HEALTH INSURANCE SCHEME FOR LOW INCOME GROUPS IN INDIA WITH A FOCUS ON URBAN POOR IN COCHIN

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ABSTRACT

The health of a nation is an essential component of development, vital to the nation’s economic growth and internal stability. Assuring a minimal level of health care to the population is a critical constituent of the development process. Since Independence, India has built up a vast health infrastructure and health personnel at primary, secondary, and tertiary care in public, voluntary, and private sectors. However, the inadequacy in the number of medical practitioners, equipments and even the basic infrastructure make the government running hospitals and Primary Health Centers the least preferred.

Meeting the healthcare needs of the population, perhaps, goes beyond budget allocations for a highly populated developing nation like India. Given the growing complexities and challenges the health sector faces, reforms in this sector are inevitable. Reforms in general should be towards making the health systems responsive through higher allocations and strengthening financial systems, ensuring local participation and public-private partnerships and autonomy of health facilities. Ideally, it is through these reforms, the deficiencies in the health sector should be addressed. However, considering the rampant corruption and lack of coordination between the centre and state governments, the focus should be to look at the option of alternative health financing in the form of health insurance which is capable to act as a protective mechanism that will help the families to access quality care from private hospitals thereby reducing the catastrophic effect of hospitalization on their marginal income to a great extent.

The premise of this paper believes an alternative finance system that will enable the poor to access quality health care without having a catastrophic effect on their income. At the
same time the insurance scheme should be capable to address the needs and requirements of particular area as the policy. The health insurance scheme should be re-designed according to socio-economic health conditions of the community. I was assigned with the task of formulating a community based health insurance for BPL population (urban poor) of Ernakulam in Kerala. This report attempts to formulate an alternative health care through health insurance by analyzing the present health care system as well as the effectiveness of the existing health insurance policies.

INTRODUCTION

With a population of 1.13 billion, India not only requires an effective and easily accessible health care system but also one which can deliver health care facilities to the masses in remote areas of the country as well as to the growing cities at low costs. This is a challenge not just for developing nations but also for many developed countries who are still trying to formulate an effective health care model which would satisfy the needs of diverse groups within their population.

The Indian health care system primarily suffers from neglect. The public expenditure on health care is extremely low, coupled with inefficient use of resources. Hence, the problem of providing effective health care services to the majority of its citizens has become an impossible task for the Indian Government.

Private health care facilities have grown tremendously in the last decade in the face of a yawning gap between the demand for health care facilities by a growing population and inefficient and inadequate supply by the government. It is now an accepted fact that the ‘Indian system of health care is already highly privatized and the state has a small presence in this sector’. Though, private health care provides services to varied sections of the society at a better quality than their public counterparts, it also has its share of problems.

Meeting the healthcare needs of the population perhaps goes beyond budget allocations. Given the growing complexities and challenges the health sector faces, reforms in this sector are inevitable. The reforms should begin with an alternative finance system that will enable the poor to access quality health care without having a catastrophic effect on their income. Such alternative mechanism should be capable to address the needs and requirements of particular area.

India has adopted the tax-based model of financing health care. The government is both the financer and provider of health care. However, decades of under-funding have resulted in poor infrastructure, vacant posts and poor quality health care. This makes the patients seek private health care for their needs, with its associated out-of-pocket payments. This has resulted in two problems. The first is that access to health care is reduced considerably. And those who do access health care are in danger of becoming impoverished. Studies show that about a quarter of Indians who are hospitalized are impoverished or in other words, fall under the poverty line every year because of exorbitant medical costs.

BACKGROUND ANALYSIS

The inability of the public sector in delivering quality health care was due to low and stagnant public spending. The public health investment in the country over the years has been comparatively low, and as a percentage of GDP, it has declined from 1.3 % in 1990 to 0.9 % in 1999. (Govt of India, National Accounts). States have indicated a simila falling
trend, from 7.02 to an estimated 5.32 per cent during the period 1985-2000. UNDP’s global HDR 2004 ratings rank India with a public spending on health at 0.9 % of GDP amounting to about US$4 per person per year, as 171 among the 175 countries, a much lower rank than other poorer South Asian neighbours like Nepal and Pakistan. However, due to the predominance of private expenditures, the country’s rank in terms of private health expenditure, as a proportion of GDP, is 18 among 175 countries. Even from this tiny public expenditure on health, the benefits have been very uneven between the better endowed and the more vulnerable sections of society to increasing cost of care and exacerbate existing inequities. Moreover, nearly 60 per cent of all public health expenditure is in form of salaries [Ministry of Health and Family Welfare 2002], which suggests that public health investments have been allocated inefficiently.

