Mutuality Matters

Quarterly Mutuality update from DHAN Collective

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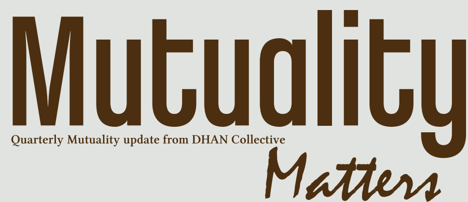
Good, Universal Healthcare – A Reality

Dutch Health Care System



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We invite articles to the magazine.

We encourage contributors to share scientific and analytical papers based on experiential knowledge on micro insurance.

The articles can be limited to 3 pages of about 2000 words with relevant pictures.

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Mutuality Matters

The UN charter mandates every nation to ensure freedom from hunger, disease and ignorance for all its citizens. While priority is given to food security and education security in this regard, the health security is often not given with adequate attention by most developing countries. This is evident from the below five percent GDP annual health spending budget of most nations like India. This translates that the public health care would be grossly inadequate in relation to the demand. The poor in the absence of a state health care / health insurance system often resorts to health spending out of pocket, which is about 60 percent of health spends in nations like India. Further with poor income and far off habitats, most of the under privileged sections of the society are not able to access health care due to non proximity and unaffordablilty. How to ensure affordable, quality and universal health care to every citizen is a challenge.

Recently in India, the state run subsidized health insurance schemes are aiming at reducing this out of pocket health expenditures by meeting the cost of most of the secondary and tertiary health care expenses. Further, the mainstream health insurers are gearing their efforts in this regard by offering products, which are mostly accessed by the elite population of the society and organized work force and these are normally driven by tax incentives. The poor mostly with the sole option of public health care access or state sponsored health insurance covers are affected lot, when healthcare is inaccessible or inappropriate. There are innovative community health insurance schemes that strive to address these gaps but however they are sporadic and inadequate. Thus there are significant gaps in reaching a level of good, universal health care system as prevalent in countries like The Netherlands, Belgium, France, Germany, Austria and Switzerland.

In all, let us work for a scenario in all countries with situations of no out of pocket health expenses by people through multi pronged approaches of accessible quality public health care systems, universal health care, state health insurance schemes and community run schemes of health care and insurance.

From Editor's Desk

Dear Readers,

Greetings from People Mutuals!

Risks are prevalent throughout the life and invariably across the globe. The foremost thing in risk management is recognition of the risks and practicing measures for its avoidance, prevention and reduction by self. For instance with respect to health risks, it is appropriate to take measures for good health rather than health insurance cover and benefits. The health insurance would provide financial compensation if the covered health risk arises, but it would not prevent the risk and the consequent loss. Thus it is apt to follow risk mitigation practices before risk financing efforts, which is very lucidly explained in Simon Kadijk's article – "The future of mutual insurance companies."

Health care and insurance are two sides of the coin and they coexist. A health insurance contract between the insurer and insured is towards indemnification of health care expenses on account of illness or injury. The existence of an universal health care system for all the citizens of a country that ensures health care for any health risk is a reality in countries like The Netherlands is indeed a eye opener for many developing countries. Such a good, universal Dutch health care system is well covered in the article by Jennifer Op't Hoog and Wim Niesing, which is a valuable article to read.

However in India, the state is increasingly focusing on subsidized health insurance schemes for poor towards reducing poverty and they are well narrated in the article on "Towards Health for All: State run Health Insurance Programs of India" by Vasimalai and Gayathri.

Apart from the government, the mainstream insurers are gearing their efforts of health risk protection of under privileged sections of the society by appropriately designed health insurance products like Samporna Suraksha, which has accessed health insurance to over 300,000 poor through the community organizations of Shree Kshethra Dharmasthala Rural Development Project. The article by Abraham details this elaborately.

However the government programs as well as the mainstream insurance products on health insurance are unable to cover the health risks in its entirety and there are significant gaps in cover and processes. These are normally left to the fate of the poor population but however there are remarkable efforts by Uplift India and DHAN Foundation by appropriately evolved and designed community health insurance programs. The community based mutual health insurance program of Uplift India is shaping into a model of an inclusive insurance program with people centered approach involving sound technical platforms. The article by Kumar Shailabh well depicts these.

Similarly the DHAN's initiative of Insurance to the vulnerable People Living with HIV is a novel model of ensuring risk cover to these vulnerable sections of the population as they are excluded under the mainstream insurance products of life and health. The concept of distribution and sharing of risks among different risk pools towards an affordable and sustainable insurance product is focused in the article on Insurance to vulnerable PLHIV by Balasubramanian.

As mentioned earlier, risk management includes the measures of risk avoidance, risk prevention and risk reduction apart from the risk financing / insurance. Thus it is more appropriate to practice the measures that would mitigate risks apart from risk financing. How the poor communities are practicing an integrated system of health care and insurance is not known much. The article on "Integrated Health care and Insurance – A community model" by Rajapandian and Sivarani reveals this and provides valuable learnings.

I look forward to your valuable feed back to enrich the magazine.

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The future of the mutual insurance companies

Simon Kadijk*

Many mutual insurance companies are once again considering their future. In Europe they are being forced to do so by the new rules called Solvency II. As well as that, the financial crisis has put a lot of pressure on insurance companies and banks since 2008. In the last article I looked in detail at the threats and opportunities of digital technology. These too are reasons for mutual insurance companies to reconsider their future.

From insurance back to risk

However, I think just 'surviving' is not the solution for mutual insurance companies. That would make their continued existence a goal in itself. A mutual is not a goal; it is a tool to serve its members. The question should therefore be what the members need and want in terms of insurance. That means the members should share a number of characteristics, as I explained in my article in the March edition. The strength of a mutual insurance company lies in providing solutions for problems which the members share. The mutual insurance company is most relevant when it operates in a niche of the insurance market.

But in fact we need to go one step further than that. The first step in the process is to recognise that a mutual does not automatically have a right to exist, but is no more than a means to an end- Enabling its members to insure themselves against risks which they share. The second step is to recognise that insurance companies are not a goal in themselves. Insurance is a tool. And its ultimate purpose is to manage risks.

Risk management

Insurance provides financial compensation if one of the risks that it covers arises. But it does not prevent loss. In fact insurance isn't the first thing you should consider, but the last thing. Because a mutual insurance company, above all, is an organisation that can help its members with risk management. Good risk management is essential for the members. Most members already do that subconsciously, but the strength of a mutual is to make its members more aware of their risk policy and to provide them with tools to do that.

I'd therefore like to take a closer look at what good risk management involves. This is a process in which we can distinguish the following phases:

1. First of all members should be aware of risks and their relative importance. We often see that an awareness of risks reduces the losses that those risks can cause. This can be achieved through workshops, brainstorming sessions and similar means. Which risks can threaten continuity in agriculture, for example? In this phase it's important to take everything into account, and not just the risks that we may think are unavoidable. The important thing is the process of awareness.
2. Once the risks have been identified and categorised, one can consider the threats caused by risks in two ways: by their frequency or by impact. A tsunami has a big impact, but the chance that there will be a tsunami in Tamil Nadu, is small. So for all possible risks that may arise, we need to assess their impact and their frequency. This analysis will allow us to draw up a matrix showing all the possible risks at a glance. To assess those risks relative to each other, we can say that the frequency times the impact will show the ultimate threat to continuity. I know from experience that many clients immediately start to think in terms of solutions when they do this for the first time. But we shouldn't do this yet, because we're still in the analysis stage.
3. The next stage is to look at the possible ways to reduce risks. This is of course always the best solution. Here again we need to carry out a broadly bases analysis. Instead of immediately looking at the costs or the practical problems, we should start by brainstorming about ways to avoid risks completely like using different building materials, working method, foods or behaviour. Prevention helps more than insurance, and this gives us a preview of our conclusions.

4. If the risks cannot be reduced, it may be possible to limit their effects. What measures and behaviour help to mitigate loss if a risk materialises? One example is to make sure that enough fire-fighting equipment is available when needed.
5. It's only now that the question of cost arises. Many risks can be avoided or reduced. But these often require high investments. This is why the second phase was important. This will show you which risks have a high frequency and/or impact, and what the measures required to reduce those risks. This helps to define a plan to manage the most urgent risks.
6. It is not until we have gone through the 5 phases described above that the question of insurance arises. After going through the processes, a number of risks have been avoided and reduced. There will be remaining risks or we may conclude that the required measures are not economically justified. But that doesn't mean there are no remaining risks. The last phase therefore involves deciding whether we want to bear those risks ourselves or we want to transfer them to a third party. Those are what we call insurance as a measure to manage risks.

