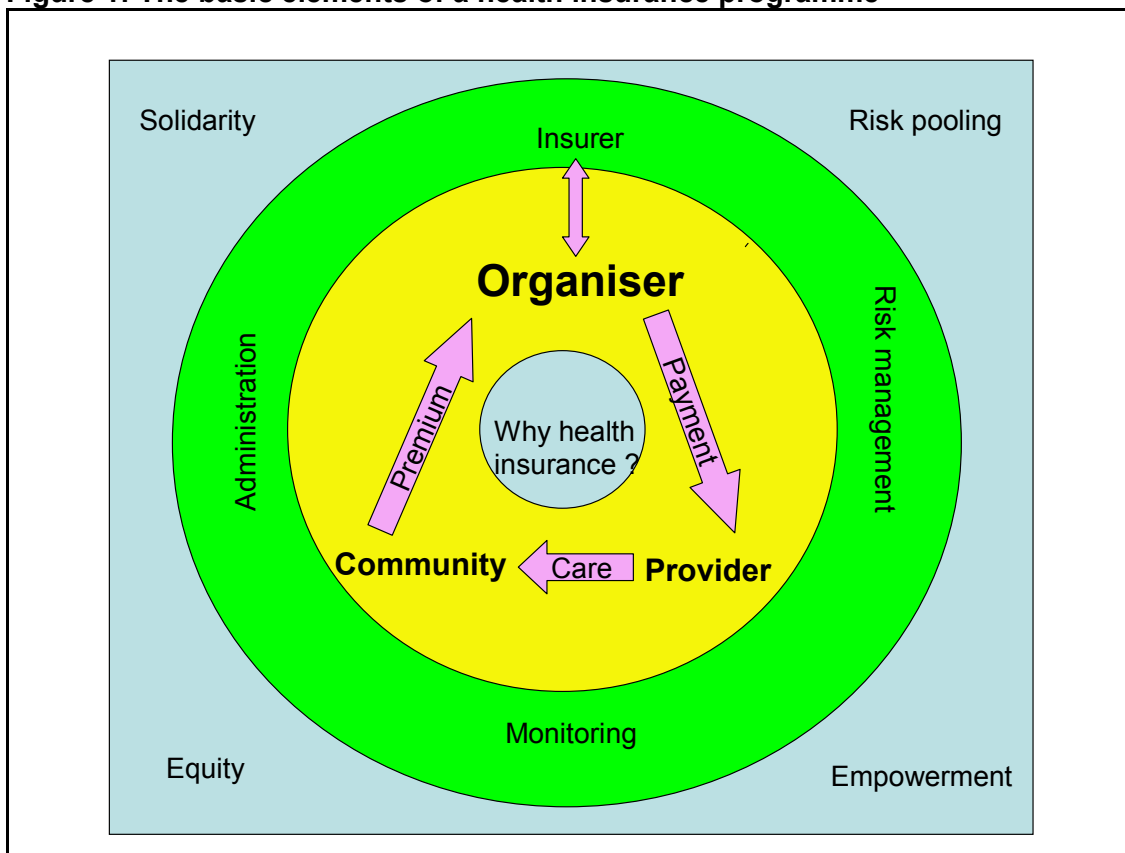
In our country, health insurance is still seen as a financial instrument and the major perspective is that of the insurance industry. This has various implications, including the stress on the balance sheet, profit margins and the claims ratio. Products are designed to enhance these components. In the process, the objectives of health insurance are totally neglected.

This document has been written from a **health systems perspective**, rather than a financial one. The focus is on using health insurance to improve access to health care and protect households from catastrophic health expenditure.

Yet another focus is on the **process** of designing and implementing health insurance plans, rather than just developing a single product. Products are easily developed, but more important is the need to market and service this product in the Indian context. This is the challenge that most companies face today.

This entire section is based on the framework that is shown in Figure 1. These are the elements that are required for developing a health insurance programme.

Figure 1: The basic elements of a health insurance programme



Why health insurance?

This is the first question that a planner needs to ask and answer. Why does the planner want to introduce health insurance at National / state / district / regional level? What is the need?

- Is there a problem of access to health care? Is the target population finding it difficult to access health care (primary or secondary)? Is there a problem of access because of financial barriers? Are the bills too high and the people too poor to pay these bills? **Health insurance could be a way of removing financing barriers and improving access to health care.**
- Is there a problem of impoverishment due to medical expenses? The population is able to pay the bills, but in the process has to borrow or sell their assets to meet these medical costs. This means that they may be pushed into poverty because of medical expenses. **Health insurance could be a way of providing financial protection against high medical expenses.**
- Is there a problem of quality of health care? People have the capacity to pay, but are not getting good quality health care. **Health insurance could be a way of negotiating with the providers for better quality health care.**
- Is there political pressure to start a health insurance programme? Is the Health Minister wanting to start a health insurance programme? This could be the wrong reason for starting health insurance in the state, but it could then be used to meet the above objectives – improving access and financial protection. Especially since there is high out of pocket payments by individual households in most of our states.

- The ACCORD health insurance programme was started because the tribals did not have financial resources to access hospital care. They preferred to lie down in their huts and die. After introducing health insurance, the tribals now pay a small premium when they are healthy and avail of benefits when they are sick. They do not have to worry about money at the time of illness.
- The DHAN foundation discovered that the single largest reason for indebtedness among their SHG women was loans to meet medical expenses. After starting their health insurance programme, women no longer have to take a loan when they are sick, as they are protected by the health insurance programme.
- With elections looming, the Assam government introduced a health insurance programme for its citizens. Unfortunately it was so poorly designed that it did not meet the needs of the people, especially the poor. Thus a golden opportunity to protect the poor was lost.

These questions need to be answered based on evidence. The latest NSSO data (60th round) gives information on the extent of out of pocket (OOP) payments in the states (Table 1). This could be analysed to understand the extent to which people are facing barriers to health care, or are becoming indebted. The common dilemma facing policy makers is “We are providing ‘free’ government health services. In such a scenario, should we introduce health insurance?” The fact is that the ‘free’ government health services are not meeting the needs of the community. This is why they are using the private health services and paying out of pocket. Of course, ideally the state and the central government should make higher budgetary allocations so that the government spending is doubled and the quality of health care in government health services is enhanced. This would mean that the government facilities are used and the households are protected from OOP.

Table 1: Out of pocket payments and indebtedness in some states in India (rural).

	All India	Poorest	Low income	Middle income	High income
% of people who do not use health services	18	24	24	18	11
% of people who use government services for OP	22 ^{1[1]}	30	26	22	18
% of people who use government services for IP	42 ^{2[2]}				
Average OOP payments made for OP (Rs)	257	191	237	243	426
Average OOP payments made for OP in Government facilities	11	9	19	9	12
Average OOP payments made for OP in private facilities (Rs)	246	163	190	211	377
Average OOP payments made per hospitalization (Rs)	5695				
Average OOP payments made per hospitalization in Government facilities (Rs)	3,238	2530	2950	3017	6374
Average OOP payments made per hospitalization in private facilities (Rs)	7,408	5431	5777	6781	10749
% of people who are indebted due to OP care	23	21	31	32	20
% of people who are indebted due to IP care	52	64	65	60	52

Source: NSSO 60th round 2004. Govt. of India.

^{1[1]} Bihar (5%), Jharkhand (13%), Maharashtra (16%), AP (21%), Assam (27%), Kerala (37%), Rajasthan (44%), Orissa (51%) and HP (68%).

^{2[2]} Bihar (14%), Haryana (21%), Maharashtra (29%), Gujarat (31%), Kerala (35%), Karnataka (40%), MP (58%), Orissa (79%), JK (91%).

But this may not be a feasible option, given the state government's fiscal situation. So a health insurance scheme could be an alternative to convert the existing OOP into a risk pooling mechanism. This would protect the households and improve access to health services.

From the above table, it is evident that there is a high OOP for both OP as well as medical reasons. There is not much inter-state variations on the last figure and it is a clear indication to introduce some financial protection measures like health insurance.

Pre-requisites for health insurance

Given the evidence that there is a need for improving access to health care and protecting the households, the next main concern is – are there situations conducive for introducing health insurance? There are some pre-requisites that need to be in place before one should consider health insurance as an option.

1. There must be a body that will be able to organize the health insurance programme. This could be the health ministry or the state health department. More important, it should have the basic capacity to organize the programme. This includes managerial, administrative, technical and social skills.
 - Managerial skills – to manage the entire programme
 - Administrative skills – to manage finances and the funds
 - Technical skills – to understand the complexities of health insurance
 - Social skills – to understand the community's needs
2. There must be a network of health care providers (public or private). Without this, it is not wise to talk about health insurance. Unlike in a tax based system, where the supply side can always defend the lack of supply by quoting the poor financial resources, in a health insurance scheme, the organizer cannot use this excuse.
3. The people must have the capacity to pay the premium. Especially in a contributory programme where the people are expected to pay the premium. However, well the programme is designed, if the people cannot afford it, there will be no takers.
4. There must be some basic data available regarding the demographic profile of the community, the morbidity rates, the utilization rates, the cost per unit utilized etc. There is adequate secondary data in our country for this (Census, NCMH, NSSO etc) and can be used till primary data is collected.

There are many more conditions that need to be satisfied, but at least these need to be in place before initiating a health insurance programme. The others could be developed along the course of the programme.

- In states with scanty provider networks, health insurance programmes may be difficult to implement, as people will not be able to access health care even though the programme takes care of the financial aspects.
- Most departments of health are busy implementing health care programmes e.g. RNTCP, RCH, hospitals etc. So there is no time or capacity to manage a fully fledged health insurance programme that requires different expertise and skills. To burden these staff with additional responsibility may not be a feasible option.
- In some states and regions, the people do not have the capacity to pay premium. They do not have ready cash because they depend on a subsistence economy. In such circumstances, the government needs to pay the premium on their behalf or organize innovative mechanisms for collecting premium e.g. in kind, etc.

Who will organize the health insurance programme?

This is one of the key elements in any health insurance programme? Who is the organizer? It could be

- An autonomous body – “The State Health Insurance Corporation” or
- The state government's dept of health or
- A ministry or a department for its target population, e.g. the Ministry of Textiles initiated a health insurance programme for the weavers, or
- A NGO for the community it works with, e.g. RAHA for the tribals, or
- A hospital for the people living in the catchment area e.g. VHS for the people living in the outskirts of Chennai, or
- A cooperative society for its members, e.g. the Mallur dairy cooperative in Karnataka, or
- A trade union, a driver's association etc, e.g. The Palakkad trader's association's health insurance programme.