India spends about 5.1 per cent of its GDP on health [WHO2005]. India has one of the highest proportions of private health financing; private expenditure constitutes 78.7% of total health expenditure in India and almost all of this represents private out-of-pocket expenditure (National Commission on Macroeconomics and Health 2005). It is ironical that in a developing country like India with over a quarter of the population still below the poverty line, the private sector expenditure dominates health spending.

Estimates show that about 80% of all outpatients and about 40-60% of all inpatients use the private health care facilities. The share of private sector in outpatient care is 65 per cent in rural areas and 80 per cent in urban areas [UNDP report 2002]. By almost any account, public sector health facilities offer care of poor quality, characterized by long waiting times, high rates of absenteeism among medical personnel, particularly in primary care facilities in rural areas, and unavailability of drugs. This state of affairs has forced a large majority to depend on the private sector.

Many NGOs running micro-finance institutions found default in repayment was predominantly due to hospital expenditure. Shepherd, a micro-finance institution in Karnataka, found that 40 % of its internal loans have been availed by their borrowers are for hospitalization. The study conducted by World Bank had similar findings. The world Bank report 2002 says that more than 40 % of individuals, who are hospitalized in India in one year, borrow money or sell assets to cover the cost. Between NSS 42nd and 52nd round, those sick but not availing treatment for financial reasons increased from 15 per cent to 24 per cent in rural areas and doubled from 10 % to 21 % in urban areas [GoI 2000].

Those who avail of treatment, pay a large proportion of their annual income. Hospitalized Indians spend more than half (58%) of their total annual expenditure on health care [World Bank 2002]. One possible consequence of this high medical expenditure could be the pushing of these families into a zone of permanent poverty [UNDP 2001]. Almost one-quarter of hospitalized Indians fall into poverty every year as a direct consequence of the medical expenses they pay, out-of-pocket, towards hospitalization [World Bank 2002].

For a developing country with a sizable BPL population, meeting the healthcare needs of the population perhaps goes beyond budget allocations. Therefore, the focus should be to look at the option of alternative health financing in the form of health insurance which is capable to act as a protective mechanism that will help the households to access the quality care from private hospitals thereby reducing the catastrophic effect of hospitalization on their marginal income to a great extent.
HEALTH INSURANCE – AN ANALYSIS IN INDIAN CONTEXT

Health Insurance is the risk coverage against unforeseen health expenditure. It is an arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals to a large extent.

The moral imperative that justifies introduction of health insurance in India is the growing impoverishment of those with low resilience to absorb economic shocks caused by having to incur unplanned and lumpy expenditures for medical treatment. Health insurance coverage in India is variously estimated by researchers as 10-12% of the population (CII annual report 2010), consisting mainly of employees in the organized sector and their families. On the contrary workers in the informal sector of the economy, constituting 93.3 per cent of the workforce (WHO report 2005) and their families, an overwhelming part of the population do not have any coverage, except a few schemes of non-governmental organizations.

Types of Health Insurance Schemes in Operation in India

1. Central and State Government Scheme for formal sector employees

(a) Employee State Insurance Scheme (ESIS)

Out of a total labour force of 411.5 million [IAMR 2003], about 8 million workers (approx.2 % of workers) have been covered under the ESI Act. ESIS covers slightly less than 30% of the organized workforce in India. The ESIS is also a contributory and mandatory health insurance scheme for workers of the factories employing ten or more employees. The contribution is paid through a payroll tax of 4.75% and 1.75% levied on the employer and the employee respectively. The state government also contributes 12.5% of the medical costs. The scheme includes employees drawing a salary of Rs 7,500 or less per month, the last revision being in April 2004.

The benefits of the scheme include medical benefits and cash benefits for sickness, maternity, disability and funeral expenses. The ESIS has its own network of dispensaries and hospitals, managed by the respective state governments. As of March 2003, the ESIS covers about 0.25 million factory units and provides benefits to 25.3 million beneficiaries through the widespread network health facilities.