Insurer has to do more than just insurance

A mutual insurance company knows about the specific risks that its customers face. Mutual have access to a lot of statistical information about the risks that their members face. They also possess knowledge about preventive measures. They have to focus on the future and they also have to take care that they do not restrict themselves to their own continuity in competition with other insurers. Mutuals arose out of the need to cover specific risks within a specific group of risk characteristics. See also the march article. That now needs to be reviewed in the 21st century. Digital technology and global developments mean there are other ways to asses, reduce and restrict risks. See also the June article. This means insurers must not only look at their own operation but more especially at the developments taking place among their members.

On the other hand insurance companies need to stay focused on their core activity – taking over risks from their members in return for the payment of a premium. In doing so, I believe insurers shouldn't take over the task of risk management, as described in the above 6 points, from their clients. It is important that the members do that for themselves, and carry out the associated tasks. The mutual has the function of providing them with guidance in doing so.

I think DHAN is a good example of how this can be done and how it is already starting to be done in practice. On the one hand there People Mutuals, focusing on insuring risks. On the other hand DHAN has different programmes to help members with risk management on health, water management and accessibility of facilities, to name just a few examples. I also think a more integrated approach can lead to even better results – putting overall policy under the title of risks and risk management. That will make the priorities clearer.

The opportunities are greater than the threats

In the second article, I wrote that digital technology means the need for mutual insurance companies is no longer self-evident. Through digital technology and individualisation members are no longer automatically dependent on the mutual as their traditional insurer for specific risks in specific regions. Insurance companies need to be aware of that. This may be a threat, but there are also numerous opportunities. On the one hand by going back to their roots, through mutual solidarity of a particular group of members who share a specific risk. And on the other hand by not regarding insurance as a goal in itself, but instead as a means of taking from the members those risks that cannot be avoided or limited.

This means that there is still a lot of work to be done on communication. Risk management is a complex process. It's also vital to ask probing questions. For example, customers may sometimes ask for health insurance. But the real underlying question is the wish for good health. Because what's the use of health insurance if you don't have access to a doctor or a hospital? If you can avoid eye injuries by a specific lifestyle or behaviour, or through specific food or hygiene, then the solution isn't insurance but education and prevention. And in some cases you'll be better served by wearing glasses than by a doctor or an optician. But what's really needed is a clear view of the future.

Simon Kadijk,
Director Donatus Verzekeringen, the insurer for churches and monuments in The Netherlands.

Good, Universal Health care – A Reality Dutch Health Care system

Jennifer Op't Hoog, Wim Niesing*

Health is one of the most important things in life. Therefore it is not strange that the World Health Organization states that it is ideal to have the access of high quality universal medical care for all in the globe. Unfortunately this ideal situation is not a reality for the largest part of the world population. A review of access to qualitatively good healthcare reveals that a distinction can be made among three types of healthcare systems around the world.

- **Good, universal healthcare**. Internationally, there are only a few places in the world where healthcare is truly good qualitatively and accessible to everyone. In that regard, it often concerns systems in affluent countries where healthcare and the financing thereof is provided for via government or where market forces are subjected to strict government regulation. That is particularly the case in countries in Europe that runs from Norway, Sweden and Denmark via the Netherlands, Belgium, France and Germany to Austria and Switzerland. There are a few other places in the globe such as Singapore, Cuba, Canada and Japan, where this exists to a certain degree. Fewer than five out of every hundred people in the world live in a country where good healthcare is universal.
- **Private healthcare with a public safety net**. In many more countries, there is no equal access to healthcare as a whole, but rather a public safety net with lesser quality healthcare to outright poor healthcare. In this regard, it often concerns the systems involving basic healthcare made available through the government or regulations and whereas access to the best healthcare can be acquired through private insurance. This is prevalent in rich western countries such as the United States and Great Britain as well as in the emerging and relatively affluent countries such as Turkey, South Africa, Russia, large parts of South America and parts of Asia. Roughly half of all people in the world live in a country where this is the case.
- **Private healthcare without a public safety net**. The reality for the rest of the world is that they live in a country where truly good healthcare is only available to the elite. They live in an area where the access to healthcare for all is not feasible and certainly not in the case of emergencies. For many, most of the healthcare system in effect is sealed off. In such countries like India, micro insurance intervention tries to address this.

The Netherlands is one of the countries where qualitatively good care is available to everyone. This article will take you on a journey to see the main characteristics of the Dutch health care system. We will touch upon the questions such as "What are the fundamentals within this system, What can you learn from it?"

The Dutch health care system can be explained under three main sections:

1. Major medical risks (care) provided under the Exceptional Medical Expenses Act – AWBZ, for long term care, home care, care for mentally and/or physically disabled
2. Basic medical care towards cure and pursuant to the Health Insurance Act – Zvw, for hospital care, medical specialists, pharmaceuticals etc.
3. Less essential health care such as dental care, physiotherapy, prevention programs etc. are covered by supplementary private insurance.

Furthermore, there is Social Support Act – WMO, which ensures care and support at home for the elderly and sick and this is delivered by the municipalities.

The new Health Insurance Act

In The Netherlands, it is compulsory for everyone to be insured for health care. Insurance is an important instrument for sharing risks and ensuring that medical care is available to all those who need it. The system of health care and insurance needed updating as it was associated with a number of challenges such as high medical inflation, low mobility of insured and medical selection by private insurers.

The new Health Insurance Act puts an end to this on 1 January 2006. The key elements of the new act are:

- A new standard insurance for all based on the solidarity principle ensuring accessible and affordable health care for everyone
- Private insurance in tune with EU legislation, permitting for profit & not for profit entities, but with public conditions
- Citizens can change insurer every year
- Insurers have to accept every insured
- Insurers are obliged to deliver care
- Insurers compete for the business of the insured
- Customers and insurers stimulate suppliers to provide better quality health care
- 50% of the premium is income dependent and is paid by employers, 45% is a nominal premium paid by the insured, and 5% is a Government contribution (for children, since for them no contribution is requested)

Premium compensation for low income people

The new system is aimed at establishing a balance between social solidarity and providing the opportunity to benefit from the dynamics of the market. Further, there is also a balance between public and private as the Dutch care system is rooted in both the public and private system. If we look at the current situation, the government is engaged with the system but is not participating directly in the actual provision of care. Health care provision is the task of the private care suppliers - Individual practitioners and care institutions.

Important fundamentals of the system are the concepts of risk equalization and the principle of solidarity. The advanced system of risk equalization is intended to make each and every individual as equally attractive as potential insured and involving a system to regulate and share the costs and expenses. The element of risk equalization is essential in order to create conditions of competitive equality between health insurers towards creating a level playing field. Without this risk equalization system, the health insurance system will most likely prove to be unsustainable. The variation in premiums between insurers should reflect on how they manage their daily business - Better and cheaper procurement and more efficient administration resulting in lower costs and this will be reflected in the premiums. However the difference in premiums should never reflect on the risk profile of the insured portfolio. There should be no groups of insured for whom there is a predictable profit or loss. The risk equalization will take place based on criteria such as age, gender, region, kind of income, social economic status and health status. Towards this, the health insurers gets an ex ante budget per insured. These ex ante budgets are estimated each year and yearly analysis is done to enhance the ex ante budgets and probably resulting in introducing new budget parameters.

The risk equalization system enables solidarity. But what does one actually mean by solidarity? The purpose of solidarity in health care is to make health care available and accessible to every citizen. This is an act of mutuality, taking care for yourself, your children and your neighbor. Insurers have the responsibility to make insurance available at a reasonable price and at the same price for everyone. Further it is also expected from individuals to be sane with their use of care and requires the health care provider to provide similar qualitative, good and right care at the right time. There needs to be no overproduction or overconsumption of health care from the patients' perspective.

Very important aspect of considering mutuality is that the health insurance companies do not have to pay taxes and on the other hand are also not allowed to pay dividend to shareholders. This means that all the revenues of the health insurers stay within the health insurance system. However from 2016, health

insurers can choose to pay out dividends but then will also have to pay taxes. Considering the way health insurers are looked upon by Dutch society and politics, making results are questioned in the public debate and hence probably no health insurer will make this transition.