Basically any group can take the initiative and organize a health insurance programme. The organizer must meet some criteria to be effective:

1. It must be **a credible and trustworthy organization**. People must have faith in the organizer and believe that it is organizing it for their welfare. Which is why when insurance companies try and introduce health insurance into a community, there few takers. The classic example being the Universal Health Insurance Scheme (UHS). People are wary about such companies. On the other hand, when it is done through NGOs who have been working with the community for long periods of time, then they are willing to enroll.

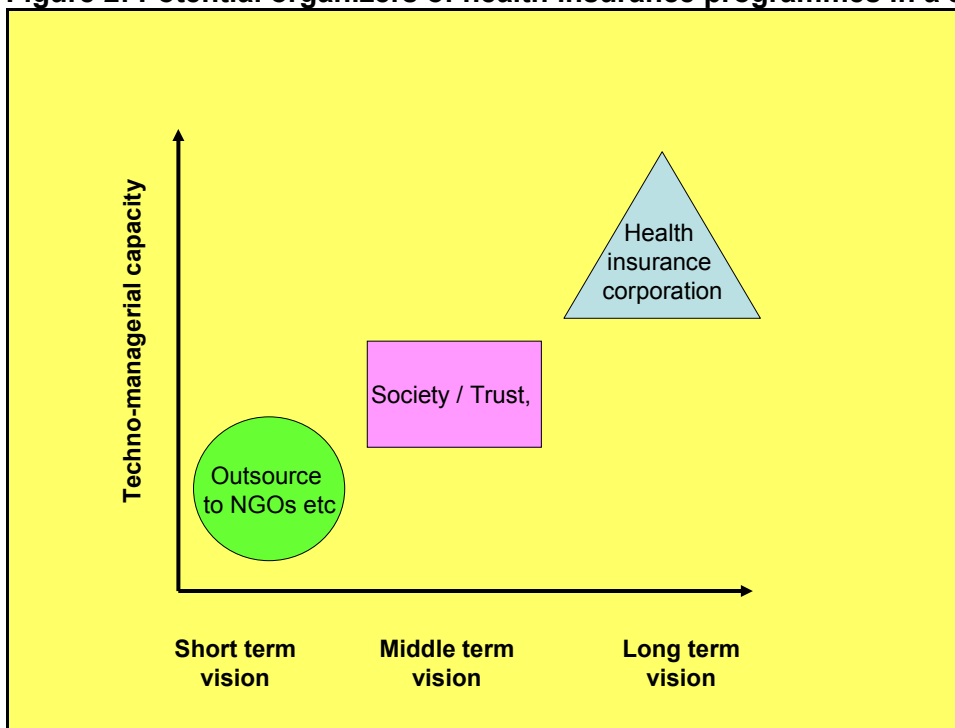
2. This organization **must have three basic skills:**

- It should have technical skills to understand the insurance concepts. Then it will be able to design a programme that is technically sound. Also this will help in negotiating with the insurance companies and the providers.
- It should have social skills to be able to discuss with the community and understand their needs.
- It should have the administrative capacity to organize the health insurance programme.

However, in larger organizations e.g. the government, the last two skills may be outsourced to independent administrators e.g. a third party administrator or a NGO.

The decision to identify the organizer may depend on various factors, e.g. if a state government wants to do a pilot for a couple of years, then it would be better to identify a NGO or a CBO who will organize the programme. However, if the state wants to cover larger populations and for a longer period of time, then an interim body like a “trust” could be given the responsibility of organizing the health insurance programme. On the other hand, if the health insurance programme is part of the health department’s drive to systematically cover its population, then it should develop a “**State Health Insurance Corporation.**” This autonomous body should incorporate related departments^{3[3]} as its members and be given the responsibility of steadily covering the entire population under some form of health insurance.

Figure 2: Potential organizers of health insurance programmes in a state



^{3[3]} e.g. labour, rural development, panchayat raj, women and child, finance etc as well as representatives from the community, hospital owner’s association and the insurance companies

This autonomous body has many advantages, one being that it will be an independent body that will be working for a specific purpose. Secondly it will not have the 'reputation' of the existing government departments. And finally being a single purpose unit, it will be able to achieve universal coverage at a faster rate. Some of its activities could include governing, organizing and monitoring the scheme, capacity building of the stakeholders, negotiating with the providers and the insurance companies, However, the ultimate decision will depend on the vision of the state government and the available capacity. If the state does not have the techno-managerial capacity, it could try and access the same from other sources, e.g. academic institutions, NGOs who have experience in implementing community health insurance programmes, representatives from the insurance industry, etc. One word of caution here, most of the resource persons from the insurance industry are used to the "profit" motive, whereas in a state government sponsored health insurance programme, the motive is improving public health indicators. So there may be divergent views if one relies solely on the industry inputs.

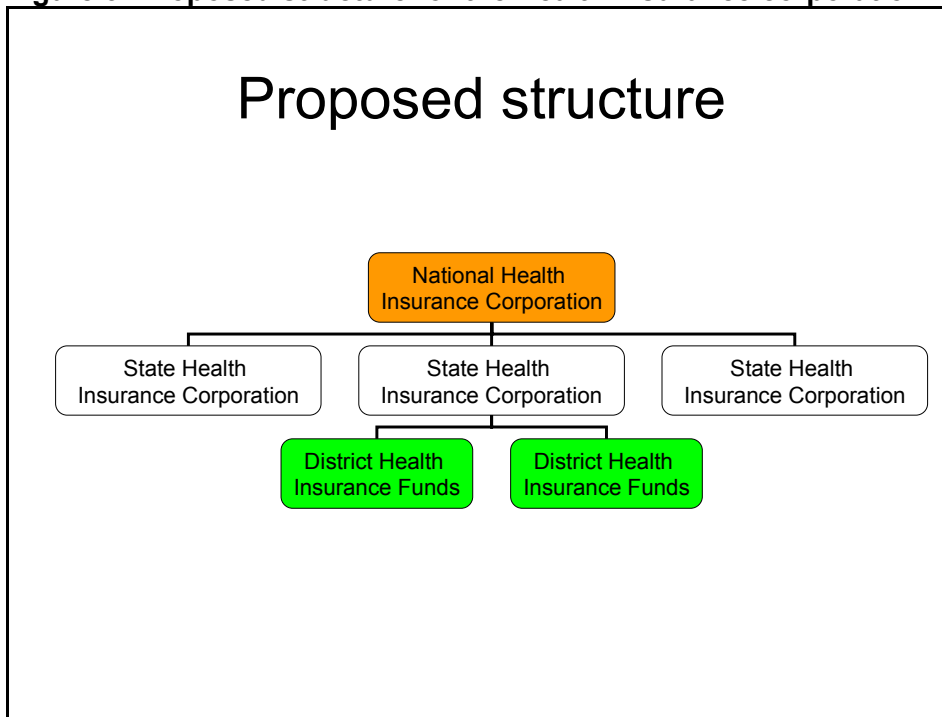
The Yeshasvini Trust organizes the Yeshasvini Farmer's Cooperative Health Scheme. The trust is a combination of Government officers and doctors. The members of the trust govern this scheme by deciding on the package, the premium and the target groups, monitor it monthly and negotiate with the hospitals. Being an independent body, the trust has the necessary credibility and is not associated with the suspicion that the Dept of Cooperatives is usually subjected to.

Role of the Health Insurance Corporation

- To provide the oversight for health insurance in the country / state.
- To explore measures to cover the population in an incremental manner.
- To ensure that the technical requirements for implementing health insurance are in place, e.g. legal framework, regulatory framework, administrative network, monitoring cell, etc.
- To manage the insurance funds (if it is the insurer) effectively.
- To provide technical and managerial support to the next level e.g. state / district.
- To liaison with the other ministries / departments.

A proposed structure is given in Figure 3

Figure 3: Proposed structure for the Health insurance corporation



Which community should be covered under the health insurance programme?

Ideally one should consider the entire population for health insurance. But given the improbability of doing this in the short to medium term, one should prioritise and select specific groups. Universal coverage can be done in an incremental way over time. This can be done either through:

- A population strategy
- A geographic strategy

Population strategy

If one looks at other country examples one notices two distinct approaches. The first is a “formal to informal” approach wherein the government initially covers the formal sector e.g. civil servants, employees in enterprises, industries and mines etc. This is an easy way to improve insurance penetration and also gives the government the time to gain experience. Once the formal sector is covered, then they progress to the informal sector. The other approach is the “indigent to formal” approach. Here the government initially covers the poor in their society by paying the premium on their behalf. Once this is done and they are able to manage this programme, they then move to the formal sector. There are of course advantages and disadvantages in each and a lot depends on the political environment.

In the Indian context, one can stratify the society into four broad categories for health insurance purposes.

1. Employees in the formal sector and their dependents. This includes employees in large corporate offices, industries, shops, etc.
2. People in the informal sector
 - a. Who are organized, e.g. farmers, traders, SHGs, etc.
 - b. Who are unorganized, e.g. vendors, maid servants, landless labourers, subsistence farmers etc.
3. The indigent e.g. BPL families, destitute, etc.

Of course this is a suggestion and one can decide on different ways to stratify society. The main advantage of stratifying the population is that one can use appropriate strategies for each stratum.

For example, the formal sector could be insured using a social health insurance mechanism. This would be easy as they are organized and can be approached through their employer. On the other hand, the indigent may be difficult to insure as they have neither the financial capital to pay premiums nor the social capital of organized groups. In such instances, it may be better to provide social assistance to this group and insure them by paying the premium on their behalf. However, the main difficulty in this measure is to ensure that they are aware of their insurance status. Many such schemes have shown that it has taken a few years before people are aware about the health insurance scheme and the benefits that are available.

Existing strata that are “organized” e.g. dairy cooperatives, driver’s associations, religious organizations, members of self help groups (SHGs), NGO communities, caste based organizations etc are excellent entry points to introduce health insurance. These are existing groups and have the advantage of inbuilt solidarity and channels for communication and premium collection. Estimates suggest that there are about 10 crore people in the informal sector who are ‘organised’ in groups e.g. traders, drivers, beedi workers etc.

The unorganized groups are difficult to insure and it is better to cover them at a later stage.

The community that should be covered depends on the local needs. However, in terms of ease of coverage, it is easier to cover the informal “organized” sector, the formal sector, the BPL families and then the informal “unorganized” sector.

Geographical strategy

Yet another approach to covering a population is to have a geographical approach. For example, one can cover an entire district. This is a feasible option, provided the organizer is proficient and is capable of designing and managing many insurance products. This is because the need of the population varies. For example, in a district, there are different groups of people; farmers, labourers, traders, civil servants, etc. Each may have different needs and requirements. One scheme will not benefit all. So it will be necessary to design different schemes for these different groups. This, naturally, is a difficult task and requires some level of expertise.

