Micro Health Insurance

Relevance of Community Managed Models

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Given the context of performance of micro health insurance models in India where most have either been found to be incurring losses or have been ineffective in covering the health expenditure for the poor, this paper examines how it can be effectively delivered if it is managed by the community itself. Most such schemes work with the community; however, they follow the partner agent model where the community has a very limited role to play. This paper argues that more role given to the community would solve the problems that are plaguing the sector at present.

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BACKGROUND

Health Care and the Poor

Three of the eight Millennium Development Goals of the UN aim at improvement in health. The right of every individual to a standard of living adequate for the health and well-being of himself and his family, including the right to medical care and security in the event of sickness, has been enshrined in the UN’s Universal Declaration of Human Rights since 1948. It can hardly be tolerated then, that in modern nation states on which it is incumbent to treat all citizens equally and to provide them at least the basic minimum needs for survival, people continue to die without treatment of diseases that can easily be cured. Responsible governments must ensure that health care services are available to all who need them.
While the association between an individual’s good health and his/her earning was never questioned, it is only recently that the correlation between a nation’s citizens’ good health and its economic progress has been accepted by policy makers in developing nations. In India, the linkage between family health and population control was accepted only after failure of the forced population control programme during the Emergency. It took the policy makers even longer—beyond 1980s—to acknowledge the crucial importance of social sectors (especially health and education) for overall national progress.

Enough evidence now exists that there is a cause-effect relationship between health and poverty, which runs both ways (Acharya and Ranson, 2005). Lack of purchasing power prevents the poor from seeking health services, and ill health prevents them from working, pushing them deeper into poverty. If they avail of health services, the burden of debt incurred for such services pushes a family into further poverty.

Among episodes of ill health, hospitalisation is the most important factor leading to the heaviest expenditure for health. It has been estimated that hospitalised Indians spend more than half (58 percent) of their total annual expenditure on health care (World Bank, 2002). As mentioned above, such heavy expenditure at a time pushes families deeper into poverty. The same World Bank publication (2002) reports that almost one-quarter of hospitalised Indians fall into poverty every year as a direct consequence of the medical expenses they pay towards hospitalisation. As Gupta (2010) reports, health is the second major reason for rural indebtedness after indebtedness due to agricultural inputs. Thus efforts to alleviate poverty must include measures to improve health facilities for the poor.

The high costs of health services lead to restraining of health care needs. On average, the poorest quintile of Indians is 2.6 times more likely than the richest to forgo medical treatment when ill (Peters and others, 2002). Hence, many people die of diseases that are easily curable. Further, as shown by National Sample Surveys between 42nd and 52nd round (NSS: 52nd round), people who were sick but did not avail treatment for financial reasons increased from 15 percent to 24 percent in rural areas and doubled from 10 percent to 21 percent in urban areas.

**Micro Health Insurance: A Possible Solution?**

The previous section establishes why health care provision by government is considered imperative. Financing of health expenditure, however,
remains a daunting task for the Indian government. Not only in India but in many nations, free universal health care services have proved to be a burden that governments have not been able to carry easily. Hence, a middle path has been proposed—to provide health insurance to the needy so that they can avail of the health services as and when needed. As at any given point of time, only a small proportion of people would need health services, the risk can be viably spread over a number of people. This would seem to be an efficient means to provide health protection to those who need it most.

India has changed its health policy directions several times—from attempting to provide free health care, it has tried user fees in government hospitals and recently introduced the targeted provision of health insurance as a means to ensuring health care services for the poor. Micro health insurance reduces government expenditure since the government pays only the premium for the poor. The rest is taken care of by the insurance company and the hospitals.

Recent National Sample Surveys have shown that people’s preference for health services is shifting to the private sector and the proportion of population availing government health services is declining (Devadasan, 2004). In such a scenario, policy makers hesitate to invest money only in the government health sector, as this appears unlikely to achieve the goal of reaching the poor; they may not be coming to government hospitals anymore. Health insurance provides a useful compromise here too: the government pays only the premium for the poor families, who then have the choice to go to any of the designated network hospitals.

However, it should be emphasised that micro health insurance is a financing tool which presupposes the existence of health infrastructure that is reasonably priced and is of good quality. Without the existence of such an infrastructure, mere provision of financing via micro health insurance is of no use. Further, for a meaningful spreading of risks, a large number of members need to be enrolled as insurance does not work well in very small groups.