How is this system paid for?

Fixed nominal premium is paid by citizens. Almost half of the care system is paid for from the fixed premium, which is the same for all insured with a certain health insurance company and this is about € 1100 in 2014[i] . The insured pays this premium to the health care insurer. Each insurer can set its own fixed premiums for the various types of policies. This increased nominal premium is intended to promote cost consciousness, as earlier to 2006 for the public insurance the insured paid a nominal premium of only € 100.

Income related contribution is paid for by citizens and employers. The Health Insurance Act obliges citizens to pay also a contribution of 7.5 percent of their income. This contribution is levied up to the first € 50,000 and therefore amounts to a maximum of € 3,750 per year. Employers are obliged to reimburse this contribution to their employees. Self employed persons and pensioners pay 4.4 percent. The income from this contribution is put into a Health Care Insurance Fund.

Government Contributions: From taxes the government gives contribution to the health insurers for the expected claims by children, since children do not have to pay a nominal premium.

No-claim reimbursement to Deductible: When the Health Insurance Act was introduced, the government incorporated a no-claim reimbursement in order to prevent unwarranted use of care. Visits to general practitioners are not included in this, as well as costs related to births. Adult insured will have part of their fixed premium reimbursed if they use less than € 255 care in any one year. For 2006, almost 4 million individuals out of 16.2 millions of insured population, had part of their fixed premium reimbursed[ii]. In 2008, the no-claim reimbursement was replaced by a compulsory deductible of € 150. The compulsory deductible increases in time since it depends on the health care costs. Over years, the compulsory deductible has increased to € 360 in 2014. Furthermore, there is a voluntary deductible and the insured can choose annually to increase his/her compulsory deductible with € 100, € 200, € 300, € 400 or € 500.

So what has this system brought so far?

Keeping this system accessible to everyone is however a costly task. One of the key challenges for The Netherlands is to lower these costs. Over the past years the overall increase in health care costs has fallen from 5.7% per year during the period 2005-

[i] Economisch planbureau Ministerie (2014) Centraal economisch plan 2014. Voorzichtig

[ii] Economisch herstel Ministry of Health, Welfare and Sports. (2010) The new care system in the Netherlands. Durability, solidarity, choice, quality, efficiency.

2010 to on average 2.3% per year during 2011-2015. At present, there are more and better choices for consumers and currently there are no waiting lists for health care, however this might become an issue. There is a high client satisfaction in The Netherlands system as evidenced by the number 1 position on Euro Health Consumer Index in both 2008 and 2009.

Challenges ahead for the Dutch Healthcare system?

- Further improvement in quality and transparency in health care
- Ending black box – High financial risks for insurers
- Need for cost containment of hospital budget
- Labor market issues in health care
- Transfers from parts of the health care from the AWBZ to the ZVW (especially nursing and care delivered at home)

What are the lessons to take from this system?

Use the power of the people to establish common goals. If you want to make good care available to everyone, you need to and want to involve everyone and let everyone take upon their own responsibilities.

Make sure the motivations are right. If you want equality, you need to make each individual as equally attractive for insurers for instance. Further it is expected that the care provider not to provide the most care but the best care for the individual, leading towards health results on a personal level and lower costs in the end.

Creating awareness, the downside of an "arranged" system does not involve the responsibility of the citizens and they are not concerned on what care costs. Making it transparent and letting the individual financially support through nominal premium and no claim reimbursement would create awareness to the right level.

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Towards Health for All:

State run Health Insurance Programs of India

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Health of a State depends on the state of health of its citizens. To keep its citizens in good health and free from diseases is one of the important goal of any welfare state. However attaining the goal of 'health for all' remains a challenge in India.

Health decides the quality of human resources which determines the ability to learn, exert labour and participate in economic activities. Health remains the prime cause and effect of poverty in India for many decades. Poor health reduces the capacity to work and subsequently the income of a person, leading to poverty. On the other hand, poverty prevents the person from taking enough nourishment through food and follow practices of personal and environmental hygiene resulting in poor health conditions. However, this doesn't reflect in the proportion of poor seeking health services. Only about 24 percent of the hospitalized are from poor economic category. They are reluctant to seek medical services as they are not in a position to finance it on their own. This expresses their vulnerability to the cost of health care.

The total health spending in India is a mere 4 percent of GDP with USD 60 per capita, the lowest among the BRICS nations. Of which 31 percent is through government spending, 9 percent is from insurance and the remaining 60 percent is from out of pocket expenditure (OOP). Most of these OOP expenditures are met by borrowing from informal sources for exorbitant interest rates. A World Bank study conducted in India concludes that the out of pocket medical costs alone push about 2.2 percent of the population below poverty line each year.

While it is important for the governments to devise programs to reduce the health risks of the most vulnerable sections, it is also important to have proper risk financing solutions like health insurance. in India, the health insurance penetration is insignificant and is much less than one percent of GDP and health insurance density is about ₹ 82 per person. However, in terms of access, 25 percent of the population has some form of health insurance, thanks to government health insurance programs. Out of the overall health insurance, 35% is through group policies and mostly private purchase of health insurance is triggered by the element of tax relief among the middle and high income group. With nearly 92 percent of labour force in informal sector, health insurance remains out of the reach of many of the households.

Health is one of the subjects that find place in the state list. However, the central Ministry of Health and Family Welfare also plays an active role with implementation of National Health Mission. With the involvement of central and state governments, India is building a robust health care system since independence. The health care financing includes three pillars.

The first pillar is funded from the tax revenues and involves the country wide network of public health care facilities. The second pillar is a mandatory health insurance programmes such as Employee State Insurance (ESI) scheme and Central Government Health Scheme (CGHS) for those in the formal sector employment. It is funded by the employers both private and government. The third pillar is the private voluntary health insurance purchased by individual households from the insurers.

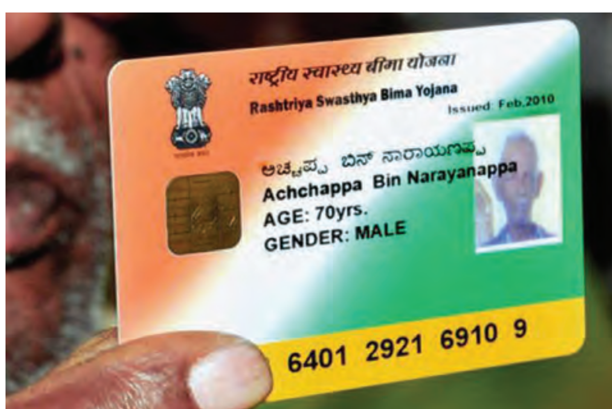
State pillar and the need for state run health insurance programs

The state pillar of health financing involves a network of Sub Centers (1,48,124) Primary Health Centers (23,887), Community Health Centers & district hospitals (4809) and State/ Union Territory owned medical college hospitals (11,993). These facilities are being used for both out-patient and in-patient care treatments to the tune of 20 percent of and 40 percent respectively.

The inadequate infrastructure and trained personnel in the public health care system forces the people to resort to the private hospitals. In order to protect the poor and vulnerable from falling deeper into the poverty trap due to heavy medical expenses, there is another sub category of state pillar is introduced in the form of social health insurance which is also funded from the tax revenues of the government either fully or partly.

The health insurance programs of the state include the programs to support those working in the organized sector and the programs meant to protect those in the un organized sector. This article focuses on the state run health insurance programmes mostly targeted for the BPL households.

These program aims at safeguarding the poor and vulnerable households from the health risks and encouraging health seeking behavior among them. Broadly they can be classified as Central programs and State programs.



Health insurance programs supported by Central Government

RSBY - Rashtriya Swasthya Bima Yojana (RSBY) is the only health insurance program being offered by the central government through its ministry of Labour and Employment. Started in the year 2008 on a pilot basis and currently it is implemented in 25 states. The program is meant for households living below poverty line and is a fully subsidized program involving only a registration fee of ₹30 per household. It covers hospitalization expenses of the family to the tune of ₹30,000 per year on a floater basis. The funding of the scheme is routed through the Ministry of Labour and Employment to the identified insurers. Biometric cards are used for authentication and identification of the insured. Cashless health care facilities can be availed from the network hospitals. Since 2014, the scheme is implemented through Ministry of Health and Family Affairs.