Table 2: Specific strategies for specific populations

Type of population	Strategy to be used
Formal sector – employed	Mandatory – Social health insurance
“Unorganised” informal sector	Voluntary – Private health insurance. Subsidy where necessary.
“Organised” informal sector.	Voluntary – Community health insurance. Subsidy where necessary.
Poor	Social assistance

How does one identify the poor? Most states have distributed BPL cards for this category of the population. However, each state has used its own definition of BPL and so there is no homogeneity. It is recommended that the government uses the Planning commission guidelines for identifying the BPL families.

- The Employees’ State Insurance Scheme (ESIS) provides benefits for the low paid workers. On the other hand, the Central Government Health Scheme (CGHS) covers the civil servants and members of Parliament, judges etc. Most established enterprises either provide health services for their employees or reimburse medical expenses.
- The Tribhuvandas Foundation covers dairy farmers who are members of the local dairy cooperative societies in Anand, Gujarat.
- Vimo SEWA covers members of the SEWA union and their dependents in Gujarat.
- The Student’s Health Home in Kolkata, provides health insurance cover for all the students in West Bengal.
- The trader’s association in Palakad district, Kerala are covered under a health insurance programme that covers their members and dependents.
- Karuna Trust provides insurance cover for all the BPL families in T. Narsipur taluk.

Defining the benefit package?

Once the community is identified, then one can look at their requirements. The possible benefit packages commonly used in our country are

- **Hospitalisation expenses** with or without exclusions. This fits into the insurance logic, of covering rare but costly events. However, because it is rare, people may not be keen to have it. They may feel that the insurance scheme will benefit only a few people. However, this maybe the need of the planners, who would prefer that the people be protected from high medical costs.
In India, most hospitalization packages are riddled with exclusions, e.g. chronic illnesses, pre-existing illnesses, TB, HIV etc. This is undesirable and ideally one should have a package that includes most common illnesses. Many insurance companies are recognizing this and are providing comprehensive packages now. Also to limit outflow, many insurance companies usually put an upper limit to the hospitalization cover e.g. Rs 10,000 per patient per year.
- **OP cover**, either as a stand alone package or with hospitalization. This is the most common demand of the people. This will ensure that they get some benefit for the premium paid. However, it is difficult to administer and monitor. There is a great danger that all headaches will land up in the doctor's clinic, increasing the cost of health care as well as of the insurance programme. Also it is difficult to verify each event and release funds. One way out is to have a voucher system, say 5 vouchers for a family of 5. This will be used for OP care among empanelled doctors. The doctor has to provide care (consultation and medicines). The doctor then needs to submit these vouchers at the end of the month and get reimbursed @ Rs 50 per voucher. Remember that OP cover is costly and increases the premium by at least 50%.
- **Transport costs** for bringing the patient to the hospital. This is usually linked to hospitalization cover and meets the transport expenses of the patient in coming to the hospital for treatment. This is a necessity in remote areas where transport costs are high and form an effective barrier.
One simple way out is to pay the patient a flat rate (e.g. Rs 250 or Rs 500) when the patient is admitted in the hospital. This can be paid by the hospital and can be reimbursed by the insurer later.
- **Loss of wages** for the patient or attender. If one is insuring BPL families, this benefit becomes imperative. This is because most BPL households cannot afford unemployment. A hospitalization episode is a triple burden for them, as they have to suffer the distress of the illness, to raise money for the treatment and also undergo a loss of income. To compensate for this, some schemes have included loss of wages compensation into the benefit package. This is paid during the hospitalization period, usually @ Rs 50 per patient per day for a maximum of 15 days.
- **Other** products like life insurance, asset insurance, personal accident insurance.

These can be used as a comprehensive package or in various permutations and combinations. The final choice depends on four factors

1. The needs of the community. If the community lives in remote villages and finds it difficult to reach hospitals; a hospitalization package per se will not meet their needs. One may need to include transport costs also.
2. The cost of the final package and whether it is affordable for the target population. Naturally a package that has all the above components will be very costly and may not be affordable to most communities. So one would have to prioritise and choose the most relevant benefits – a balance between the community needs and the technical needs.
3. The administrative burden in delivering this benefit package. Hospitalization is a rare event and can be easily administered. On the other hand, OP cover is more difficult to administer, and requires innovative mechanisms.
4. Availability of these services. It naturally does not make sense to cover hospitalization expenses, if there are no reasonable hospitals in the locality.

We propose a stratified benefit package that will meet the needs of varied population groups.

An essential package (Blue card)	Basic hospitalization cover, with no exclusions. Includes maternity. Maximum limit upto Rs 15,000 per family per year. Patients admissible only in general wards.	Includes transport expenses upto Rs 300 per episode of hospitalization.	Includes loss of wages upto Rs 50 per person per day for a maximum of 10 days in a year.
An optimum package (Silver card)	Basic hospitalization cover, with no exclusions. Includes maternity. Maximum limit upto Rs 30,000 per family per year. Patients admissible in semi-private wards only.		
An enhanced package (Gold card)	Basic hospitalization cover, with no exclusions. Includes maternity. Maximum limit upto Rs 50,000 per family per year. Patients allowed to use single rooms.		

The upper limits can be changed, depending on the costs of admissions in the region^{4[4]}.

The stratified benefit package can be open to all those who want to subscribe.

^{4[4]} One simple way to do it is to visit some of the providers and get a list of admission bills in the past one year. Sort this by the bill amount from low to high. Find out the figure for the 90th percentile and this could be the upper limit. This means that the insurance cover will protect 90% of the insured patients. It will be even more if one introduces cost containment measures (see later). Do not try to cover all 100% as a few outliers will skew the figure for the rest of the population.

The premium

The premium is the amount that needs to be paid by either the households or the government to become insured. While of course the premium should be affordable, there are many other issues that need to be considered while deciding the premium.

Calculating the premium

To calculate the premium, one requires some basic data. While this is usually done by actuaries in an insurance company, it is desirable that the planners / managers of the insurance scheme also have some idea about calculating the same. This will ensure that informed negotiations take place with the companies.

Some of the basic data that is required are:

1. The details of the benefit package.
2. The cost of each unit of the benefit package e.g. average cost of hospitalization, cost of each episode of transportation etc.
3. The probability of this event occurring in an individual. This can usually be obtained from secondary sources e.g. NSSO data etc.
4. The approximate administrative costs.

We use an example to cost the blue card

	Cost per event	Probability	Rupees
Hospitalisation	5000 ^{5[5]}	30 ^{6[6]}	150000
Transport	300 ^{7[7]}	30	9000
LoW	300 ^{8[8]}	30	9000
Premium			168000
Admin cost ^{9[9]}			16800
Total premium for 1000 individuals			184800
Total premium per individual			184.80
Premium / family^{10[10]}			211.00

^{5[5]} The median cost of all hospitalizations in the set of providers.

^{6[6]} The probability of hospitalization / 1000 individuals; based on NSSO figures. The upper limit has been calculated, anticipating higher hospitalization rates due to insurance.

^{7[7]} Amount reimbursable per hospitalisation

^{8[8]} Rs 50 per day, for an average hospitalization of 6 days.

^{9[9]} Approximately 10% of the total premium

^{10[10]} 120% of the individual premium

Estimated premiums for the three packages

Benefit package	Premium amount* (per family of five per year)	
Basic	Rs 200*	Rs 150#
Optimum	Rs 400*	Rs 500
Enhanced	Rs 750*	Rs 600

* From actual data and based on a software

Calculated by an actuarial

There are various other ways of calculating the premium. The above is also called “community rated” premium and is usually a flat rate for all the members. Income rated premiums, where the premium increases with the economic status of the individual (though the package remains constant) is ideal in a social health insurance programme like ESIS etc. On the other hand, most insurance companies in our country advocate the risk rated premium. This varies depending on the medical history of the individual. While it is ideal for individual policies, it is totally inappropriate where one is insuring large numbers. Mainly because the risks are pooled and so the effect of the high risk is diluted within the larger pool of low risks. And of course operationally it is impossible and costly to assess the risks of each and every individual.

Ways of reducing the premium to make it affordable are

- Reducing the package, so that it costs less. For example one could exclude treatment of TB, or of family planning operations, or RTI treatment saying that these are available “free” in the government sector.
- Reducing administrative costs
- Enrolling as a family unit

- At ACCORD, the tribals pay Rs 30 per person per year for a comprehensive benefit package with a maximum limit of Rs 3000 per patient per year.
- At DHAN foundation, the premium is Rs 150 for a family and the benefit package is a comprehensive cover (excluding deliveries) with a maximum limit of Rs 10,000 per patient per year.
- The Yeshasvini scheme covers surgeries for an upper limit of Rs 2,00,000 per patient per year for a premium of Rs 120 per person per year.
- The Universal Health insurance charges Rs 248 for a family of five and provides cover upto a maximum of Rs 30,000 per family per year. However, this policy has all the standard exclusions.

Collecting the premium

While fixing the premium is a technical matter, collecting it depends on the target population and how close the organizer is with the community. The easiest way to collect premium is to use existing channels.

- Membership payments - if one is insuring SHG members, then one can use the existing channels to collect the premium. The same can apply for association members, union members etc.
- Deducting at source - if one is insuring cooperative society members, then one can instruct the district officer to deduct the premium amount annually from the member's dues and send it to the organizer.

In the case of BPL members, the government may want to pay the premium upfront on behalf of the families. This has the least administrative costs.

In the case of unorganized sectors, e.g. landless labourers, or vendors etc, it may be very difficult to collect premiums. The only way out is to have a voluntary enrolment mechanism which is easy enough for the people.

Enrolment unit

While the common unit for enrolment is the individual, this not a good option, as it promotes adverse selection. On the other hand, it would be better to enrol as large a unit as possible. If one is enrolling SHG members, then one could say that all the members of the SHG should enrol. Or if cooperative society members are enrolling, then at least 50% of the society members should enrol for this society to become insured. In the beginning, this may be difficult, as people may have a lot of scepticism about the

programme. So it may be reasonable to enrol all the family members as one unit. This way, one can ensure that adverse selection is minimized.

- JRHIS in Wardha has family as the enrolment unit.
- Student's health home has the school as the enrolment unit.
- SEWA has the individual as the enrolment unit.

Collection periods and waiting periods

There are two possibilities while collecting premium. One is to collect it during a fixed period. The other is to collect it continuously. The latter is difficult as one has to keep continuous watch on renewal periods etc. Also it encourages adverse selection as people will tend to join when a family member is sick. So a fixed collection period (of two or three months) is more desirable. However, it is necessary to fix this when the community's finances is the highest, so that they can use their disposable income to pay the premium.