(b) Centre Government Health Scheme (CGHS)

There are currently about one million cardholders and the total number of beneficiaries is 4.3 million. The scheme offers a range of services through allopathic dispensaries and also through the units of alternative medicine like Homoeopathy, Sidha etc. The facilities like outpatient care, emergency/inpatient care, free drugs supply, laboratory and radiological investigation, etc, are being provided through such dispensaries and the network of polyclinics, and laboratories etc. The beneficiaries are referred to the designated hospitals for the services that are not available at the dispensary level, and the expenses are reimbursed. About 500 such hospitals are recognized across 17 cities. It also uses the facilities of government and private hospitals to provide inpatient care. These bills are reimbursed later. The employee contribution ranges from Rs 15 to Rs 150 per month depending on the salary. The pensioners can avail of a 'whole life
card’ by paying 10 years’ contribution at the time of retirement. This almost flat structure of contributions, and the almost negligible amounts make CGHS a very different scheme from the ESIS. The funds of the CGHS are allocated from the ministry of health and family welfare.

However, both ESIS and CGHS have been grappling with inferior quality of care. The poor infrastructure and facilities under these two systems has been the subject of various articles and discussions. For ESIS, on the one hand, there are issues of poor quality of infrastructure, shortage of medicines and drugs, and substandard quality of the available drugs; on the other hand there are operational issues of negligence and corruption in the system and instances of employers depriving workers of their right to coverage. As for CGHS, quality and accessibility problems have continued to plague the system. Studies have discussed issues like long waiting time, high out-of-pocket costs of treatment, and inadequate supplies of medicine, equipment and staff. Even for the reimbursement, the administrative formalities are cumbersome. Both the above schemes are managed by the government and are exclusively for the workers in the formal sector (less than 10% of the labour force). They together cover about 3% of the population including beneficiaries and their families. However, some other sectors of the government are also covered by noncontributory schemes, which are in the nature of social welfare schemes, and are essentially benefits given to the various categories of employees in the government sector.

2. Commercial Health Insurance Policy

Insurance policy provided by both the public and private insurance companies in India. Voluntary medical insurance programme that provides for reimbursement of hospitalization / domiciliary hospitalization expenses for the illness suffered or accidental injuries sustained during the policy period. The premium is calculated on the basis of the age and there is a maximum cap on the benefit. The benefits are only hospital treatment, with specific upper limits for each category of service. It also provides income tax benefits for those who subscribe to it. Private health insurance schemes and they are generally targeted towards well-off people in selected cities. The premiums are relatively high and out of reach of majority of the population. This policy is usually used by the elite of Indian society, more as a tax benefit rather than as a medical insurance.

3. Policies sponsored by Central and State Government

Medical insurance is now being actively promoted by the central government and a number of state governments as a means of covering the costs of healthcare. For the past few years, a number of schemes have been initiated to cover populations that do not have health insurance, especially for the vulnerable sections of society under the net of social security. I would like to mention a few of the major health insurance schemes initiated by centre and state governments.

(a) Universal Health Insurance Scheme (UHI)

The was launched by central government in the year of 2003, it was proposed as a group insurance scheme with a membership of at least 100 families. The beneficiary family has to pay Rs 356 as premium for a family of 4 members. The BPL family can avail a discount of Rs 100 on the premium. It was targeted at groups such as cooperative societies, groups or associations of informal workers that are already in existence. Subsequently, the scheme was made available to individual families as well. The scheme was
designed on the assumption that even the poor can contribute towards their own health insurance and the amount that is sought to be mobilized will be significant. The scheme set an ambitious target of covering 10 million BPL families in the first year. The policy was open for both BPL and APL category. The scheme set an ambitious target of covering 10 million BPL families in the first year.

**Drawbacks of Universal Health Insurance**

(a) **Inequitable distribution in different states and lack of coordination between central and state ministries**

Around 50 per cent of the policies sold are in the following four states alone:
- Maharashtra (21%), Andhra Pradesh (10%), Tamil Nadu (9.58%) and Gujarat (9.19%).

Only around 9,400 BPL families have been covered. The coverage was minimum with backward states. This suggests that mostly non-BPL people enrolled the policy. These are the states with more cooperatives and SHGs, more health insurance schemes and better infrastructure. The less participation of backward states shows lack of awareness and unaccountability of state governments to spread the message. The central government too did not bother to look in to the matter of less enrollment.