The program has got many positive features including a well informed process of enrollment, contingent facilities for issue of bio metric cards in case of power failure, affordable registration fee of ₹30, etc. However, it is not free from challenges. The challenge begins with enrollment administration of members. The program allows the enrollment of BPL based on the guidelines of Central Planning Commission and this often differs from the list of poor identified by the states for various other welfare schemes. Power failure in the hospitals makes the bio metric cards dysfunctional leading to out of pocket payment by the insured. In some places, the practice of collecting higher amount as registration fee is noted. Lack of awareness has resulted in only 1.2 percent of the insured getting the benefits. The scheme has not taken off in several states like Tamilnadu, Andhrapradesh, Puducherry, etc. The state Governments are keen in promoting their own health insurance programs which are mainly meant to cover tertiary care health expenses. Although the benefits and /or target area/ communities do not overlap, the emphasis is given more on their own health insurance programs in these states.

Universal Health Insurance Scheme

This is the fore runner of RSBY and was launched in the year 2003. The scheme was implemented through the four public sector general insurance companies. The scheme was universal in the sense of being inclusive providing coverage to households below poverty line (BPL) and above poverty line (APL). It involved a two- third premium subsidy till March 2013 for the BPL households by the central government through its Ministry of finance. The universal nature of the scheme also lies in coverage of even preexisting illnesses and maternity benefits. In spite of such features the coverage under UHIS was minimal when compared to the potential with only 2, 61,635 persons in 2012-13. The poor coverage is due to various factors primary being lack of awareness created among the poor to avail the benefit of such scheme. Lack of pro poor administrative systems available, inadequate network hospital facilities nearby their locality are also important factors

among others. Added to this, the subsidy given for BPL households was withdrawn since April 2013. The move might have been in the lines of avoiding duplication of subsidies for the same insurance coverage under UHIS and RSBY although they were implemented through two different ministries. However, the target households under RSBY are the BPL households identified as per the guideline of Central Planning Commission whereas the BPL for UHIS is based on the BPL identified by the respective states. The UHIS eligible households falling under RSBY eligible category are very minimal. Hence many BPL households who were getting benefits under UHIS are left with no subsidies and are required to pay full premium. This is resulting in poor renewals and new enrollments under UHIS.

Health insurance programs of State Governments

Health insurance programs of State Governments invariably focus on covering tertiary heath care expenses. Karnataka state is one of the pioneers in offering health insurance through its Yeshasvini scheme of since the year 2003 through its ministry of cooperation. The members of cooperative societies across the rural areas of entire state, both BPL and APL are eligible to enroll themselves. The state is also implementing Vajpayee Arogyashri Yojana health insurance scheme only for the BPL households in the Gulburga division of Karnataka since the year 2009. Both the schemes are implemented through exclusive trusts without involvement of any insurance companies for the financial administration of the schemes. However, both the schemes engage Third Party Administrators for the claim administration.

From the table below it is evident that in spite of multiple health insurance schemes available in the state, there are significant portion of households under BPL who are non members of cooperative societies living under rural and urban areas of non Gulburga divisions of Karnataka are left without any health insurance support.

The state government of Andhra Pradesh implements Rajiv Arogyashri Yojana (RAY) since 2007 and is a fore runner of Chief Ministers Comprehensive Health Insurance scheme (CCHIS) of Tamilnadu in 2009. The eligibility for availing coverage under the scheme are based on the household income level of ₹75,000 and ₹72,000 per year respectively certified by Village Administrative Officer. The schemes cover about 938 and 1016 tertiary care medical and surgical procedures involving hospitalization. The benefits also include some diagnostic and follow up procedures related to hospitalisation. The schemes are administered through select insurers and their TPAs through the identified network hospitals both public and private.

The insurance coverage and gaps in the state of Karnataka are given in the following table:

S.No	Division	Rural/ Urban	BPL/ APL	Members / Nonmembers of Cooperative societies	Scheme
1.	Gulburga Division	Rural	BPL	Members of Cooperative	Yeshasvini
		Rural	APL	Members of Cooperative	Yeshasvini
		Rural	BPL	Non members of cooperative	VAY
		Urban	BPL	Non members of cooperative	VAY
2	Non Gulburga divisions	Rural	BPL	Members of cooperatives	Yeshasvini
		Rural	APL	Members of cooperatives	Yeshasvini
		Rural	BPL	Non members of cooperative	No insurance
		Urban	BPL	Non members of cooperative	No insurance

The state of Maharashtra has initiated a similar scheme called Rajeev Gandhi Jeevandayee Arogya Yojana in the year 2012 covering both BPL and APL identified through the ration cards issued by the Public distribution department.

Similarly the Odisha state has initiated the Biju Krushak Kalyan Yojana, providing health insurance cover of 1 lakh to farmer families irrespective of BPL or APL. This program is planned to cover about 60 lakhs farmer families comprising of about 5 crores of people.

Although the state government health insurance programes have not met their full potential, the initial success of these programes as a powerful political measure by way of reaching to the poor households directly in addressing their critical need, makes the other states to contemplate on initiating similar programmes. While most of the central and state government supported health insurance programmes march towards the goal of universal secondary and tertiary health care, it is an important duty of the governments to pay enough attention on the public primary health care system. Ignoring health care in primary stages have proven to manifest into illnesses that need secondary and tertiary care treatments in later stages resulting in loss of health and productive time besides financial losses and even loss of life at times.

In view of the above the following way forward action points are suggested for the consideration of different stakeholders.

Way forward suggestions:

1. Comprehensive health insurance cover for both secondary and tertiary care treatments available for all states; States to top up with the base coverage by including additional health procedures involving additional quantum of benefits (and not additional category of households). The same applies for other agencies/ departments of the government. Example: Ministry of Cooperation in Karnataka.
2. The non BPL category should be able to get the coverage by way of making cent percent premium payment on their own. This will reduce the incidence of adverse selection and reduces the premium rates significantly.
3. Uniform package rates for all medical procedures approved by the Ministry of Health and family welfare irrespective of the existence of insurance coverage or not.
4. Identification of beneficiaries for the purpose of health insurance needs to be uniformly followed. There should not be separate beneficiary list for central government and state government programmes. The cost spent on separate identities could well be used to financing the social insurance program.
5. The medical facilities and manpower of government hospitals and Primary Health care Centres need to be upgraded in such a way that the equal emphasis is given for primary, secondary and tertiary care treatment.
6. More importantly, awareness about the health insurance needs to be created on a continuous basis. This should be part of regular health camps jointly organized by the MoHFW and the State health departments involving NGOs and community organizations. The camps should address comprehensive health risk management measures including healthy food habits, sanitation and personal hygiene, use of safe drinking water, avoidance of postponement of treatments for illnesses and the access of health insurance in compensating the financial loss due to the health care expenses. This would increase the health seeking behavior of the beneficiaries by way of availing medical treatments besides reducing the health risks.

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Sampoorna Suraksha –

An initiative of SKDRDP for health risk mitigation of poor

Abraham. M.K*

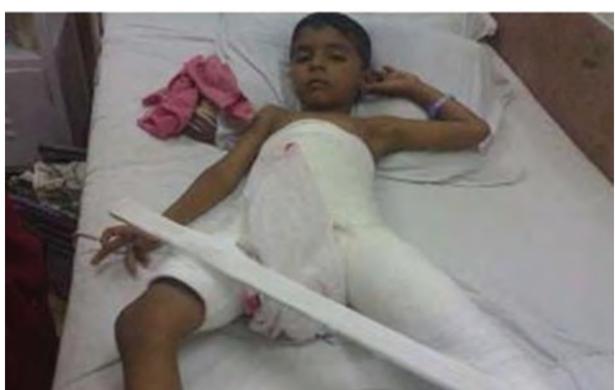
Sampoorna Suraksha is a unique family health care scheme launched in the year 2004 by Shree Kshethra Dharmasthala Rural Development Project, a large sized NGO popularly known as SKDRDP, based out of Dharmasthala in Karnataka.

Shree Kshethra Dharmasthala is a famous Hindu religious shrine of South India. Protection to the seekers (Abhayadana) and feeding of the visitors (Annadana) are two of the many charities practiced at this "Shiva Temple" run by the Heggade of the temple for over seven centuries. Dr.D. Veerendra Heggade the presiding Heggade for over the four decades has been an acclaimed visionary of our times. As the part of various charity activities of the Kshethra Shree Heggade launched SKDRDP in the year 1982. Poverty reduction and development of the poor households is the prime motto of SKDRDP. "Sampoorna Suraksha" meaning 'Total security', is one of the several initiatives undertaken by SKDRDP for poverty reduction.