Waiting periods are used – again to prevent sick people from joining and using the benefits immediately. Usually the waiting period is for a month after paying the first premium. This applies only to those who are joining for the first time or joining after a break. Obviously, a person who is renewing his insurance on time does not have to wait any more.

How to empanel the providers?

Providers are an essential element for any health insurance programme. Without this, one cannot even consider a health insurance programme. So before any organizer contemplates a health insurance programme, he should review whether there is an adequate distribution of providers.

The providers could be public or private or NGO providers, could be clinics or hospitals, could be practitioners of allopathic or AYUSH. The choice depends on the benefit package. For example, if one is covering OP and IP, then one should empanel a set of clinics and hospitals. On the other hand, if one is covering only IP, then it makes sense only to empanel hospitals.

Identifying providers requires a balance between technical capacity and people's choice. So ideally one should do it with representatives of the target population. There are two options:

- One is a free for all – allow people to choose any hospital, as long as it meets the minimum criteria, e.g. more than 15 beds, registered with local body etc. The advantage of this is that the patient has total freedom to choose. However, it is difficult to monitor many institutions. And worse, one cannot introduce any quality measures as there is no MoU between the organizer and the hospitals.
- Empanel according to set criteria – develop a set of criteria and then empanel the hospitals only if they meet these criteria. It may be advisable to have reasonably strict criteria, so that quality is assured. Many hospitals may refuse to cooperate if the criteria are too strict. So one must maintain a balance. The advantage here is that one can negotiate for quality health care, for cost control measures and anti-fraud measures. Also the patient should understand that by empanelling providers their choice may be limited, but they get additional benefits like cashless service, assured quality and low costs (leading to low premiums).

It is not necessary to empanel all the providers, rather only those who meet the criteria. One of the bargaining points for the organizer would be the additional income that the provider would make if they are empanelled. Hospitals in Gujarat who were empanelled under the Chiranjeevi scheme had a turnover of a few lakhs every month, just from the insured patients.

The most important aspect is to **purchase** care. For this, the government needs to change its mindset from providing to purchasing health care. Providers in the government also need to have a change in mindset as they need to compete with the private sector providers for patients. This could be an excellent opportunity to improve the health services, both the government as well as the private and make them accountable to the larger good.

Some suggestions for empanelment are given below:

- be registered with the local administration
- be acceptable to the local community
- have a resident medical officer (allopathic or ayurvedic or homeopathic or sidha or unani) available round the clock
- have at least 3 nurses (or nursing assistants), one for each shift
- have facilities to admit at least 10 patients at a time
- have its own pharmacy or access to an independent pharmacy that will supply medicines to the patients
- have its own laboratory or access to an independent laboratory where investigations will be done on a credit basis for the insured patients
- be willing to use generic medicines for the treatment of the insured patients
- be willing to follow standard treatment guidelines for the treatment of the insured patients
- be willing to provide cashless services to the insured patients
- not charge any money from the patient. All services (medicines, investigations and consumables will be supplied by the hospital)
- accept the tariff rate developed by the insurance organizer
- maintain necessary records and registers (e.g. IP register, OT register, Labour room register, pharmacy register, accounts register) as per the prescribed format
- allow inspection of its records by prescribed representatives including medical audits, chart audits etc.
- be willing to change its treatment practices if some indicators (e.g. infection rates, Caesarean rates, admission rates, investigation rates, etc) are found to be higher than average.
- be willing to submit claims as per the requirements
- be willing to wait for at least 30 days for reimbursements
- bear the cost of the fraudulent bills in the event of any fraud or any wrong billing

Negotiating with the providers

While empanelling providers, the organizers need to negotiate for some benefits. These include:

- Development of MIS so that the records of the insured are identified easily.
- A cashless system for the patient,
- Cost containment measures like
 - Essential drugs
 - Generic medicines
 - Standard treatment guidelines for common conditions
- Quality of care measures like
 - Medical audits
 - Chart reviews
 - Appropriate evaluation protocols
- Special privileges for the insured like
 - Different queues
 - A special desk for the insured (this may be manned by volunteers or representatives of the TPA).
 - Adhering to the referral system
 - Accepting only cases that have a pre-authorisation (unless it is an emergency)
- Fixed tariffs and payment systems (see later)
- Submitting claims in standard formats

Once the terms and conditions are negotiated, it is advisable to have a written MoU with the providers highlighting what are the responsibilities of each stakeholder. This way, misunderstandings are reduced to a minimum and the patients benefit the maximum.

Public versus private

This is a major issue in most health insurance schemes started by the states. Should one empanel only public providers, only private providers or both? The issues for each are discussed below:

Only public providers (as in Karuna trust).

- Plus points
 - Government health services are strengthened
 - Quality can be easily improved
 - Can be used as a tool to motivate government staff
 - More benefits at lower costs

- Minus points
 - Choice for the patient is limited
 - The insurance plan may appear meaningless as the patient anyway gets 'free' or subsidized care at the government hospitals
 - Most governments do not have directives on how to use the user fees, leave along insurance reimbursements. This means that the money collected will stagnate in bank accounts.

Only private providers (as in most CHIs)

- Plus points
 - More choice for the patients
 - Improved access as there are many more providers
 - More services will be available for the patient
- Negative points
 - Cost control, anti-fraud measures and quality are difficult to enforce
 - Criticism that public money is being used to fuel the private sector

Ideally one should have both public and private providers. But for this certain conditions need to be in place:

1. The public sector hospitals should be able to receive the insurance reimbursements. Currently most states permit user fees. So this should be broadened to include reimbursements. However a few studies and anecdotal evidence suggests that most of the user fees languish in bank accounts as the concerned officers are reluctant to spend this money without written instructions. So if the insurance reimbursements are to be used for the benefit of the patients, then clear cut guidelines on their use should be developed.
2. The public sector should be allowed to compete with the private sector. This means that powers be devolved to the district medical officer, so that he / she can take decisions that will improve the performance of the government hospitals. This could include incentives for the staff, so that they are motivated to provide good quality care.
3. The mindset of the government doctors should change from salaried employees to private practitioners.

Paying the providers

This is a much neglected element in the entire health insurance programme. On the other hand, it can be a very powerful tool with the organizer to reduce costs. The most common method currently used to pay providers is "**fee for service**". For example, a patient goes to a doctor, gets care and pays the consultation fees, goes to the pharmacy and pays for her medicines. This means that the patient pays the entire cost of health care at the time of use. It is a very inefficient manner of paying providers for two reasons:

- It places a burden on the patient at the time of illness. And there is no risk pooling. The entire burden has to be met by the patient.
- It encourages the doctors to provide more services (whether necessary or not) so that he can maximize his profits.

There are other efficient payment mechanisms that can be introduced and will help contain costs. An effective measure is the “**payment per case**” method. In this a particular diagnosis is paid a previously decided flat rate, irrespective of the costs incurred. Thus a delivery could be reimbursed Rs 1000 even if the actual cost of the treatment is Rs 1200 or Rs 800. This has tremendous administrative benefits, as the organizer does not have to scrutinize individual bills. Also the incentive for the provider to prescribe extra services does not exist any more. The only drawback is that it can compromise quality of care, as providers may actually skimp on relevant treatment to make profits. This is also called “**diagnosis related groups**” (DRGs).

Yet another measure is the “**capitation**” method. Useful when reimbursing OP services, providers receive payment according to the number of people registered with them, not for the actual services given. Under-prescription can be countered by introducing competition between the providers. Thus only those providers who are providing good quality care will have people registering with them.

A third method is to pay providers a fixed “**budget.**” The providers have to provide all the required services within this budget. Useful, if the budget is just right. If budgets are calculated based on past utilization, there maybe a tendency for over using the budget, so that the provider gets higher allocation in the subsequent year.

More details are given in the Appendices. It is clear that the organiser requires considerable technical skills to introduce alternate systems of provider payment.

Who is the insurer?

Who will take the risk of managing the insurance funds, ensuring that it is enough to meet the needs of the programme? One option is to link up with existing insurance companies, either private or public. This has many advantages:

- Management is in professional hands
- Risk pooling is increased as the funds are merged into the larger pool of “non-life” insurance
- The organizer is free to manage the programme
- The company has enough capital reserves to provide buffer, in case the claims ratio exceeds 100%
- It is legally acceptable by all concerned

The disadvantages are:

- The insurance company will not be as flexible as desired
- Changes in the scheme will require necessary clearances at various levels and will take time
- The objective of the insurance company is “profits” and not necessarily access to health care. This conflict of interest may lead to tension between the organizer and the insurance company
- The insurance company will of course add to the administrative costs and hence load the premium
- Any balance, left over from the premium will be deemed as profits by the insurance company. On the other hand, if the government is managing the funds themselves, this money can be used as reserves or carried over to the next year.


Thus the government will have to decide on one way or the other, depending on the circumstances. If it has the financial and technical capacity, it may be better off managing the funds on its own. On the other hand, if the above is limited, then it may be better off seeking the help of insurance companies.


Administration of the scheme


Normally the organizer takes on the insurance function as well as the administration function of an insurance programme. However, given the wide range of tasks involved, it is better to outsource this to another body, e.g. a third party administrator (TPA) or a NGO. This would be better than trying to do everything. The TPA need not be one registered with the IRDA. It could be any organisation that has the capacity to do the work. Even a district federation of SHG members, or a district cooperative society (with adequate technical inputs) can play this role. They need to have accounting skills, social skills and technical skills. The last maybe lacking even among TPAs. One way out is for the organiser to provide this support either directly or through existing technical organisations. In the long run, capacity building of these district bodies will be required.


While short listing a TPA, one must ensure that they are willing to:


- ✚ **Enrol members** - The TPA should make the list of insured members and issue them the necessary insurance cards. These could range from ordinary cards to smart cards, depending on the availability of funds. Currently a laminated photo card costs about Rs 10 per card.
- ✚ **Create awareness** - Creating awareness is not a one time activity. It definitely needs to be initiated before the introduction of the health insurance scheme. It should also continue on a regular basis, even after the scheme has been implemented. The messages should be simple and should answer the queries that the people have about health insurance and their experiences with it.


- 
Monitor the flow of premium funds - The TPA should ensure that the funds collected reach the end point without leakages. This is an important task and enhances the credibility of the entire scheme. People will trust an initiative that has checks and balances. However, one must be wary of introducing too much bureaucracy also.

- 
Empanel providers – Negotiating with the providers, ensuring that they accept the prescribed terms and conditions and then empanelling them is an important task that should be the TPA's main activity.