(b) **Less demand due to exclusions**

All pre-existing diseases and maternity are excluded. Maternity benefit is significant among the poor as total fertility rate is around 2.91. The other conditions laid down include that hospital should be minimum of 15 beds (10 in case of class ‘C’ cities having a population less than five lakh) with fully equipped OT, fully qualified nursing staff round the clock and fully qualified doctor should be in charge round the clock. Majority of health facilities in India cannot meet some of these conditions.

(c) **Access confined to Government hospitals**

While the availability of quality healthcare infrastructure will increase the demand for insurance, unfortunately, central government’s pilot scheme did not empanel any of the private hospitals for free treatment. The policy holders despite paying the premium have to visit the public hospitals, with no basic amenities. In most of the rural areas there are no public hospital with prescribed condition. This suggests the need to improve healthcare infrastructure and provide greater subsidy to states having a higher percentage of BPL population.

(3b) **Rashtriya Swasthya Bima Yojana (RSBY)**

The scheme was launched by the government of India in 2007 with a total outlay of 20000crs. Central Government plans to bring all the BPL population under the net of RSBY in 5yrs. The free public insurance schemes introduced by the government earlier were unable to gain a momentum because the service given was confined to government hospitals and public insurance companies.

**Unique Features of RSBY**

- Cashless transactions up to Rs 30000 in any of the empanelled hospitals. The BPL has to pay only Rs 30 to register themselves in to the scheme. Centre and state governments share the total expenditure.
Coverage extends to five members of the family
RSBY provides the participating BPL household with freedom of choice between public and private hospitals
Every beneficiary family is issued a biometric enabled smart card containing their fingerprints and photographs. All the hospitals empanelled under RSBY are IT enabled and connected to the server at the district level.
The key feature of RSBY is that a beneficiary who has been enrolled in a particular district will be able to use his/her smart card in any RSBY empanelled hospital across India.

Shortcomings of RSBY
- Poor BPL data base - Lack of good hospitals in interior villages which necessitates distance travel.
- Dissatisfaction among empanelled hospitals over the rates and delay in reimbursement of dues.
- Better monitoring is needed. Or else as the number of insured expands in future, the focus of the company and hospitals may shift from real poor to beneficiaries with better means
- No beneficiary guidance system in majority of states except Haryana and Gujarat

4. Community Based Health Insurance Scheme (CBHS)/ Micro Insurance

The term micro insurance is relatively new as it was used at first in 1999 in a foreign publication. Its purpose is to promote the development and proliferation of good value insurance products for people of low income. Community-based health insurance, in another words can be defined as a mechanism that allows for pooling of resources to cover the costs of future, unpredictable health-related events. It offers individuals and households protection against the uncertain risk of catastrophic medical expenses in exchange for regular payment of premiums. This regular small amount of prepayment helps the community in avoiding high out-of-pocket expenditure at the time of hospitalization. The World Health Report 2000 noted that micro insurance represent the most effective way to protect people from the costs of health care, and called for investigation into mechanisms to bring the poor into such schemes. CBHI programmes offer a hope for reducing the financial burden caused by sickness to a large segment of the low-income population.

The term “micro insurance” typically refers to adapting insurance services mainly to clients with low income and no access to mainstream insurance services. However the concept was first appeared as a new financial service within microfinance but sooner other NGOs that are not into microfinance but into other developmental activities too came up with innovative insurance schemes for the poor. Most of these NGOs offer comprehensive assistance packages with the underlying assumption that health is only one aspect of development and should therefore be tackled along with other social problems in holistic fashion. Micro insurance run in accordance with generally accepted insurance practices under IRDA and is funded by premiums as in the case of conventional insurance policies.

Features of Community Health Schemes

The membership of these CHIs scheme varies from 1000 to more than 20 lakh. Most of the schemes operate in rural areas and cover people from the informal sector. Enrollment is usually facilitated by membership of the organizations, for e.g. micro finance groups,
cooperatives, trade unions, etc. The annual premium ranges from Rs 20 to Rs 120 per individual. All the schemes offer hospitalization; this ranges from the classical mediclaim product to a very comprehensive cover with minimum exclusions.

Most providers of CBHI are either NGOs or private for-profit organization. The utilization rates of community based insurance policy range from 6 to more than 240 per 1000 persons insured. The latter obviously indicates extreme adverse selection. The main strengths of the CBHIs schemes are that they have been able to reach out to the weaker sections and provide some form of health security; increase access to health care; protect the households from catastrophic health expenditures and consequent impoverishment or indebtedness.