Micro health insurance derives the adjective “micro” from amount of premiums charged which are considerably low to be affordable to the poor. The rationale is to equip the poor to tide over the sudden loss of assets or unexpected expenditures with the help of micro insurance (Alliang AG and others, 2006). Low premium rates, however, translate into rationing of benefits to maintain viability of the scheme. In other words, micro health
insurance charges lesser premium, but covers only a limited amount of medical expenditures. (Radermacher and others, 2006). Theoretically then micro health insurance is not as effective as the free provision of health care services. Yet, given the reality of deteriorating standards of government health care infrastructure, it might prove to be a better strategy.

In the end, the crucial test of appropriateness of micro health insurance as a health financing tool is to check whether its risk cover is adequate for the hospitalisation costs incurred. In a small survey of about 100 rural households in Vidarbh carried out by Parikh and Shailabh (2011), it was found that the average hospitalisation expenditure was around Rs. 12,000. Thus, the health insurance that covers hospital expenses upto Rs. 15,000 could indeed prove to be considerably useful to the poor and save them from indebtedness. At the same time, however, complex operations like amputation of leg, paralysis, removal of knot, and so on, can cost much more and can push the poor into indebtedness. This implies that some combination of public provision of health care services and micro health insurance will have to co-exist to provide maximum relief to the poor.

The revolution of micro finance was based on the premise that if small loans were provided to the poor, the relief they obtained would be considerable. The same assumption underlies micro insurance, that providing small claim amounts will relieve the poor from considerable debt burden. The similarities between the approaches towards self help groups and micro insurance show why micro insurance is legitimately a part of micro finance.

Why Community Managed Health Insurance?

The micro insurance sector has made significant strides in India. A report by Allianz AG, GTZ and UNDP (2006) suggests that India has the most dynamic micro insurance sector in the world. It has 102 micro insurance products, the largest that has been reported by any country.

In India, the most prevalent method of delivering these products is through the partner-agent model. Under the partner-agent model, any institute, (like a micro finance institute, an NGO or a for-profit business firm), acts as an agent which sells the insurance policies of a company for a fee/commission. The agent uses its ties with local communities for selling these policies. The arrangement works out to be beneficial for both: the insurance company would have found it difficult to reach these communities without the agents. Also, with the agents, it gets many more members. The agent, on the other hand, especially if it is an NGO,
manages to get micro insurance for the group that it works for, without having to understand the complex business of premium calculation and risk management. In short, this model utilises the comparative advantage of each partner so that each can focus on its core business.

Few NGOs and insurance companies in India practice the agency model. In such cases, the organisation or company sells the micro insurance products directly through its office. Its marketing team sells the products in various geographical areas or the client comes to its sales agency office to buy the product. However, because of lack of funds, NGOs undertaking such work find it difficult to assume larger risk and have to limit their operations to a small number of clients. Likewise, an insurance company working independently lacks good knowledge of the local community’s requirements and hence is not able to generate much business. Consequently, there are very few examples of agency models in India.

With both these types of models, some difficulties reported are the same as the ones found in textbooks of health economics—adverse selection and moral hazard. Adverse selection means those people who are already ill tend to become members of the scheme. Hence, the probability of a member falling ill increases to almost 100 percent when it should not be more than 15-17 percent. The term moral hazard refers to fraudulent practices by members such as not reporting chronic illnesses, faking hospital/medicine bills, demanding services of a specialist for minor illnesses, and such. Moral hazards increase with increase in membership. Thus claims ratio often rises up to eat away the premiums earned and the insurance company starts incurring huge losses. To counter such problems, insurance companies start rejecting claims or increasing premium rates or both. So, when claims are not honored, the under privileged members become indebted. And if the premiums are raised, most of the poor drop out of the scheme. Either way, the system becomes dysfunctional.

Community managed insurance models, initiated in France and represented by some initiatives in India, provide a solution in such a scenario. The term ‘community managed health insurance (CMHI) models’ should be differentiated from the term ‘community based health insurance (CBHI)’. The latter is a loosely defined term. Any insurance model that is designed for the low income groups has been called a community based model in the literature. Active involvement of the community in managing at least some insurance activities is rarely present. This paper deals with only those health insurance models where the community plays an important role.
Such models can be managing the entire business of insurance provision locally by collecting premiums, evaluating claims and making the payments. In the partner agent model outlined above, the claims are collected by the NGO and are submitted to the insurance company. These claims are never discussed in a meeting with the community. In contrast, the community managed insurance models follow the modus operandi of Self Help Groups (SHGs).