- 
Fixing tariffs – once the hospitals have been empanelled the TPA needs to discuss tariffs with them. This can be done using various ways. One simple way is to do it on a district basis. Invite the hospitals and classify them into three broad categories; <25 beds, 25 – 75 beds and 75 – 150 beds. Rarely there may be a fourth category of > 150 beds. Ask each provider to list out the common conditions that they treat in their hospitals. Once this list is available, a tariff can be fixed, based on average costs for each category. This would be a case based tariff. To make things easier, one could divide the conditions into broad categories like minor medical admissions, major medical admissions, minor surgical admissions, major surgical admissions, normal obstetrical admissions, surgical obstetrical admissions etc. Average tariffs could be fixed for each of these categories.


- 
Provide pre-authorisation services – To prevent demand side moral hazard, one needs to ensure that patients are treated at the appropriate level. One way is to have a pre-authorisation service that will screen patients and clear admissions to those patients who require it. This is an important activity and needs to be performed scrupulously. This is the place where the TPA interacts with the patients and if it is unsatisfactory, then the renewal rates may be affected. The main issue to monitor here is the turnover time between the receipt of application from the provider and the response.


- 
Process claims and reimbursements – The cashless system is the optimum method of processing claims and reimbursements. In this, the insured patient goes to the provider and receives care. At discharge, the patient walks out without paying any money. The bills and necessary documents^{11[11]} are submitted to the TPA who reimburses the hospital. The TPA then submits the same to the insurer (be it the organizer or the insurance company) who then reimburses the TPA. However, the TPA and the provider needs to monitor the amounts closely, so that wherever the patient has exceeded his / her limits, the balance money is recovered from the patient at the time of discharge.

- 
Minimise fraud – The TPA should keep a strict tab on fraud and prevent it wherever and whenever possible. Some of the sources of fraud are –

^{11[11]} Minimum documents could be discharge summary, list of all the medicines prescribed and investigations performed (with results) and the final bill with detailed breakdown.

abuse of the insurance card by a non-insured, wrong diagnosis, high bills, false bills, etc.

 **Develop a management information system** – the TPA should develop the reporting system so that data flows from the field to the organizers. This includes reports from the premium collectors, to data from the hospitals, to data from the insurers about claims. Of course other than this, the TPA should interview patients and community representatives to get feedback on their perceptions. A mix of quantitative and qualitative data is required.

 **Provide regular reports to the monitoring committee** – for details, see later

Monitoring the programme

This is an oft neglected element in the implementation of any health insurance programme. At the maximum, fund position is monitored. But there are many important indicators that require to be monitored. Some of these are given below:

INDICATOR	DEFINITION	Monthly	Annual
Coverage rate	Number of people enrolled in a defined population		+
Penetration rate	Number of people enrolled from among the target population		+
Distribution rate	Number of people enrolled per distributor		+
Enrolment trend	Trend over the years		+
Renewal rate	The number of people who are renewing their membership		+
Member satisfaction	The number of members who are satisfied with the services	+	
Insurance card rate	The number of members with an insurance card		+
Quality of claims	The number of claims with the proper documents at the first instance	+	
Utilization rate	The number of members who fell sick and required care	+	
Claims rate	The number of members who fell sick, and have claimed insurance benefits for their illness episode	+	
Reimbursement rate	The number of members who have been reimbursed their claims	+	
Top diseases	The top five disease conditions for which claims are being made		+
Top providers	The top five providers from where the maximum number / amount of claims are being made		+
Median Medical costs	The median costs of hospital bills	+	
Referral rate	The number of patients who were given pre-	+	

	authorisation		
Quick ratio	The ratio between the liquid assets and the liabilities	+	
Administrative expenses ratio	The ratio between the administrative expenses and the total expenses		+
Claims ratio	The ratio between the amount of claims reimbursed and the amount of premium collected		+
Turn over time for pre- authorisation	The time taken between receipt of pre- authorisation and the decision conveyed	+	
Turn over time for claims settlement	The time taken between receipt of claims and reimbursement	+	

A monitoring cell (nominated by the organizers) need to meet monthly and look at these indicators. This monitoring cell can be at the district level (if there is capacity), however, it definitely has to be at the state level. Action should be taken as soon as any discrepancy is seen. This is an excellent motivator for the staff as they realise that their actions are being scrutinised.

Managing risks

Minimising adverse selection, moral hazard, fraud and cost escalation are very important for the success of any health insurance programme. Some of the measures to achieve this is given below.

Risk	Measures to manage risk
Adverse selection	<ul style="list-style-type: none"> • Have a large unit of enrolment, e.g. a family, a village, a self-help group • Have a definite collection period • Have a definite waiting period • Have a compulsory enrolment as opposed to a voluntary enrolment • Exclude pre-existing diseases
Supply side moral hazard	<ul style="list-style-type: none"> • Have a flat/case-based payment mechanism as opposed to a fee for service mechanism • Preferably pay the providers a fixed salary – this will minimise incentives for interventions • Insist on standard treatment guidelines • Insist on medical / chart audits
Demand side moral hazard	<ul style="list-style-type: none"> • Have a referral system or a pre- authorisation system • Introduce co-payments
Fraud	<ul style="list-style-type: none"> • Introduce photo identity cards for the insured • Use social audits to identify fraudulent admissions • Take strict action against fraudulent events • Keep proper registers and records
Cost escalation	<ul style="list-style-type: none"> • Try different provider payment mechanisms • Insist on standard treatment guidelines • Insist on generic medicines

These measures as stand alone methods as well as in combination are powerful tools to enhance the chances of success.

Values in health insurance

The four values in health insurance – equity, solidarity, risk pooling and community empowerment have been discussed in the above text. Community empowerment will take place when the community pays the premium and requests for better quality services. Risk pooling is enhanced when there is risk sharing between not just the healthy and the sick, but also between the rich and the poor. Equity is strengthened when people pay according to their ability and get benefits according to their need. And this is possible only when people are bonded in solidarity. As it is difficult to promote solidarity solely through a health insurance mechanism, it is important that health insurance programmes be piggy backed on existing institutions that have inherent solidarity e.g. a trade union or a SHG federation.

Conclusions

The above framework is a guideline to help planners develop appropriate health insurance plans. The main inputs are from the local situation. The final plan will depend on this. Most of the important elements have been covered in this document. Details like cost, prevalence etc have been suggested, but ultimately the planner has to use local and regional data. It is not difficult to access this data, most are available. All it requires is a little effort to collate the same.

Section 2

Some schemes

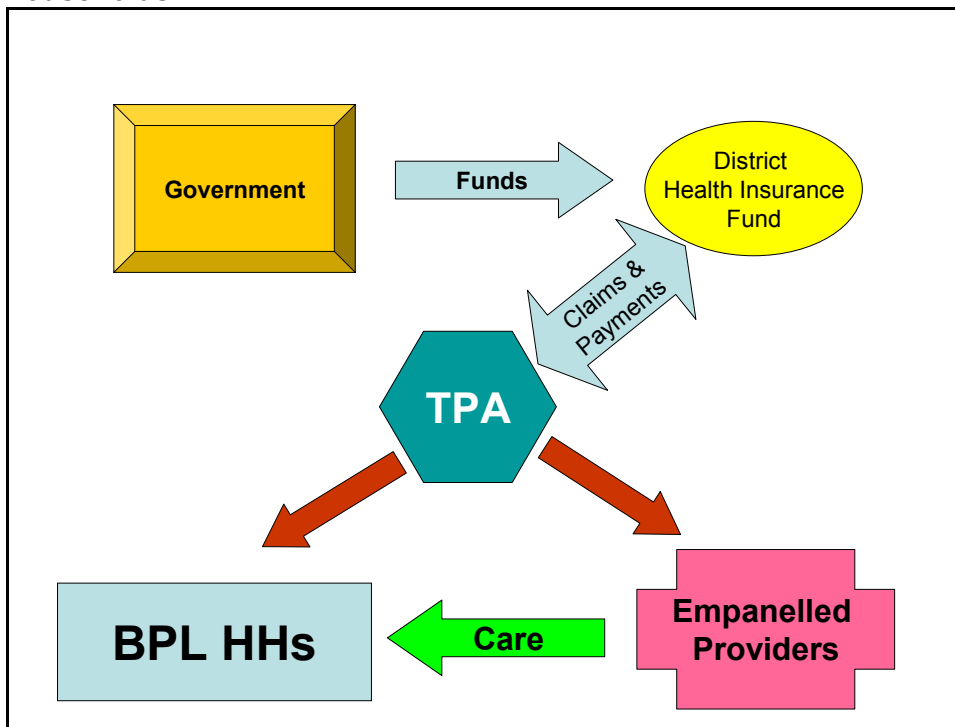
In this section, we present a few health insurance schemes that are 'readymade' and can be implemented directly in a region or amongst a specific population. Please note that the theoretical basis for each 'scheme' is provided in Section 1.

Health insurance programme for BPL families

People living below the poverty line (BPL) have difficulty meeting basic needs like food, shelter and clothing. Health care for them becomes a luxury and many are not able to access the health services for want of financial resources. These are the groups who require protection when they are ill. Unfortunately the current government health services are not able to meet their requirements, due to various reasons. So one may need to address their needs on a priority basis.

In their case, one would prefer to use social assistance rather than a traditional health insurance programme. The basic design is given in Figure 4

Figure 4: Possible design for developing a social assistance programme for BPL households.



Organizer of the programme

The state government or the district government organizes the programme, with the help of NGOs.

The community

In this case, the community to be insured is the BPL families in a district or the state. They can easily be identified by the BPL cards. While there may be many objections to the validity of the BPL cards, if the margin of error is not too much, one can accept it as an initial identifier. Later, one can refine it with time and experience. The list of BPL families can be obtained from the Rural Development dept, or from the Panchayat Raj Dept, or from the Revenue Dept.

The benefit package

In this case, as most of this population will be suffering from communicable diseases, a low end package will easily meet their needs. So the basic package with hospitalization, transport cover and loss of wages cover would be the optimal package for them. OP cover may be considered, but organizing it may be difficult and also expensive.

Hospitalisation cover for all conditions, upto a maximum of Rs 15,000 per family per year;
Transport costs of Rs 300 per hospitalisation episode;
Loss of wages compensation of Rs 50 per patient per day hospitalised (maximum limit of 10 days).

The premium

The premium as calculated would be about Rs 250 for a family of five. This maybe unaffordable to many BPL families. So there are two options possible:

- ✚ Totally subsidise the premium
- ✚ Partially subsidise the premium

These two options have various implications. In total subsidy, the government will pay the premium on behalf of the families to the insurer. So the people are insured at one go. However, from varied experiences, it is clear that most of such families are not aware of their insurance status. It takes at least 2 – 3 years of concerted effort to create awareness in all the families. Thus this option should be considered only if the government has the funds to cover the BPL families consecutively for 3 – 5 years. Else the entire money will be wasted and there will be nothing to show for the effort and resources spent.