The poor are particularly vulnerable to the health risks. They are trapped in the vicious circle of debt with the sudden incidence of diseases and accidents. Most suffer throughout of their life in silence as health care is unaffordable. SKDRDP launched Sampoorna Suarksha programme during the year 2004, precisely for mitigating such hardships of poor households.

The Salient Features are:

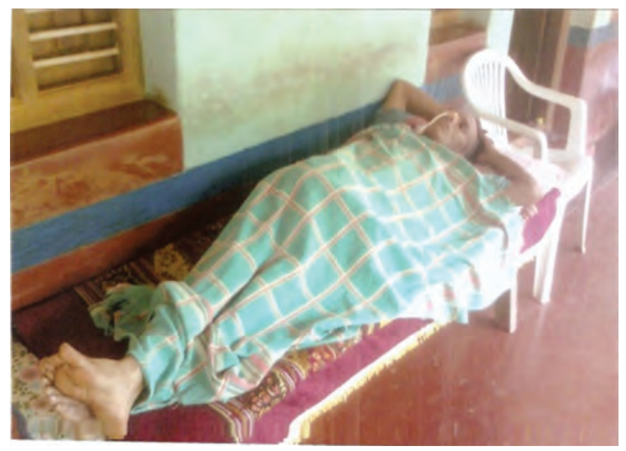
- This is a contributory micro health insurance scheme for the members and dependents of self help group members organized by SKDRDP.
- The programme is designed on the basis of mutual help. Interested SHG members and their family members can participate in this programme to protect them from health risks and risks due to accidents.
- Members dwelling under a same roof aged from 3 months to 80 years (no specific relationship) are entitled to be members.
- Both cashless and reimbursement claims are entertained.



- SKDRDP has its own wing to ensured smooth function of the scheme.
- Yearly contribution is collected along with the weekly savings of the members of the self-help group so that it does not strain the finance of the family.
- The scheme has been formulated on the basis of the SHG members needs after studying the prevailing health insurance models in the country.

The benefits are:

- For a single member, he/she can get cashless treatment to the maximum of ₹10,000/-. For more members family cover the, under the programme increase by ₹10,000/- for each member. The coverage is on floater basis in multiples of ₹10, 000/- per person up to maximum 6 members of a family. The premium is ₹280 per member.
- Medical treatment is made available on credit bill facility in the recognized hospitals which are well equipped with modern amenities.
- A consolation amount of ₹5000/- is paid for natural death.
- Accident death compensation is ₹10000/-.
- Partial/Permanent disability compensation ranges from ₹5000/- to 10000/-.
- Hospitalization expenses for maternity (for the first two deliveries) ₹2500/- for normal and ₹7500 for caesarian delivery.

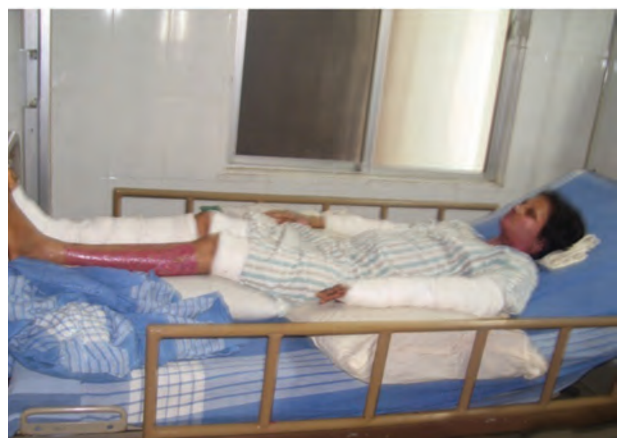


At present the scheme is implemented in seven districts of the state covering 11.8 lakh lives. During the year, about ₹ 32.95 crores have been paid as premium to the Oriental Insurance Company for the above cover.

Every year the enrolment to the scheme begins in the month of January and the coverage starts from 1st April to 31st March of the year. The entire enrolment process is managed through SKDRDP network in each taluk and villages. Hospitalization preauthorization request from any network hospital is processed and instant decision is conveyed by a team of doctors to the hospitals. The hospitals then give treatment to the patients on the basis of credit billing on cash less basis. Further as soon as the member is hospitalized, the SKDRDP project official of the area visits the hospital, verifies the patient's member details and signs a declaration as a identification process. The discharge of patient would not take place without this process thus preventing fraudulent practice from the initial stages itself. The bills submitted by the hospitals are processed by Medi Assist-TPA, who submits to the insurance company for settlement to hospital.

Under the reimbursement procedure, claim documents are submitted through the concerned project office of the member. After verification of documents, the Medi assist office pays the amount to SKDRDP, who in turn will send the claim amount to project office for disbursement to the members.

In the current year from 1st April to 31st August, about ₹13 crores have been distributed to 23000 beneficiaries. From the inception of the scheme in 2004, a cumulative sum of over 200 crores has been distributed to 6.64 lakh beneficiaries.



Performance Status is furnished below

Year	Families enrolled (in '000s)	Members enrolled (in '000s)	Benefits	
			No.	Amount in crores of rupees
2004	54	186	11,810	3.51
2005	77	196	13,299	3.32
2006	146	400	22,759	6.76
2007	223	720	42,172	12.07
2008	253	933	67,861	21.38
2009	294	1,177	98,402	33.20
2010	420	1,662	136,980	46.99
2011	420	1,660	123,123	46,86
2012	367	1,272	71,825	42,68
2013	293	1,090	66,233	40.00
Upto 31st Aug 2014	310	1,177	23,000	13.00

**Abraham. M.K, Director, Sampoorna Suraksha, Shree Kshethra Dharmasthala Rural Development Project, Dharmasthala*

Building a peoples' movement in Health Micro Insurance

Kumar Shailabh*

Insurance is intrinsically a mutual concept. However the commoditised approach to insurance emphasises on the individual insured person as a customer and consumer. It represents the individualisation of risk amelioration, and the conversion of the insurance policy as a product. Insurance thus becomes a commodity, to be bought and sold in the market like other products.

Against this background health becomes an interesting risk to cover because of its strong base in human behaviour and cultural beliefs that puts the design of commercially developed health insurance products with their primary motive of profit into question.

When the context is of the poor, low income groups, this situation is further compounded as their risks are perceived to be higher and their paying and understanding capacity to be lower. Thus health with its complexities and insurance with its profit motive make the paradigm of health micro insurance a challenging task.

It was this challenge that motivated Uplift Mutuals a decade ago to begin a journey of setting up health micro insurance for the poor, that could provide them not just with meaningful risk management but took their needs as the main input and their decision making as the prime mover.

There are four pillars on which the Mutual model designed by Uplift works

1. Inclusive Risk Pooling
2. People-Community centred
3. Technically Sound
4. Health Services as an ecosystem

Inclusive Risk Pooling

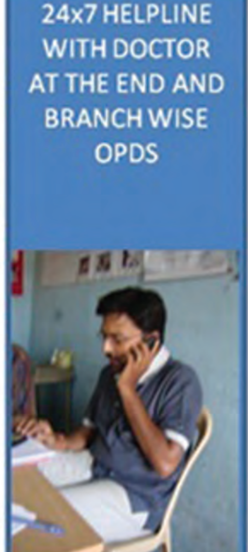
People Community Centred

Insurance companies often practice what is commonly known as cherry picking and lemon dropping. Picking good risks and leaving out bad risks is a typical formula used by commercial insurance products. At Uplift, discussing and debating with communities especially women, a lot of learning emerged vis a vis risks. As a result of these discussions it was realized that for risk pooling to make sense for the poor, it has to be inclusive and respond to the real needs of the people. The many features imbibed thanks to this learning is no age based pricing-one price for all, no age entry bar, product exclusions validated by the community based on their context (normal maternity is covered in some communities), informed risk management (rationalized utilisation of services) and focus on family enrolment to ensure that girls are covered.

The main component of a mutual scheme is that the buyers and sellers of insurance are not different, they are often the same. As such at Uplift Mutuals right from product design to claims decision community via their elected representatives play the role of decision makers. An elaborate Information education and

Technically Sound

Health Services as an Ecosystem



services in consonance with feedback received from communities. Scheme data has regularly been presented to community representatives and explained to them in the most lucid manner.