However, sustainability is an issue as these initiatives are dependent on government subsidy or donor assistance. They provide limited protection in view of the very little cross subsidy between the rich and the poor, resulting in the small size of the revenue pool which also constricts getting a better bargain from the providers. A disturbing factor in these programmes, barring one or two is the very low claim ratio, ranging from 0.25 to 0.66, which indicates that the scheme is not able to overcome the barriers that are hindering access or the cover provided is too inadequate or the members too ignorant about their entitlements. It is also seen that the poorest of the poor get excluded on account of their inability to pay their share within the specified time limit.

Some NGOs manage the scheme by themselves, which may be ‘illegal’ within the current IRDA regulations. Also, some of the schemes cover very small numbers and so the potential for scaling-up is restricted. Moreover, many of the schemes see health insurance as an end in itself and do not seek to either promote preventive and promotive health care or extend adequate provider linkages.

TYPE OF INSURANCE ARRANGEMENTS

Broadly, there are three types of health insurance arrangements exist in our country. a)

a). The intermediary model
Nodal agency collects the premium, but passes it onto a formal insurance company. The latter, in this case takes the risk of running the insurance

b). The provider mode
Here, the provider, (usually a NGO hospital) provides health insurance for the community around .Premium is collected from policy holders to meet the expenses to a certain extent.

c) The Insurer model
The nodal agency takes the role of the insurer, collects money from the community and purchases health care for its members. NGO, here performs the role of an insurance company.

The appropriateness of the model depends very much on the context defined by the size of the target population, its geographical scatter, and the nature of the nodal agency. The choice of an appropriate insurance arrangement should be guided by the criteria of equity, adequacy and efficiency.
Provider model does not require a nodal agency or NGO. For smaller groups that are also geographically located in remote places with minimum infrastructure can best be covered through this model. Here package will be comprehensive including outpatient treatment but premium lower than other models. The fund management will be institutionalized and easy.

Provider model usually will have more outreach, more efficient as it generally meant to cover a small population in a remote area. The policy will have no upper limit and the cost recovery will be least here. The resource pooling will be less as the scheme covers a limited population.

The above model requires an external financial support.

The Insurer model will be appropriate for a well established, financially sound NGOs. The nodal agency to link between policy holders and hospital. The members have to be well trained to collect the premium and manage it efficiently. The benefit package will be limited, premium higher than the provider model as the nodal agency have to negotiate with hospitals. The scheme in long run, in order to cover more population requires skilled personnel to look after various aspects of operation.

Intermediary model requires well negotiation with both insurance company and health providers. This model suits best to cover a large population, wider areas. The benefit package will be limited with more exclusions as two parties on the other end are running a business to make profit. The financial risk is transferred to the insurance company, requires more supervision to curb fraudulent cases. The scheme will be more self sustainable as risk sharing is large.

Kerala: The Health Scenario

Although Kerala is known for its achievements in health, poor and vulnerable populations are often excluded from accessing fair quality health care. High economic costs of health care often preclude those who do not have the ability to pay, especially in the wake of the highly developed ‘for-profit private health care system’ in the State. The Centre for Developmental Studies (CDS) Thiruvanthapuram, in a study conducted in 2007, found that 10% of households in Kerala spend more than their annual income on health care. Clear inequalities exist as the burden of health care is three times higher for the poor (14.4% of their income) compared to the rich (4.4% of their income- Study report of Ukar & George published by CDS)

The research paper published by CDS in 2005, presented a shocking revelation that catastrophic health care spending pushes about 4% of the households below the poverty line in a year in Kerala, of which 2.5% are on account of OP care burden.

RESEARCH METHODOLOGY

The study was conducted by the analysis of primary and secondary data. The primary data collection was done through purposive sampling. Personal interaction with stakeholders to understand the needs, demands, requirements and awareness with regard to the necessity of an insurance scheme was conducted. The tool for primary data was face to face interview and an interview schedule was prepared for that purpose.

Secondary data from magazines, books, journals, e-resources and annual reports published by WHO, World Bank, Planning commission and Ministry of Health Family
welfare are collected. The duration of the study was seven weeks starting from 11/05/09 till 28/06/09.

**Sample size**

The sample size was 150 households of BPL category from Tammanam and Elamkulam villages of Ernakulam district in Kerala. Majority of the villagers are employed in informal jobs as tailors, daily wage labours, house maids etc. Though they are defined as villages, they very much constitute *Urban Poor* definition as they belong to Cochin city agglomeration and live in the fringes of Cochin Corporation area.