The second option is however a difficult one to implement. The government can subsidise the premium and collect only an affordable amount from the BPL families. However, the difficulty is in collecting this premium. As is clear from the UHS experience. One way out is to request all the ANMs, the ASHA and the Anganwadi workers to collect the premiums from the BPL families and pass this to the District Health Insurance fund. They may be given a performance based incentive for collecting the premium. However, in such a case, they should be empowered to distribute the insurance cards to the insured families. A second or third step in distributing these cards may not be feasible and desirable.

The enrolment unit should be the family, nothing less and the premium (if collected) should be during a definite collection period. Given the difficult enterprise, waiting periods may be waived in this instance.

Providers

As the government providers have not been successful in meeting the needs of the BPL families, it may be necessary to have a combination of public and private providers. The latter should be empanelled keeping in mind the preferences of the families. The TPA (or similar local body) should do the empanelling. The criteria for empanelling are given earlier (Section 1). The providers should be willing to

- ✚ Provide cashless hospitalization service for the insured card holder
- ✚ Provide all the facilities, including medicines and laboratory investigations at the hospital
- ✚ Accept the tariffs and payment mechanisms

Public providers who are empanelled should be willing to accept the insurance reimbursements. This money may be used partly to finance the essential requirements in the hospital and partly as an incentive to motivate the staff.

Insurer

In this case, and especially in the early years, the claims ratio will be very low. So it is better that the government is the insurer. The government transfers funds to a district health insurance fund who then manages it. Any premium collected from the people is deposited into this fund.

Administration

Independent TPAs could be appointed to manage the scheme. As stated above, they could be given specific tasks, especially in creating awareness among the BPL families. Where available, local NGOs could be appointed as the TPAs. Their main roles would be create awareness, enrol members, issue id cards, maintain lists of members, empanel providers, negotiate with them for quality services, low cost and administrative conveniences; process claims and reimbursements and monitor the entire programme. Further details are given in Section 1.

Indicators to be monitored

The main indicators to be monitored are given above (Section 1). The most important indicator to be monitored is the utilization rates, especially in the first few years. If premium is being collected, then coverage rates also need to be monitored. Renewal rates give an idea about the satisfaction of the programme.

Risk management

As entire populations are insured upfront, adverse selection does not have any role here. On the other hand, moral hazard may be an important risk to be minimized. Some of the ways out are:

- ✚ Have a flat/case-based payment mechanism as opposed to a fee for service mechanism
- ✚ Insist on standard treatment guidelines
- ✚ Insist on medical / chart audits
- ✚ Have a referral system or a pre-authorisation system
- ✚ Introduce photo identity cards for the insured
- ✚ Use social audits to identify fraudulent admissions

Conclusions

The challenge in this model is to identify the BPL families. While many criticise the existing BPL cards for their inaccuracy, it could be a good enough starting point. With time and with specific interventions, the BPL lists could be refined so that false positives and false negatives are minimised. More important, such schemes should not be reduced to populist measures, flash in the pans that appear during election times. To be a sustainable model, such schemes should be functional for at least 3 years with full subsidy and then with a tapering subsidy over the next five years. This way, the people will have faith in the scheme and will also get into the habit of purchasing health insurance.

Health insurance programme for members of SHGs

The author uses SHGs just as an example. The same model can be used for cooperative societies, for associations, for trade unions, for beedi worker's associations etc.

In most southern states, and in some northern states, self help groups (micro credit groups / micro finance groups) are well established. These are usually formed of women in low income and middle income strata, who meet once a month to save. Many of these groups have federated into large district level structures and control crores of rupees.

Evidence, from recent times, indicates clearly that the main reason for taking loans are medical expenses. So many of them are willing to take the next step of microfinance i.e. micro health insurance.

Community

The SHG members and their dependents are the eligible members who should be able to enroll in this HI programme. To reach out to them, it is better to tackle the larger federations who are well established. For example in Kerala, the government decided to introduce health insurance through the Kudumbashree – a government sponsored federation of SHG women. At last count, they had 25 lakh women members.

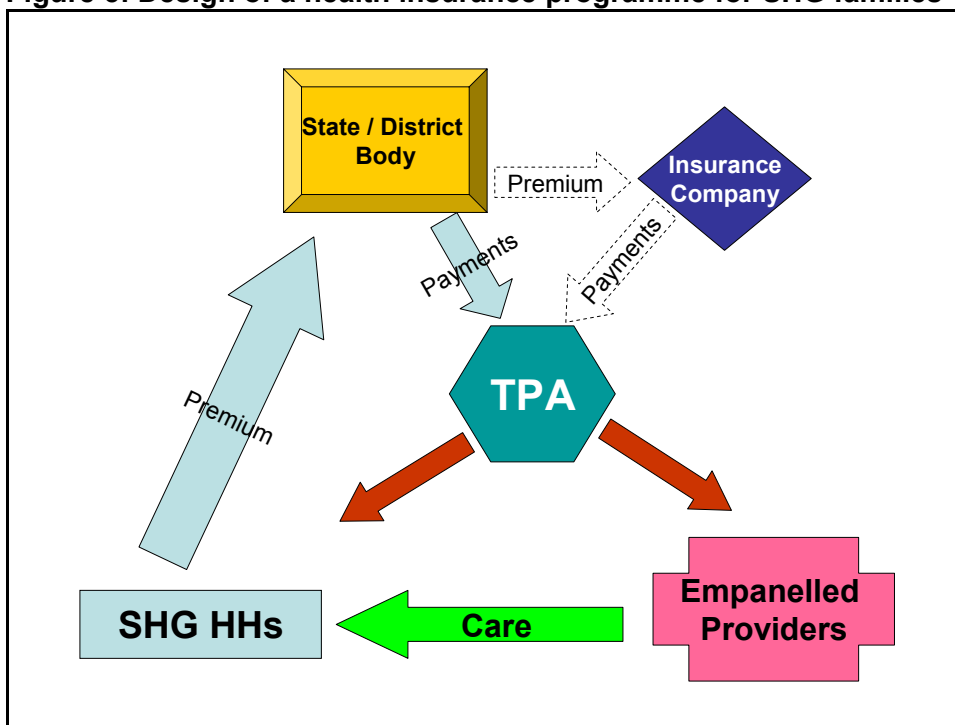
Organizer of the HI programme

Depending on the state's interest, the size of membership and vision, the options are:

- The State Health Insurance Corporation
- A trust / society initiated by the state government for health insurance
- The district health society
- A NGO
- The Dept of H&FW

The advantages of each are given in Section 1. The last would be the most undesirable option, as then this activity would be diluted amongst hundred other activities. The proposed design is given in Figure 5.

Figure 5: Design of a health insurance programme for SHG families



The benefit package

This segment of population is categorised as “near poor”, usually above the poverty line. They have some assets and are able to save, even if only small amounts. More important, they have access to credit when needed. So in this case the optimum package (silver card) would be an ideal benefit package for them. This includes hospitalization cover upto a maximum of Rs 30,000, with no exclusions. The premium would be between Rs 350 to Rs 400 per family per year, depending on the state.

The premium

The premium as calculated is Rs 400 per family of five. This may seem a high premium for a low income family. However, given their practice of meeting once every month, the premium can be collected in monthly instalments and paid at one point in time to the local collection agent.

While most SHGs identify only the women as members, for the sake of the health insurance programme, the member and her dependents should be insured. It would even be better if the entire group could be insured rather than individual families. The premium could be collected through existing SHG channels – from individual members to the group, from the group to the cluster; from the cluster to the Block level federation and from there to the district. The money can be deposited into the District Health Insurance Fund.

The providers

Where such health insurance programmes are implemented, one must empanel government as well as private sector providers. This can be done after discussing with the community and the relevant local district officers. The criteria for empanelment are given in Section 1.

The providers will be paid on a case base mechanism or a DRG mechanism. Tariffs will be formulated earlier itself, based on local prices. Later, after conducting costing exercises, one may arrive at more exact tariffs.

Insurer

If the size of the pool is large, e.g. an entire state, the programme may be able to manage the funds on its own as a stand alone health insurance fund. However, if it is small e.g. a district, then it maybe advisable to link up with an insurance company. The insurer in this case will be a health insurance company. The company could be selected after floating a tender with the requirements and choosing a company that provides the lowest premium and also agrees to the conditions laid out.

Administration

The Health Insurance corporation and the insurance company will together decide on a TPA. This could be an organisation registered with the IRDA or an independent NGO that has the capacity to manage. The TPA has to have the capacity to service the programme at the district and sub-district level. The main activities that the TPA should do are given in Section 1. The indicators that need to be monitored by the Health Insurance corporation are also given in Section 1.

Risk management

The main risks to be managed here are adverse selection, moral hazard and fraud. Measures for these are clearly given in Section 1.

Conclusions

As stated earlier, this model can be used for various 'organised' groups in the 'informal sector'. And depending on the scale of the programme, it could be at the district or state level. Once this programme has been established, it could be expanded to cover other groups in the locality. And more important, it could be used to cover groups like landless labourers, subsistence farmers etc, who normally are out of any formal activities. These groups could be allowed to join the scheme on a voluntary basis.

OP care in areas where there are no hospitals

In some of the states, especially the northern states and NE states, where hospitals are not available in the rural areas, a hospitalisation based health insurance may not be feasible. In these regions, people use the existing “unqualified” medical practitioners as well as qualified medical practitioners to meet their health care needs. But because of various reasons, even these practitioners are very costly and people are not able to access them because of financial barriers. So in such a situation, providing a cover for OP and transport would be a reasonable option.

Community

The people living in these regions. Where possible, try and use the existing organised groups e.g. those communities working with NGOs, SHG members, religious groups, etc.

Since it is a voluntary health insurance, the danger of adverse selection is high. To minimise this, the family should be enrolled.

Organiser of the health insurance

As a pilot programme, this should be outsourced to a credible NGO in this region. The NGO should be given the technical inputs and the managerial freedom to cover this population.

Benefit package

The main benefits would be OP care. Each enrolled family would be given an insurance card along with 5 pre-printed vouchers. These vouchers can be exchanged at empanelled providers for health care during the year.

Other than this, the family will also be reimbursed travel costs for one episode of hospitalisation, up to a maximum limit of Rs 500. This can be obtained from the NGO organiser who will verify the hospitalisation status and the validity of the insurance card before reimbursing the money.

Premium

The premium for this package will be about Rs 300 per family (of 5) per year. As most of these families would be very poor, the government could subsidise the premium by 50%, paying the NGO directly for each family insured. So the NGO has to collect only Rs 150 from the families.