Uplift has recently upgraded its MIS to a sophisticated web based system (UTTAM) that has allowed it bring greater efficiencies in enrolment and claims management and an array of reports that will help its communities better manage their mutuals.

Uplift has a set of skilled technical human resource that work on right from product design, process design, back office management, training and capacity building, and medical services provision

One of the earliest realizations that came through community feedback was that for the Mutual scheme to provide value to its members it should invest in access to health services as it was critical for the mutual scheme to work. After a decade the single most important learning of Uplift has been that health insurance is a lot about health care management.

Uplift has created a multilevel access for its members by creating a preferred provider network, a 24X7 helpline managed by doctors for emergency and normal guidance, a referral system and dedicated human resource to guide people to relevant health care and follow up and a dedicated Out Patient service system to provide the first level of quality care. This has helped Uplift communities in saving a huge amount of money in out of pocket expenses by knowing where to get a good treatment at a good rate. The tangibility brought by these set of services has helped the communities understand the consumption of health care and its merits and demerits.

Uplift Mutuals has been able to setup Mutuals with communities that have shown an interest in designing such schemes for themselves in Maharashtra, Rajasthan and Tamil Nadu with over 200,000 members participating in the mutual scheme across member organisations in the past decade. The absence of regulations for such a people governed model has affected its growth prospect compared to the client value it has been able to achieve.

Uplift Mutuals through its built operate transfer franchise model is currently working at over seven locations to equip communities to setup manage their health micro insurance with end to end support and guidance. It has been ten years that Uplift Mutuals has been working to create a people's movement in health micro insurance and the journey has just begun!

***Kumar Shailabh**

Working with Uplift Mutuals for over a decade now

www.upliftmutuals.org

Including the Excluded:

Insurance to the Vulnerable People Living with HIV

Balasubramanian. S*

Background

India has a population of over one billion, around half of whom are adults in the sexually active age group. India's National AIDS Control Organization estimates that 5.7 million people of its population are HIV positive. The first AIDS case in India was detected in 1986, since then HIV infection has been reported in all states and union territories. Four southern states of Andhra Pradesh, Maharastra, Tamilnadu and Karnataka account for around 63% of all people living with HIV (PLHIV) in India. Tamilnadu is identified as one of the six high prevalence states in India. The state has still around 1.78 lakh of infected people. The prevalence of infection in the state was 1.13 percent in 2001 and is reduced to 0.34 percent in 2006.

Under the National AIDS Control Programme (NACP), all Indian districts have been categorised according to HIV prevalence into A, B and C class districts. Of Tamil Nadu's 31 districts, 22 are A category districts, five are in B category and four in C category. One of the hotspots for HIV infection are the subepidemic region of Salem district, Tamil Nadu state, India.

The magnitude of the problem is that the young and middle generation is getting wiped out and the older generation has to shoulder the additional responsibilities of caring the children with a meager income they survive upon. In view of these, financial safety net mechanisms providing financial support to the family of the PLHIV are warranted for economic well being.

Under these circumstances, a pilot project providing insurance to PLHIV was implemented for ensuring financial support to their families. The project involved safeguarding PLHIV from life risks and providing them as well as their family members, a health risk cover. It is pertinent to note that the PLHIV are excluded under the life and health insurance products of commercial insurers. Whereas s tailor made insurance product by them would involve high premium rates and small benefits which would make them inappropriate and wean the PLHIV from accessing these products.

Insurance needs of PLHIV:

Most of the PLHIV are in the young and middle ages which are the most productive period of life. The death of the person would put the family in doldrums. A life insurance cover would offer safety net in this regard. PLHIV are susceptible to infections and increased health care has to be accessed to them which warrant a health insurance cover providing primary healthcare and hospitalization benefits in addition to life cover.

Project Features

The fundamental premise of the project is ensuring access of life and health insurance cover to PLHIV along with the general population without discrimination. Thus, the project involves an integrated pool of high risk PLHIV and general population with normal risk, so that the risk is

shared across on the basis of mutuality resulting in insurability of PLHIV at affordable rates. The life and health risks of general population are transferred to Life Insurance Corporation (LIC) of India and National Insurance Company (NIC) under the Janshree Bima Yojana / Aam Adhmi Bima Yojana and Universal Health Insurance Scheme. Since the risks of PLHIV are excluded in the schemes, those risks are retained by the community organizations which offer similar benefits that are offered to general population by the insurance companies, with an uniform premium.

The life risks of general population are covered under LIC Aam Aadhmi Bima Yojana (AABY) by transferring a premium of ₹100 per person. For covering the health risks of five member family, an annual premium of ₹150 is paid to National Insurance Company Limited towards Universal Health Insurance Scheme (UHIS). The life and health risks of PLHIV are covered under the mutual insurance with an ear marked premium of ₹125. The remaining ₹75 is for meeting the administrative cost of federations for insurance education, members' enrollment processes and operational costs. The premium pattern is furnished in the following table:

S. No.	Components of Premium	Premium (₹)
1	Premium paid to LIC JBY (₹ Per person)	100
2	Premium paid to NIC UHIS (₹ Per family)	150
3	Contribution for risk retention	125
4	Administration cost	75
	Total	**450**

The benefits / cover available are as below:

Life insurance	(₹)
Natural death of the member	30,000
Death due to accident of the member	75,000
Permanent total disability due to accident of the member	75,000
Partial total disability of the member	37,500

Health insurance	
Cashless hospitalization expenses to the family of five (Member, Spouse and first three dependent children)	30,000
Death due to accident of bread winner of the family	25,000
Child Birth	
Normal delivery	2,500
Caesarian delivery	5,000
Wage loss compensation when the hospitalization period exceeds three days, for a maximum of 15 days	50 / day

The premium is paid to the insurance companies for all the enrolled people whether they are PLHIV or not. The policy is issued by the companies as a group insurance policy in the name of the federation. Under life insurance, when there is death or disability, the claim papers are processed by the federation and sent to the companies. LIC settles the life insurance claims by way of direct credit to the bank account of the nominee. The non admissible claims of PLHIV are paid to the nominee on similar lines from the mutual insurance funds.

Under health insurance, NIC ensures cashless hospitalization care through its Third Party Administrator (TPA), if the hospitalization is in the networked hospitals with pre authorization by TPA. The other than PLHIV claims are processed by the federation and sent to the company, who would settle the claim to the beneficiary through the federation. The claims of PLHIV are not admissible by the company and are paid to the beneficiary / nominee on similar lines under mutual insurance.

Life insurance coverage

The total insurance coverage has increased over years and as at March 2014, about 61088 persons are covered under comprehensive life insurance programme in Salem district. The details of growth of life insurance coverage for the past three years is narrated as follows:

S. No	Federation	2011-12			2012-13			2013-14		
		F	M	T	F	M	T	F	M	T
1	TVVK	2,650	2,406	5,056	2,716	2,404	5,120	2,665	2,494	5,159
2	SAGVK	793	5,917	6,710	6,570	14	6,584	3,941	3,672	7,613
3	SANVK	3,132	3,038	6,170	3,270	2,966	6,236	3,548	3,225	6,773
4	GVK	1,124	126	1,250	1,058	898	1,956	1,125	1,013	2,138
5	MUVK	3,493	3,290	6,783	3,810	3,434	7,244	84	7,042	7,126
6	SPMVK	6,472	213	6,685	3,287	2,874	6,161	6,000	0	6,000
7	SVK	2,925	2,775	5,700	2,820	2,873	5,693	3,520	3,480	7,000
8	SKVK	9,115	472	9,587	4,913	4,528	9,441	5,089	4,690	9,779
9	SVVK	9,817	89	9,906	5,332	4,984	10,316	4,765	4,735	9,500
	Total	39,521	18,326	57,847	33,776	24,975	58,751	30,737	30,351	61,088

The age wise composition of people covered under life insurance for three years period is furnished below:

Age group	Population insured											
	Insured population including PLHIV			Insured population excluding PLHIV (LIC AABY)			PLHIV (Mutual)			% of PLHIV to total insured population		
	F	M	T	F	M	T	F	M	T	F	M	T
0-10	0	0	0	0	0	0	0	0	0	NA	NA	NA
11-19	2,533	2,634	5,167	2,533	2,634	5,167	0	0	0	0	0	0
20-24	4,045	2,744	6,789	3,992	2,713	6,705	53	31	84	1.31	1.13	1.24
25-34	29,024	16,039	45,063	28,928	15,970	44,898	96	69	165	0.33	0.43	0.37
35-44	35,488	24,509	59,997	35,369	24,361	59,730	119	148	267	0.34	0.60	0.45
45-49	13,359	10,654	24,013	13,302	10,560	23,862	57	94	151	0.43	0.88	0.63
50-59	16,900	14,867	31,767	16,866	14,821	31,687	34	46	80	0.20	0.31	0.25
>60	2,205	2,685	4,890	2,202	2,657	4,859	3	28	31	0.14	1.04	0.63
Total	**103,554**	**74,132**	**177,686**	**103,192**	**73716**	**176,908**	**362**	**416**	**778**	**0.35**	**0.56**	**0.44**

It is found that the HIV prevalence among the insured population in the district is 0.44 percent as against the national prevalence of 0.27 percent. Further the HIV prevalence is higher with males than females. The PLHIV is accounted based on the data of identified people.