**Objectives of the study**

1. To analyze and evaluate the health insurance policies in rural and urban India that includes a detailed study of public as well as community health insurance schemes/policies meant for BPL group. The study focuses on the features, shortcomings, impact of insurance coverage on the health of poor etc.
2. To formulate an alternative community health insurance model for BPL group on the basis of analysis and evaluation of primary and secondary data.

**STUDY FINDINGS AND ANALYSIS OF PRIMARY AND SECONDARY DATA**

**Analysis of Primary data**

1. **Total number of members in the Family:** The average size of the family in surveyed villages is between 2 to 5 (78%). The families with more than 7 members are mere 5%. As the family size is small, a comprehensive micro insurance programme will be less risky.
2. **Monthly Income of the Family:** The monthly income of 55% of households is between Rs 2000-3000. Only 5% out of total 150 surveyed households earn less than Rs 2000 in a month. The BPL families of Kerala in general are well off than their counterparts in many other states. It is remarkable that 40% of the interviewed households earn more than Rs 3000 on regular basis. This will help them to spend for health insurance and seek better health care compared to their counterparts. Another revealing fact is that urban poor in Kerala are well off compared to their counterparts (from the literature review, it had been found that urban poor is impoverished in most of Indian states)
3. **Frequency of consulting doctor:** The fact that only 10% of the households visit hospital is encouraging for any micro-insurance firm that intends to run an insurance programme in the village.
4. **Incidence of hospitalization in the past one year:** 40% of the villagers’ hospitalization rate is nil which shows that the general health condition of the villagers is good. Only 10% had taken inpatient treatment for more than 3 times in one year.
5. **The mode of meeting the cost of hospitalization:** The majority of the villagers meet expenses by borrowing or selling their assets. Only 10 households had liquid cash to meet unexpected expenditures. The study findings follow the pattern described by World Bank report on the ways of meeting the hospitalization costs.
6. **Types of health facilities villagers’ access:** The availability of hospital facilities are favourable in both villages. When 64% visits public hospital regularly, only
6% find the nearby Primary Health Centre reliable. 30% of the surveyed people opt for private hospitals/clinics. The villagers think that they can save the consultation fee even though free medicines are hardly available. The primary health centre has no specialist doctors and available doctors are irregular.

7. Major share of annual health expenditure: The study shows that 75% of annual health expenditure goes to consultation, medicines, laboratory charges etc. This shows that OP expenditure too can be catastrophic in the wake of increasing rates of drugs and diagnostics.

8. Type of medical system the family follows: Despite the popularity of Ayurvedic treatment among the Keralites, only 18% of the respondents prefer this traditional method of treatment. The homeopathy has only 2% of takers. The above graph shows the inclination towards the allopathic treatment. The survey pointing fingers at the failure of encouraging ‘AYUSH’ under National Rural Health Mission by Central government.

9. Accessibility to any type of medical insurance & Type of Insurance: Among the respondents, 46% are of policy holders out of which more than 80% are private policy holders. Unfortunately, only 9 families are enrolled into government insurance schemes. Surprisingly, the presence of micro insurance is less in the villages. Only 6 respondents from total have purchased a micro insurance scheme. When enquired further it came to know that they are totally unaware of such schemes in operation in India.

10. Utilization rate of insurance policy: The utilization rate of insurance policy among the card holders are quite low. 25 respondents have not utilized the insurance card so far. Only 3 members used the card on the event of hospitalization. The reason behind such a dismal figure is unawareness about the scheme they subscribed to, cumbersome reimbursement procedure, about the necessity of health insurance as well as the benefits of the insurance policy they hold.

11. The reason for not being enrolled in to any insurance policy: 30 members out of 55 non-policy holders are even unaware of the benefits they can avail from the insurance card they hold. There is a lack of basic information about the details of empanelled hospitals, renewal, types of ailments the policy covers etc. 15 members had a number of misconception about the credibility of the policy due to exclusion, complex reimbursement procedure etc. 11% complained that no insurance scheme offers free OPD. There are many who believe that the money spend on insurance will go waste.

12. Major drawback of Health Insurance policy/Service delivery: 40 members out of 45 policy holders shared betraying experiences of the delay of reimbursement caused. Someone even complained they were forced to be bribed. Many did not understand the logic behind exclusions. Many policy holders could not use the card even once due to this reason.