Providers

As stated earlier, most of these regions will not have hospitals and even qualified doctors. In such circumstances, one may have to empanel “unqualified” medical practitioners, or AYUSH practitioners. This should ideally be done in consultation with the local community, and only credible practitioners who provide some modicum of quality care should be enrolled. Preference should be given to those practitioners who live in the villages and are available 24 X 7.

The NGO should reimburse the providers on the basis of the vouchers, Rs 50 for each voucher. This would limit the unnecessary medication and injectables that is the wont of such practitioners. The other way of paying the providers is through a capitation system. The community should be asked to register with a particular practitioner. The NGO pays the practitioner Rs 50 per patient registered. With this money, the practitioner should provide OP care to the registered patients. This mechanism has limited tendency for fraud, the only drawback is that the practitioners may restrict the treatment given. However, if there is a possibility of competition between the providers, then this will also be taken care of.

Insurers and the administrators

The NGO becomes the insurer, as it is collecting funds (from the people and the government) and managing the funds. This may not be acceptable with the IRDA which does not recognise such stand alone models of health insurance. So other options should be considered e.g. simplest would be to call it a "Health Fund" rather than a health insurance programme.

The NGO should reimburse the providers on a monthly basis (if voucher system) or pay the capitation fees in three monthly advances. They should however monitor the scheme closely, especially monitor the extent of fraud. Social audits should be used for minimising this and the community representatives should be available in the claims committee. Random checks on claims should also be made, to verify that vouchers are not being misused by the insured community.

The NGO should also negotiate with the providers for empanelling them and providing the desired quality of care. It should of course create awareness among the population about the benefits of health insurance and the possibility of improving their access to health care.

Risk management

The main risk here is that of moral hazard and fraud. Every headache may land up at the doctor's clinic for treatment. The people should be informed about the price of abuse. If they use their vouchers for frivolous conditions, then when they really fall sick, there may not be any vouchers for their health care. This may reduce moral hazard. Also if people save vouchers, then it may be carried over for one year. This would be an incentive for patients not to abuse the system.

Fraud is a potential problem as anybody can borrow their neighbour's voucher and seek care. Of course, one can introduce some identification mechanism e.g. a ration card, or a voter's id card, or a BPL card etc. But as stated earlier, social audit is more effective. Responsible members of the community / NGO field staff should verify random claims.

Monitoring

The main indicators to monitor are the coverage rates and the utilisation rates. This will give an idea about the inflow and outflow and will allow the NGO to plan for the next financial year.

Conclusions

This programme should be a pilot to test whether insuring OP services is feasible in poor rural areas. The programme should be monitored closely to understand what are the other measures that need to be introduced to make it run successfully.

Using UHIS

The UHIS was launched with much fanfare, but unfortunately was not accepted by the people due to various reasons. Latest data (Sept 2005) suggests that only 45,118 families have been insured and the claims ratio is about 11%

While we shall not go into the reasons for its failure, we suggest some measures to make more acceptable to the community.

Organiser of the health insurance plan

The department of health could be the main organiser of the plan. It can take on the governance of the programme, and outsource the administrative functions to independent agencies. For example, it could appoint a TPA (or a large NGO) who would market the product among NGOs, SHG groups etc. This same TPA would administer the scheme.

There are other possibilities,

- One is for the State Health Insurance Corporation (or the Trust) to organise the marketing and servicing of the UHIS; or
- The other is to identify a NGO with significant presence in the districts and who is involved in health; or
- The federation of SHG at the state level, e.g. Kudumbashree (in Kerala).

Community

The community is restricted to BPL families.

Benefit package

The benefit package is the standard UHIS. However, this package would be more acceptable if maternity was included. The government may have to pay an additional amount – in the range of Rs 50 per family.

While this package does exclude pre-existing illnesses, if one is insuring in large numbers, it will not be feasible for all the insured to undergo a medical check up. Thus this condition will become non-functional. Also many of the conditions that come under pre-existing illnesses and chronic illnesses like diabetes, hypertension, IHD etc do not affect BPL families. So one should not be unduly worried by this clause.

The other elements of the package, i.e. personal accident cover and wage loss compensation cover can remain as it is.

Premium

The premium will be as per the current guidelines. However, one may need to add Rs 50 to the family premium if one has covered maternity also.

	Actual premium	Subsidy by Gol	Premium payable by household
For an individual	Rs 365	Rs 200	Rs 165
For a family of 5	Rs 548	Rs 300	Rs 248
For a family of 7	Rs 730	Rs 400	Rs 330

The family should be the enrolment unit. However, the package is restrictive when it describes the family of 5 and 7. These restrictions can be waived and anybody in the family can be insured.

The premium of Rs 248 (or Rs 330) can be collected in its entirety or the state government can also add to the subsidy. If the state government plans to provide a 100% subsidy, it should recognise two aspects. One is that as the people have not contributed, they will not be aware of their insurance status. So it is necessary to invest considerably on insurance education and awareness building. The second is that in the long run, this may not be sustainable. So it may be desirable in the initial years, till people become accustomed to the insurance mechanism. Once the demand is created, the subsidy can be progressively reduced.

The administrator of the scheme will collect the premium from the designated groups and hand it over to the government health insurance fund. This premium will then be handed over to the insurance company.

Premium collection will be during a fixed period. And as per the policy, there will be a waiting period of 30 days.

Kudumbashree is the federation of all government sponsored Self Help Groups in Kerala. There are about 22 lakh women who are members. The department of panchayat raj introduced the UHIS through this organisation. The premium was subsidised by the government of India (Rs 300), the state government and the local panchayats. The individual household had to pay only Rs 33

Providers

One must empanel the providers. This is the work of the administrator of the scheme. The TPA should use the guidelines given in Section 1 and empanel the providers in the districts and sub-districts.

Payment mechanisms for the providers are clarified in Section 1. The department through a decentralised District Insurance Fund can reimburse the hospitals directly. However, the payment should be on a case basis or DRG basis.

Insurers

The four public sector non-life insurance companies are the insurers of the product and they take the risk. While the insurance company will receive the premium, it will also distribute 50% of the premium to a designated government account as a rolling fund. This fund will then be used to settle claims. The insurance company will top up this amount as and when necessary. At the end of the year, if there is any balance, then it is transferred back to the insurance company.

Administration

The government needs to appoint a TPA for this scheme. This could be a registered TPA (as per IRDA guidelines) or it could be a large NGO with significant presence in the districts. They should be given the responsibility of

- Creating awareness about the plan
- Marketing the plan to groups (NGOs who work with BPL / SC / ST families; SHGs with significant BPL memberships; LAMP societies; employee welfare associations with significant BPL employees etc).
- Issuing identify cards and developing and maintaining enrolment registers
- Collecting the premium from the people and depositing the same in the designated insurance fund
- Empanelling hospitals
- Developing STGs, tariffs
- Developing a referral / pre-authorisation system
- Having a desk in some of the important hospitals to receive the insured patients
- Processing claims and passing it to the district insurance fund
- Tracking reimbursements
- Monitoring the programme as per the indicators (Section 1)
- Conducting medical / chart audits on a random basis

The TPA / NGO would be paid fees (5% of premiums collected) for administering the plan. This could be an indirect subsidy of the scheme by the state government.

Risk management

The various measures to reduce risk are

- Family as the enrolment unit
- Referral / pre-authorisation system
- STGs, audits, essential drugs etc.

Appendices

Appendix 1

Some definitions

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.*

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.

Cap: A limit of the benefit amount that an insurance company will pay. The cap may be an overall maximum, such as an 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.

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

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.

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.

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.

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. 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).

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.

Pre-authorisation 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.

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

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.

Appendix 2

Some health insurance products in the government / NGO sector NGOs

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
ACCORD	Tribals	ACCORD	Royal Sundaram Insurance Company	ACCORD	ACCORD hospital	Rs 30 per person per year	Hospitalisation expenses upto a maximum limit of Rs 3000. No exclusions.	Collection period, Salary for providers, essential medicines and STGs
Karuna Trust	SC / ST population in T' Narsipura taluk of Mysore district	Karuna Trust	National Insurance company	Karuna Trust	Government hospitals	Rs 20 per person per year	Medicine cost @ Rs 50 per inpatient day. Loss of wages @ Rs 50 per inpatient day	Collection period, Flat rate
Yeshasvini	Members of the cooperative societies	Yeshasvini trust	Yeshasvini trust	Family Health Plan Ltd.	Private hospitals	Rs 120 per person per year	Cover for surgeries upto a maximum of Rs 200,000 per patient per year.	Collection period, Only surgical conditions, Pre-authorisation, Tariffs fixed for procedures, photo id card,
RAHA	Tribals	RAHA	RAHA	RAHA	Network of "mission" clinics and hospitals	Rs 20 per person per year	Unlimited OP cover, Hospitalisation cover for a maximum of Rs 1250	Collection period, Salary for providers, Strict referral system, co-payments.
JRHIS	Farmers	JRHIS	JRHIS	JRHIS	MG Medical College	Rs 100 per family per year.	OP cover by VHWs, Hospital cover at medical college	Family as the enrolment unit, collection period, referral system,

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
DHAN foundation	Members of SHG and their dependents	KKVS – the SHG federation	KKVS – the SHG federation	KKVS – the SHG federation	6 empanelled hospitals	Rs 150 for a family	Hospitalisation expenses upto a maximum of Rs 10,000. Some exclusions	Family as the unit, co-payments, referral system, collection period.
SEWA	Self employed women and their dependents	SEWA	ICICI – Lombard	SEWA	Public and private hospitals	Rs 85 per person per year	Hospitalisation expenses upto Rs 2000 per patient per year.	Collection period,
Student's Health Home	Students	SHH	SHH	SHH	SHH	Rs 5 per student per year	Unlimited OP and IP at SHH run facilities	School is the enrolment unit, providers paid fixed salaries. Definite collection period, referral system,
VHS	Rural population	VHS	VHS	VHS	VHS	Rs 100 per person per year	Hospitalisation expenses upto maximum limits	Nil

Government

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
Universal Health Insurance Scheme	BPL families	?	4 public sector insurance companies	?	Any hospital	Rs 548 for a family of five (Rs 300 subsidised by the Gov.	Hospitalisation cover upto a maximum limit of Rs 30,000 per family per year. Personal accident upto Rs 25,000 Loss of wages @ Rs 50 per patient day.	Family as the enrolment unit, waiting period.
Kudumbashree (proposed)	SHG members and their dependents who belong to BPL families.	Kudumbashree and Govt of Kerala	ICICI Lombard	SHGs	Empanelled hospitals	Rs 399 per family per year, Rs 366 subsidised by government	Hospitalisation upto a maximum of Rs 30,000 per family per year. No exclusions Personal accident upto Rs 100,000 Loss of wages @ Rs 50 per patient day for a week.	Family as the enrolment unit.
AP scheme (proposed)	BPL families	AP Government	4 public sector insurance companies	A TPA	Empanelled hospitals	Rs 548 for a family of five (Rs 400 subsidised by the Government.	Hospitalisation expenses upto 25,000 for surgical conditions and Rs 75,000 for serious conditions. But only for the first three days for medical conditions.	Waiting period. Co-payments after 3 days for medical conditions.