Life insurance claims

There were a total of 935 deaths among the insured population during the three years period and of them 7 deaths were PLHIV. The claim details are furnished below:

Age group	Life insurance claims									Mortality Rate (%)								
	Death claims including claims of PLHIV			Death claims excluding PLHIV			PLHIV death claims			DHAN project experience for population including PLHIV			Population excluding PLHIV			PLHIV		
	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T
0-10	0	0	0	0	0	0	0	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
11-19	1	2	3	1	2	3	0	0	0	0.04	0.08	0.06	0.04	0.08	0.06	NA	NA	NA
20-24	5	5	10	5	5	10	0	0	0	0.12	0.18	0.15	0.13	0.18	0.15	0	0	0
25-34	33	43	76	32	42	74	1	1	2	0.11	0.27	0.17	0.11	0.26	0.16	1.04	1.45	1.21
35-44	50	147	197	48	146	194	2	1	3	0.14	0.60	0.33	0.14	0.60	0.32	1.68	0.68	1.12
45-49	30	104	134	30	102	132	0	2	2	0.22	0.98	0.56	0.23	0.97	0.55	0.00	2.13	1.32
50-59	91	269	360	91	269	360	0	0	0	0.54	1.81	1.13	0.54	1.81	1.14	0	0	0
>60	36	119	155	36	119	155	0	0	0	1.63	4.43	3.17	1.63	4.48	3.19	0	0	0
Total	**246**	**689**	**935**	**243**	**685**	**928**	**3**	**4**	**7**	**0.24**	**0.93**	**0.53**	**0.24**	**0.93**	**0.52**	**0.83**	**0.96**	**0.90**

Health Insurance

Health insurance coverage

The health insurance access under UHIS has grown from 15694 persons during 2011-12 to 97411 persons during the year 2012-13. The subsidy under UHIS was withdrawn from April 2013, which has resulted in an insurance coverage of only 28115 under UHIS during 2013-14. However the federations have started implementing an inclusive mutual health insurance product which provides primary health care and hospitalization care cover. The status of health insurance coverage under UHIS, during the three year period is furnished below:

Year	Population insured under Health Insurance											
	Insured population including PLHIV			Insured population excluding PLHIV (NIC UHIS)			PLHIV (Mutual)			Percentage of PLHIV to total insured		
	F	M	T	F	M	T	F	M	T	F	M	T
2011-12	7,787	7,989	15,776	7,754	7,940	15,694	33	49	82	0.42	0.61	0.52
2012-13	49,487	47,924	97,411	49,289	47,666	96,955	198	258	456	0.40	0.54	0.47
2013-14	13,982	14,133	28,115	13,924	14,051	27,975	58	82	140	0.41	0.58	0.50
Total	**71,256**	**70,046**	**141,302**	**70,967**	**69,657**	**140,624**	**292**	**357**	**678**	**0.41**	**0.51**	**0.48**

It is found that HIV prevalence among the persons insured for health under UHIS is 0.48.

Health insurance claims

There were about 1329 hospitalization claims during the three year period among the above insured population and of them 36 hospitalizations were of PLHIV. The details are as below:

Year	Hospitalizations						% of PLHIV hospita lisation to total		Hospitalization rate (%)			Average cost of Hospitalization (₹)		
	Insured Population including PLHIV		Population excluding PLHIV		PLHIV									
	No	Amt (₹)	No	Amt (₹)	No	Amt (₹)	No	Amt (₹)	Population including PLHI-V	Population excluding PLHIV	PLHIV	Hospita lisation including PLHIV	Hospita lisation excluding PLHIV	PLHIV
2011-12	564	31,95,974	557	31,60,785	7	35,189	1.24	1.1	3.58	3.55	8.54	5,667	5,675	5,027
2012-13	606	33,79,750	594	33,17,134	12	62,616	1.98	1.85	0.62	0.61	2.63	5,577	5,584	5,218
2013-14	159	13,64,496	142	12,76,516	17	87,980	10.7	6.45	0.57	0.51	12.14	8,582	8,990	5,175
Total	1,329	79,40,220	1,293	77,54,435	36	1,85,785	2.71	2.34	0.94	0.92	5.31	5,975	5,997	5,161

The hospitalization percentage is higher at 5.31 for PLHIV as against the 0.92 for general population. The average cost of hospitalization for PLHIV is ₹5161 as against ₹5997 for general population.

Mutual Solidarity Fund

Since the PLHIV are excluded under the existing life and health insurance products, this project envisaged an inclusive insurance where the PLHIV risks are retained with communities under mutual insurance. To safeguard the event of claims exceeding premium, a mutual solidarity fund was created as a safety net mechanism. As the mutual insurance claims of all these years were within the premium, there was no occasion of falling back on this safety net fund.

Way forward

The project has been piloted in 9 blocks of Salem district involving significant poor. Similar pilots need to be initiated in additional locations covering significant population of PLHIV as well as reaching to the high risk populations of migrants, truckers etc.

Moreover, the experiential learnings needs to be disseminated to different stakeholders including government, insurers, regulator, civil society organizations and HIV positive networks to create a facilitating environment for PLHIV insurance product development with pro client norms and processes at affordable premium.

***Balasubramanian S,** Chief Executive, People Mutuals

Integrated Health care and Insurance

A community model

Rajapandian.R & Sivarani.B*

Introduction

Since independence, India has achieved a lot in terms of health improvement. But still the country is way behind in achieving health indicators when compared to many fast developing countries. In case of government health care system, the quality and access of services has always remained a major concern. The private health care market is growing rapidly and developed as forerunner in terms of creating accessibility and quality services in India. The private players are capturing the market innovatively which attract the clients towards them. However, with proliferation of different health care technologies and general price rise, the cost of health care has also become very expensive and unaffordable to large segments of population. The efforts of government are not enough to control the situation towards making health services affordable and setting policies towards that. Though the private health system is emerged as bigger one, they concentrated much on curative care rather than prevention and promotion programmes. Further the private health system tries to make use of every opportunity including moments of crisis. Hence the government and communities are exploring different health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases.

Health insurance is one of the mechanisms among that to pool health risks of the community towards reducing their out of pocket expenditure on health. In India, health risk is much greater when compared to western and American countries since the infectious diseases are much prevalent due to population at higher side and poor awareness on health aspects. At the same time, health insurance access is also very meager at less than 5 percent at national level. In this regard, the individual and society also have the responsibility to address the issue and solution has to evolve from grassroots.

Community health insurance programs are such solutions for addressing the issues of out of pocket health care expenses, wherein the personal expenditure is converted as social expenditure through pooling of risks by communities. The community health insurance program of DHAN Foundation involving integrated health care and health financing is one such initiative.

Genesis of DHAN Community Health Insurance

Kadamalai Kalanjia Vattara Sangam is one of women SHG federations promoted by DHAN Foundation in 1990s. Over 200 SHGs comprising of 3,500 member households of poor are part of the federation. This federation is situated in Kadamalaigundu-Mayiladumparai Panchayat Union of Theni district, Tamil Nadu. This block is one of the remotest blocks in the district and has poor infrastructure facilities of roads and other modes of communication. The block is of hilly terrain with people living in scattered villages amidst thick forests. Dry farming is the major livelihood. Due to lack of adequate transport and communication, the access to government health care services is difficult and poor have to travel by different modes to reach Kadamalaigundu to get these services. Often the rural poor of this area resort to local quacks for their health care, resulting in complications leading to hospitalization at government hospital or private hospitals at the district head quarters, which are much far off.