13. The annual amount willing to spend for a comprehensive insurance policy: It was found that 41% of households showed willingness to spend up to Rs500 for a health insurance policy in case the OPD is included. Even the 3% with the lowest monthly incomes showed interest in the policy.
CONCLUSION

Health insurance is emerging to be an important financing tool in meeting health care needs of the poor. Neither market mediated nor government provided insurance is an appropriate way of reaching the poor. Community Based Health Insurance (CBHI) is more suitable arrangement for providing insurance to the poor. Development of private health insurance in the country has both potential risks and benefits in improving the access of the poor to health services. Appropriate regulatory changes can minimize the risks and turn potential benefits into concrete gains for the poor. However, currently even the private health insurance market lacks development for the want of proper regulatory decisions both on the supply of health services and on the demand for health insurance.

CBHI, which is more appropriate insurance arrangement for the poor, could take different forms and each of this form may be suitable depending on the characteristics of the target population, their health profile, and health risks to which the community is exposed. Indeed, for a country as diverse as India there can be no Pan India model and all different, innovative forms need to be explored.

The Insurance Regulatory Commission (IRDA) needs to relax the rules and regulation that will encourage civil society organizations such as NGOs, SHGs etc to evolve micro-insurance schemes as per the needs and requirements of a particular society. At the same time, the insurance schemes should not be an instrument for exploitation. IRDA has to frame the rules that will permit only those organization with certain years of experience in the community development of particular area.

IRDA has to form a separate cell to deal with health insurance matters exclusively. There should be an effort on the part of health insurance providers to a certain level to uniform the rate of treatment and diagnostics charges by various hospitals. That will make the hospital charges reasonable thereby pave the way for deduction of premium and promotion of more micro-insurance organizations.

A number of micro-insurance programmes does not focus on the quality of products and services. Some neglect the aspect of efficient marketing, operation utilizing the technological advancement to the best. Besides, negotiating with Insurance company on the one side and health providers on the other side requires certain amount of skill and experience. The government has to offer the required support for making arrangements and guidelines for availing such service.

The government can make the existing social insurance programme more efficient by collaborating with the NGOs, SHGs in the locality. That will reduce the cost of mobilizing people and make the policy more credible. However, a definite criteria needs to be set for such organization if it is allowed permission to share the power. The agency which offers insurance for certain community can involve the associations of local nature.

Micro-health Insurance scheme can be a platform for more developmental and income generating activities. The pooled money can be utilized for microfinance and income generating programmes. The inclusive participation and growth can be achieved only when the issues of the neglected sections and area are addressed. The organization can devise the schemes to enhance the quality of the life of unorganized workers, respond to the development needs of the community. However, such diversified activities require skilled human resources. Hence, training should be given to meet the goal of the organization achieved.
Develop the products for different segments of the population, carry out baseline survey or analyze the reliable secondary data in order to obtain the information about health status, economic condition, occupation etc before expanding or initiating operations in a new geographical territory. Policy has to be re-designed according to the changing needs of the various sections of the society.

Many public sector insurance companies and micro-insurance organization are running under loss due to the unprofessional method they adopt. An insurance firm will be sustainable only when efficient methods are administered in underwriting, premium collection, claim processing, monitoring fraudulent cases etc. In order to curb moral hazard, all the hospitalizations should be monitored by trained community workers. Not many data are available about the functioning of the community based insurance programme. The efficacy of various programmes in different situations need to be studied and documented for further reference.

The Alternative Model

The model which I have evolved for low income strata has emulated the features of the Insurance schemes that are currently under operation in various states. The Insurance card model which I am recommending will focus basically on three categories within BPL population, classified according to three income slabs. As I have mentioned earlier, the baseline survey should be conducted before initiating the scheme. The insurance scheme which I prescribe will segregate the BPL population into three sections.

Features of the model

a) **Cashless scheme instead of reimbursement**

Due to cumbersome reimbursement process, despite being enrolled in to an insurance scheme, the policy holder has to borrow the money to pay the hospital bill. The standard reimbursement period can extend from one week to 6 months. The hospital in interior villages cannot adopt cashless scheme overnight. However, the method can be followed in those areas where technology permits.

b) **Keep the premium reasonable and make the collection and claim mechanism simple**

The premium should be affordable and acceptable for the target community. At the same time, if the community can afford certain reasonable amount, the same has to be charged to run the scheme financially sustainable.

c) **Keep the benefit packages acceptable by**

- Minimizing the exclusions
- Including OP consultation along with hospitalization.