If the programme is managed by the community, the problem of asymmetry of information is less because members know about each other’s families. This makes it more difficult to hide vital information regarding health problems and preconditions of the prospective members. Thus, it becomes highly improbable that only the vulnerable members of the family would be insured. Adverse selection is less likely to happen.

Fraudulent claims could be easily prevented if the local community is handling the claim submission. The members would know validity of each claim. Moral hazard will be less.

In short, just as the micro finance movement addressed the problems of adverse selection and moral hazard (as the members were known to each other), the probability of choosing a person who was untrustworthy was less (adverse selection thus was addressed) and lying about loan utilisation was less feasible because other members were staying close by and would hence know the truth. Thus moral hazard was also taken care of. Similarly, choosing only those people as health insurance holders who are already suffering from some illness is less likely in a saving group because (i) all the borrowing members would be enrolled, so the probability of them all being ill is low and (ii) if the enrolment was voluntary and members tried to buy insurance only for the ill family members, others would prevent that from happening.

Another important advantage of the community managed insurance model is increased medical intelligence: information about various health care providers is available more easily as people tend to share their experiences in the meetings. Thus villagers are in a better position to avoid those hospitals that charge excessive rates or give false advice.

It has been reported about partner agent models that people are often not aware of either the concept of health insurance or even that they are insured (Acharya and Ranson, 2005). As a result they do not put forward their claims to avail the benefits of having taken the insurance. Here, the whole purpose of providing insurance is defeated. In community managed
health insurance programmes, as the entire discussion about claims and reimbursement takes place in the monthly meetings, members are generally aware of the insurance benefits.

However, SHGs are known to leave out the poorest of the poor (mainly because of the compulsion of saving a certain amount every month). Because there is a strong correlation between poverty and caste, Scheduled Castes (SCs) and Scheduled Tribes (STs) are suspected to be left out too. According to a study by EDA Rural Systems and APMAS (2006), 51 percent of the members in their sample were poor, 55 percent belonged to the SC/ST. Limitations suffered by the SHG movement would affect the spread of micro health insurance also, because it would be based on the micro finance movement. However, it would still mean extending the health insurance services to a large base of population that is now covered by SHGs and thus reaching out to many who at present are left out of the insurance coverage. The WHO study by Spann and others (2011) confirms this by reporting that “There is strong evidence that CBHI improves resource mobilisation for health and that it improves health service utilisation and provide financial protection for members in terms of reducing their out-of-pocket expenditure. There is only weak evidence suggesting that CBHI has a positive impact on the quality of care and social inclusion. Findings are inconclusive on community empowerment”.

However, there is one more problem related to this issue that needs to be noted. It has been a major challenge in India to convince people to buy insurance of any kind. The concept of insurance has not yet gained currency in India. Even if people buy insurance, they pay the premiums just once. It has been difficult to convince them to keep paying premiums every year. Compulsory insurance is the solution that has been worked out for this problem. Micro health insurance has always been provided as compulsory deduction of the premiums from the loans taken. This would however mean that the ones who do not take loans would not get the benefit of the insurance cover. It is hoped that over the years, with the discussions in the groups and resulting spread of awareness, the demand for such insurance might increase.

The presence of a committed NGO is absolutely essential for establishing a CMHI programme. The community would need extensive training to understand the concept of insurance and managing it. It is not easy to understand the use of insurance, let alone manage insurance claims. One of the organisations under study in this paper, ‘Uplift’, doubles its role as not just trainer but being an organisation that manages the mutual funds for
health insurance. Such an organisation at the top of the federal structure would also be required.

This paper makes a theoretical case to use the vehicle of SHGs for initiating community managed health insurance programmes. It is portrayed as an additional service that would be provided by the SHGs. To make the insurance programme scalable, just like the federations of SHGs, the insurance can also be organised at different levels so that insurance claims of one group, if exceeds the payments, can be borrowed from the higher level body. The premiums that are in excess of claims can be pooled together to meet the needs of the district, and later, the state. Such spreading of the risks would help in strengthening the system.

**Evaluation of Selected Micro Health Insurance Models**

In the following sections, we look at three well known micro health insurance experiments in India. We try to understand how they have tried to improve the access to health services for the poor. We show how they are fraught with problems that make them either unviable (Yeshasvini) or ineffective (RSBY). We then show how participation by communities can make a meaningful difference in such schemes. Finally, we describe a successfully run community managed health insurance scheme that can act as a model for emulation.