A study conducted by the federation during 1998, revealed that the member families spend about 20 percent of their household income on health. Towards meeting the health expenditure they borrow from different sources and the SHG credit portfolio towards health expenditure itself accounted for 15 percent. Kadamalaigundu federation decided to address this and a primary care clinic was initiated by the federation during the year 2000 and the community health pilot commenced with about 3,000 poor families. It involved a health insurance cover of ₹ 10,000 for a contribution of ₹150 for a family of 5 including the wife, husband and children. The program involved reimbursement of 75 percent of hospitalization expenses at selected hospitals at Kadamalaigundu and Theni, where the services were provided at pre negotiated terms and prices through an MoU.

Growth of Mutual health programmes

On seeing the success and benefits of community health insurance pilot, similar programs were initiated in additional four federations of SHGs in the district. On learning this, National Insurance Company (NIC) designed a tailor made insurance product for DHAN Federations during 2006, which involved primary care services from federation clinics with 25 percent co payment and reimbursement of 75 percent of hospitalization expenses at the selected hospitals. There were inherent issues in getting hospitalization benefits at the private hospitals and this paved way for establishment of community hospitals at Theni and subsequently at Madurai and Salem. The program in collaboration with NIC was in operation till 2011, which resulted in enhanced health seeking behavior and health insurance awareness & access.

The community federation clinics and SUHAM hospitals are health care providers ensuring quality health care at affordable prices. Leveraging on these health care service institutions, the community health insurance evolved into a provider model of community health insurance. At present this program is implemented in Madurai and Salem districts of Tamil Nadu state. The details are as below:

- Annual contribution is ₹200 for the member families
- Primary health care benefits: (Available only in community federation clinics and SUHAM hospitals)
    - ⇨ Free primary care consultation including specialists consultation at federation clinics / SUHAM Hospitals without any restriction on number of visits
    - ⇨ 12-30% cost discount on medicines
    - ⇨ 20-25% cost discount on lab, x-ray and diagnosis
- Exclusions: Nil
- Hospitalization health care benefits:
    - ⇨ ₹15,000 per family per year, with a ceiling of per illness cover of ₹7,500
    - ⇨ ₹5,000/- as maximum claim amount for caesarian deliveries
    - ⇨ ₹2,500/- as maximum claim amount for normal deliveries

The cover of per illness cover of ₹7,500 is subject to the following sub limits:

Hospitalization Benefits	Limits
Room Rent	₹ 175/day
Surgeon cost	₹ 3000/ hospitalization
Anesthetist cost	₹ 2000/ hospitalization
Medical practitioner	₹ 100/day
Specialists	₹ 200/visit
Nursing charges	₹ 75/day
Anesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray Dialysis, Chemotherapy, Radiotherapy Cost of Pacemaker, Artificial Limbs & Cost of organs and similar expenses.	₹ 4000/ hospitalization

Experience of provider model of community health insurance

The program is found to be useful by the communities in accessing quality health care and affordable health insurance. The poor are able to access free consultations with specialists like cardiologists, neurologists, diabetologists and such other experts leading to improved health through early diagnosis

and health management. The program during the period 2012 - 14 has accessed community health insurance to 73,217 poor households comprising of over 2.5 lakh persons. The contributions paid by communities were ₹1.93 crores and benefits realized so far are ₹1.67 crores.

Learnings

Usually primary health care expenses were mostly out of pocket and this is one of the pioneering initiatives of community health insurance in meeting the cost of primary health care of poor apart from hospitalization care. Due to the existence of strong social capital and community run clinics and hospitals, the initiative is viable and sustainable.

Risk management includes the measures of risk avoidance, risk prevention and risk reduction apart from the risk financing / insurance. Thus it is more appropriate to practice the measures that would mitigate risks rather than mere risk financing. Taking this into cognizance, DHAN implements community health programs of HIV awareness, anemia control, Reproductive and Child Health, Water Sanitation and Hygiene, towards improving the health of communities, thus insulating poor from health risks. This also reduces the incidence of health risks.

Moreover the analysis of the health risks from the benefits data, aids in focused interventions to reduce identified health risks in specified areas.

Rajapandian R
Chief Executive
SUHAM Hospital Trust

Sivarani B
Programme Leader
DHAN Foundation

Tata-Dhan Academy

Announces

First International Course - Advanced Reflective education and Training (ART) on Micro Pension

December 2-4, 2014

The world's population is growing older rapidly. Older people will outnumber the younger by 2050 for the first time in the world's history. Most of the aged people in developing countries, who have worked all their lives in the informal sector are left in poverty without any regular income. With traditional family support systems eroding, millions have to work hard even in old age. Governments are initiating social pensions for reducing old age and intergenerational poverty. To complement this, enhancing the availability, accessibility and affordability of contributory micro pension would be a major thrust area of development stakeholders. Towards this direction, the Advanced Reflective education and Training (ART) on Micro Pension, an international program is organized by DHAN Foundation, India and SDMO, Micro Pension Foundation, The Netherlands.

The program aims to facilitate learning among the participants on Community managed micro pension besides basic concepts and models of micro pension in order to make them appreciate its effectiveness as a tool to reduce old age poverty and the challenges in micro pension and potential solutions would be highlighted.

The participants of the programme include practitioners of micro finance/ micro insurance/ micro pension, their networks, Non Government Organisations, academics, researchers, donors, insurers, governments and international development agencies.

The course comprises of four modules:

Module 1: Community organisations facilitating old age security to poor

Module 2: Global perspectives on old age pension

Module 3: Pension architecture

Module 4: Micro Pension - Challenges and solutions

The learning process includes, case studies, videos, group discussions, resource lectures, seminar and field visit. The faculty members are leading micro pension practitioners from India and the Netherlands, micro pension experts, researchers and academicians.

Venue: JC Residency, 14, Lady Doak College Road, ChinnaChokkikulam, Madurai, Tamil Nadu 625002. Phone: 0452 420 0388.

Fee: USD 750 for international participants and ₹ 30,000 for Indian participants for the course towards food, stay, tuition, course materials, field visits and local sightseeing.

The application form can be downloaded online at http://www.dhan.org/tda/artmp01. The filled in applications along with the fee should reach us on or before October 31, 2014.

For further information, please contact:

Ms. S. Gayathri (Course Coordinator)

International ART on Micro Pension - Tata-Dhan Academy

T. Malaipatti, Thenkarai(BO), Mullipallam (SO), Sholavandan (Via), Vadipatti Taluk, Madurai District 625 207. Tamil Nadu, India.

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Tata-Dhan Academy

Announces

Twelfth International Course -
Advanced Reflective education and Training (ART) on Micro Insurance

December 8-11, 2014

ART course enables participants from around the world to learn from large scale successful, sustainable, and viable experiences in micro insurance.

Participants

Micro insurance practitioners, micro finance institutions, micro finance networks, NGOs, researchers & academia, donors, insurers, governments and international agencies.

Course Design

The course comprises of five interdependent modules.

Module 1: Micro Insurance through mutuality, focusing on demand stream perspectives of insurance as well as the alternative distribution approaches to reach insurance to poor.

Module 2: Micro insurance and life and non-life risks, covering different micro and mutual products, models, principles, practices and challenges

Module 3: Micro Insurance product design lab, involving actuarial experts with a hands on practical session on actuarial analysis.

Module 4: Micro insurance sustainability and regulations, focusing on safety net mechanisms including reinsurance and broad perspectives of global micro insurance regulations

Module 5: Micro Insurance International perspectives, with the sharing on country specific micro insurance experiences

Field visit

Visit to community organizations and health care providers, implementing micro and mutual insurance.

Faculty

The faculty members are leading micro insurance practitioners, micro insurance trainers, consultants and academicians.

Registration

Fee: USD 1000 for international participants (INR 40,000/- for Indian participants only) for the course towards food, stay, tuition, course materials, field visits and sightseeing.

Application form

The application form can be downloaded online at http://www.dhan.org/tda/art12.php.

The filled in application form along with the fee should reach us on or before October 31, 2014.

Please send filled-in applications, or requests for further information to:

Ms. A. Umarani (Course Coordinator)
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