Many insurance schemes do not support even the basic maternal treatment and the expensive treatments for ailments such as cancer, TB etc. The model which I visualize will have only minimum exclusions.

The belief that the poor are too impoverished to be able to save and contribute towards meeting their health care costs has been proved false by increasing popularity of Community based Insurance. The same was reflected in the survey results conducted in two
villages of Ernakulam district. The idea behind introducing multiple policy is to create demand among BPL families to enroll into the insurance policy. The model which I have designed follow the pattern of credit card the banks offer with varying usage cap. The poorest of poor, can entitle to have the benefits up to Rs 5000 in a year. The beneficiaries, can alter the plans if they are willing to pay higher premium amount.

a. Blue Card

This is the basic card framed for the bottom strata of the BPL population. The villages, there will be a small section of population which are at the bottom of poverty line. Their monthly income as I have specified in the graph could be between Rs 1000 to Rs 2000. The premium which they could afford, required to be the lowest compared to the other two groups because they are the most vulnerable sections within the society.

Common features of the model

- Cashless scheme
- Maximum insurance coverage: Rs 5000, 30 days waiting period, no exclusion for pre-existing diseases
- OPD limit: Rs 1000 /yr
- Annual premium: Rs 150 for the entire family
- Mode of collection: Monthly
- Transportation charge: Maximum Rs 500/yr in case of hospitalization
- Insurance to cover death and disability: Rs 10000 for death and Rs 5000 for disability

The logic behind imposing waiting period is to prevent the extreme adverse selection. Unless there is no waiting period, people naturally prefers to take policy only when they are inflicted by disease which will make the scheme more risky.

Transportation charges of up to Rs 500 are given only to blue card holders as such payment should not deter them from seeking treatment.

b. Silver Card

This type of the card can be used for better income than the first group. The card is meant for the monthly income category of Rs 2000 to Rs 3000. The group is capable to afford more as compared to the blue card holders.

- Cashless scheme
- Maximum insurance coverage: Rs 10000, 1 month waiting period, no exclusion for pre-existing diseases
- OPD limit: Rs 15000
- Annual premium: Rs 250 for a family of 4, Rs 50 extra for each additional member
- Mode of collection: Monthly/One time payment
- Insurance to cover death and disability: Rs 15000 for death and Rs 5000 for disability

(For one time premium payment, insurance cap has been increased to Rs17000 as an incentive.)
c. Gold Card

This card can satisfy the requirements of highest group with the income slab of more than Rs 3000 per month. The policy coverage is higher for them.

- Cashless scheme
- Maximum insurance coverage: Rs 300000, one month waiting period
- OPD limit: Rs 1000
- Annual premium: Rs 500 for a family of 4, Rs50 extra for each additional members
- Mode of collection: One time payment
- Insurance to cover death and disability: Rs 30000 for death and Rs 15000 for disability

The policy will include hospitalization, diagnostics, room rent, medicine charges etc. The outpatient treatment for a maximum Rs 1000 will encourage people to subscribe the policy.

The schemes should be flexible and should be capable to address the changing trends in the health sector viz., demographic, social and managerial challenges. The model initially can begin with multiple insurance policies to cater with different segments within BPL itself. The mode of collection too is different for the first category. However, further changes can be made in premium, collection mode and benefits as per the requirements of various stakeholders.

The model looks more practical in a community where NGOs or SHGs are active. A share of pooled amount can be used for premium amount. In Kerala, even though the income generation activities of Kudumbasree are not active and successful, there is a wide participation by women in saving and inter loaning activities. The NGOs or Government can enforce a mandatory participation for enrolling in to such microfinance groups.

In our country, there are millions affected by communicable diseases due to their unhygienic life style, lack of clean water and sanitation facilities. During the rainy seasons waterborne and vector borne diseases are common in Kerala. Every year hundreds are succumbed to dengue, Chickunguniya fever during the rainy season. The awareness and preventive measures will be taken with the support of local Panchayat authorities. When the model of insurance once starts its operation can take support from various stake holders.

No insurance model can change the health condition of a society overnight. The aim for a healthy society can be achieved only when the health insurance scheme is accompanied by awareness programmes, health education and preventive care. The health condition of a society cannot be changed with the subscription of Insurance policy. Physical and mental health of a person hinges on numerous factors such as life style, food habits, availability of clean water, pollution level etc.
REFERENCE

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