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
Karnataka scheme (proposed)	BPL families	Karnataka government	4 public sector companies	Dept of Health staff (for collection of premium).	Any hospitals, especially public sector hospitals.	Rs 548 for a family of five. Rs 300 subsidy from Gol.	Hospitalisation cover upto a maximum limit of Rs 30,000 per family per year. Personal accident upto Rs 25,000 Loss of wages @ Rs 50 per patient day.	Waiting period, family as the enrolment unit.
Assam scheme	All Assam citizens except government servants/ those with more than Rs. 2 lakh per annum income	Assam Government	ICICI Lombard	?	?	?	Hospitalisation expenses upto a maximum of Rs 25,000 for select disease conditions e.g. cancer, IHD, Renal failure, stroke etc.	Mandatory cover of the entire population.

Appendix 3

Prices of some common conditions

Minor medical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 25 beds	26 – 75 beds	76 – 150 beds
AGE	2000				
Acute abdominal pain	2000				
Acute asthma	2000				
Pleural effusion	2000				
Amoebic hepatitis	2000				
Amoebic abscess	2000				
Typhoid	2000				
Heat stroke	2000				
Allergic disorders	2000				
Acute psychosis	2000				
Acute fevers	2000				
Seizure disorders	2000				
ARI e.g. Bronchopneumonia, Bronchiolitis.	2000				

Medium medical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 25 beds	26 – 75 beds	76 – 150 beds
Acute upper GI bleed	4000				
Acute cholecystitis with medical management	4000				
CCF	4000				
Acute HT encephalopathy	4000				
Cardiac arrhythmias	4000				
Acute myocarditis	4000				
Status epilepticus	4000	2500			
Acute paraplegia	4000				
Acute meningitis	4000				
Acute encephalitis	4000				
Acute Coma	4000				
Acute pneumonia	4000	4500			
Acute pneumothorax	4000				
Acute nephritis	4000				
Diabetic ketoacidosis	4000				
Thyrotoxic crisis	4000				
Hypoglycemic coma	4000				
Cerebral malaria	4000	1000			
H'agic fevers	4000				
Acute arthritis	4000				
Neonatal sepsis	4000	7000			
Severe anaemia		2400			

Major Medical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 26 beds	26 – 75 beds	76 – 150 beds
Acute pancreatitis	8000				
AMI	8000				
Cardiogenic shock	8000				
Cerebro vascular accidents	8000	10,000			
Acute respiratory failure	8000				
Acute renal failure	8000				

Minor Surgical admissions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 26 beds	26 – 75 beds	76 – 150 beds
Normal delivery	1500	500			
Septic abortion		1100			
Delivery with APH		4750			
Delivery with PPH		3500			
Delivery with Eclampsia		8000			
Delivery with obstruction		2200			
Excision biopsy	1200				
Closed reduction of long bones	3500				
Minor amputations	1000				
Closed reduction of dislocations	1500				
Circumcision	1000				
Dilatation of urethra	1000				
Hydrocoele	4000				
Tonsillectomy	3500				
FB removal – trachea, oesophagus	1500				
Polypectomy	3500				
Cataract	2500				
Angiogram	4500				
Lumpectomy	4000				
Haemorrhoidectomy	4000				
Herniarapphe	5000				

Medium Surgical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 26 beds	26 – 75 beds	76 – 150 beds
Hysterectomy	8000				
LSCS	7500	2200			
Oophorectomy	5500				
Gastrectomy	20000				
Pyloroplasty	13000				
GI with Vagotomy	7000				
Gastro duodenostomy	13000				
Cholecystostomy	9000				
Laposcopic Chole	13000				
Appendectomy	5500				
Intestinal resection	9000				
Colectomy	6000				
Inguinal hernia	6000				
Amputation	7000				
Arthrodisis	9000				
Open reduction	9000				
Fracture neck of femure	12000				
Nephrostomy	13000				
Uretero-lithotomy	9000				
TURP	10000				
Thyroidectomy	9000				
Tympanoplasty	7000				
Laryngotomy	12000				
Radical mastectomy	9000				
Pacemaker implantation	10000				
Cataract surgery		1800			

Major surgical procedures

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices
Open heart surgery	75000		
Closed heart surgery	45000		

Appendix 4

Utilisation rates of some common conditions

Name of condition	Cases per lakh population ^{12[12]}
Birth asphyxia	25
Neonatal sepsis	25
LBW	570
ARI	322
Normal delivery	2108
Puerperal sepsis	18
Septic abortion	5
APH	12
PPH	21
Eclampsia	25
Obstructed labour	32
LSCS	92
Severe anemia	248
Complicated malaria	40
Diabetes mellitus (without insulin)	2065
Hypertension	1714
COPD	1461
Asthma	2330
Major surgeries	438
Accidents	438
IHD (prevalence)	3353
Stroke	118
Schizophrenia (without hospitalisation)	289
Mood disorders	1543
Epilepsy	913

^{12[12]} Source: Report of the National Commission on Macro-economics and health.

Note: all the cases in the community will not land up at the hospital. So one will have to reduce the same to the appropriate level depending on local circumstances, while calculating premium.

Appendix 5

Provider payment mechanisms^{13[13]}

The manner in which health care providers are paid can significantly affect both the cost and quality of care, and in these ways helps in optimal use of resources^{14[14]}. Once a patient has taken the step of contacting the provider, it is thereafter the provider who determines, to a large extent, the demand for his or her own services, and the kind and quantity of treatment required^{15[15]}. Thus, the provider payment mechanisms determine the quantity of services consumed as well as their costs. They are an important component in the strategic purchasing of health services by insurers, with the other component being negotiating and contracting with providers so that they agree to provide health services according to the requirements and conditions of the insurers^{16[16]}. Negotiating and contracting have been discussed in another module.

It must be remembered that like any other provider of services, the health provider would also like to maximize his income. He could do this by attracting more patients, over-treating these patients, increasing the number of visits by the same patients, or by charging more for his services. The provider payment mechanisms chosen by the insurer must contain costs, but also give the provider an opportunity to earn a reasonable income to motivate them to provide quality services. Commonly used provider payment mechanisms are discussed below.

Fee-for-service

The providers are given a fee for each service, procedure or act provided to a patient. It provides an incentive to providers to provide health services, and this could be perceived as leading to better quality. However, this incentive effect could itself lead to overproduction of health services (supplier-induced demand), a tendency to reduce the time spent per activity and to encourage repeat visits as they generate fresh fee. It has been suggested that the overproduction can be counteracted by combining this mechanism with fixed fee schedules, ceiling budgets, or by co-payments for patients. By far, this is the pre-dominant provider payment mechanism in our country, though it is also perhaps the most expensive, and has high administrative costs for processing claims and prevention of fraud.

Daily (per diem) payment

This is a simple and easy to administer method for inpatient treatment, but like the fee-for-service method, it has a weak capacity for cost-containment because there is a similar incentive to expand the length of stay of patients, and/or to increase the number of admissions. The hospitals also have an incentive to cut down on the inputs to limit

^{13[13]} Copied from “Empanelling Providers” (Dr Somil Nagpal) in “Training Manual for health insurance managers.” Institute of Public Health, Bangalore. 2006.

^{14[14]} Carrin G, James C. Reaching universal coverage via social health insurance: key design features in the transition period. WHO, Geneva. Discussion Paper, 2004.

^{15[15]} Normand C, Weber A. Social Health Insurance- A Guidebook for Planning. WHO and ILO, 1994.

^{16[16]} WHO, Geneva. Community based Health Insurance Schemes in Developing Countries: facts, problems and perspectives. Discussion paper, 2003.

their costs. Attempts have been made to provide a progressively reducing per diem payment, which could remove the incentives to prolong the inpatient stay. A ceiling budget for the hospital could also be used, like that in fee-for-service.

Case payment

This is based on managing the whole case, rather than a single act as in fee-for-service, and can be used for both ambulatory and inpatient care. The system is easy to administer, and could be a flat rate system where all types of cases are paid the same flat rate, or a system where the type of case determines the quantum of payment. An important example of the latter is the Diagnosis Related Group (DRG) payment method followed in many countries, where hospitals are paid an all-inclusive flat payment for a patient's treatment according to his/her diagnostic group. The system encourages efficient providers, but the effect could be offset by encouraging increased admissions and by the "DRG creep", the tendency to record a more complicated diagnosis if that qualifies for a higher DRG slab. There could also be an incentive for providers to transfer the more complicated (and thus more expensive) cases towards other providers, particularly public providers, rather than managing them.

Capitation

Under the capitation system, providers receive payment according to the number of people served and cover services for each enrolled member for the entire enrolment period for a pre-specified sum. There is no incentive to provide excessive health services, but it could give rise to the opposite problem of potential underproduction. Further, referral of cases to higher levels of care could affect the potential of this method in containing costs. Competition amongst providers may also help lessen the problem of under-production, as providers' income is dependent on the number and type of people served and people, once given the choice to select their provider, are likely to enrol with the providers who provide due care. The administrative costs of this method are very low, and are especially suited in primary care settings.

Budgets

Budgets are the predominant method of funding the government health system in our country. As with capitation, there is no link between the quantity and mix of health services given to the individual patient and the total amount received by providers. However, if the budget is insufficient or utilized inefficiently, not enough services may be produced and this results in other providers having to provide the necessary care. Also, when budgets are not very strict, and as they are often based on historical costs, there is no incentive for providers to minimize costs, and there is even a perverse incentive to exceed the budget ceiling as it implies a higher provision in the next year. Underproduction and waiting lists are thus common where budgets are the sole mode of financing services.

Salaries

This is where the insurer employs personnel to provide health services and pays these personnel a salary, unlinked to workload handled. Here again, overproduction is unlikely but underproduction is, because fixed salaries may not provide sufficient motivation for sustained good performance. Administrative costs are low, but it may be difficult to

encourage and retain good personnel. Ensuring variable, performance-related factors in the salary could be an important way of ensuring better quality.

Combinations of these payment mechanisms can also be attempted. For example, the NHS in the UK uses capitation for paying its general practitioners, but they are also paid fee-for-service for certain specified activities, bonus payments for certain performance targets etc. Different mechanisms can also be combined at different levels of care, to optimize the cost-quality balance.