Community managed health insurance is at its nascent stage in India. There is just one organisation that is experimenting with it in India. This paper thus is a theoretical case built for such a way of administering health insurance and the potential benefits arising out of it.

**YESHASWINI**

Yeshasvini’s goal is to provide quality health care all over the state of Karnataka at affordable prices. The target group comprises farmers organised in cooperative societies (for example, Karnataka Milk Federation). Farmers pay a relatively small annual premium that allows them access to high-quality treatment including critical operations of the stomach, gall bladder, bones, eyes, uterus, brain and heart.

The scheme is designed as follows:

Members of the cooperative society and their family (spouse and children) are insured for a year. The secretary of the cooperative society advises members to join as the scheme provides a good cover against hospitalisation risks. Membership is voluntary.
The premium to be paid by members is Rs. 60/- per year per individual for the first two years and after that it is Rs. 120/-. The government gives a subsidy of Rs. 30/- per individual. Dependents can be insured at the same rate as that of the member. The scheme covers more than 1,600 surgeries and all costs connected for staying in a general ward. Admission charges, bed charges in a common ward, nursing charges, anesthesia charges, O.T. and the surgeon’s charges are all covered, as well as the costs of consumables and medicines during and after the operative period, post-operative charges and surgery related investigations. Additionally, OPD is free for the members, but drugs prescribed in OPD have to be purchased. Diagnostic tests/investigations are also available at discounted rates of 30 percent.

The network hospitals are the only designated health care providers in the scheme. Spread throughout Karnataka, they are mainly private hospitals. Some are highly specialised hospitals. The scheme started with 80 network hospitals and grew to more than 150.

The maximum coverage for a person per year is Rs. 2,00,000/- ($4,545). This is sufficient for two of the most expensive operations and some smaller ones. The price for surgery paid to a network hospital is about 30 percent below the average price charged. In case of complications, the treating hospital has to bear the additional cost; the scheme does not reimburse for it.

Yeshasvini has hired Family Health Plan Limited to administer its scheme. It is a company that works for profit; it is given a commission to administer the insurance scheme.

The scheme utilisation shows how beneficial the scheme is perceived to be. Within the first seven months, 5,000 members underwent different kinds of surgeries and 23,500 farmers or family members had ambulatory consultations. The scheme had more than 2 million members in 2004. It helps many poor clients to get surgeries that they otherwise could not or could hardly afford. The inclusion of free OPD in the benefit package protects clients from other financial hardships.

However, it should also be noted that in the first two years itself, claims far exceeded the amount of premium collected from the members. In 2009-10, the claims premium ratio was 157 percent for Yeshasvini, which is not financially viable. With increasing claims, the insurance premiums will have to rise. As had happened in the third year of existence of Yeshasvini, the membership and renewal rate will decline substantially with such
high claims ratios. As the scheme relies heavily on subsidies from the government for premium payment, government subsidies will also have to rise.

A Critique

Yeshasvini has covered a large number of people and is one of the largest health insurance schemes in the country. The overall response from members shows that it is perceived to be very useful. However, there are some major problems that need attention. In the following paragraphs we list these problems and discuss how some of them can be dealt with better if the community participates in managing the health insurance scheme.

- The claim premium ratio is extremely high. Soon no insurance company would want to undertake their business. If government is asked to pay most part of the increased premiums, it would mean a major drain on the government coffers. So, the scheme seems unsustainable. However, cases of adverse selection and moral hazard are expected to be lesser in CMHI; hence, the scheme might turn out to be more sustainable.

- Karnataka is a large state. Pre-authorisation to be obtained from a central authority (required by the scheme), at least for smaller surgeries, becomes too cumbersome and prolonged a procedure. Often patients are brought to the hospitals in the cities and when pre-authorisation is sought, it takes days. They find it difficult to go back and at the same time, waiting for the pre-authorisation proves both costly and sometimes dangerous for the fragile patient. CMHI might be able to deal with this problem better, because such authorisations are handled by the community itself or by a local full time micro insurance executive.

- The nature of the scheme increases the problem of moral hazard. People go for specialist treatment or expensive tests even when these may not be warranted. Hospitals also inflate their bills or insist on giving such expensive care, because the insurance scheme pays for it. This can be partially improved with CMHI. Members guide each other as to which hospital is reliable and better to visit. Moreover, members tend to question the decisions of the hospitals. Moral hazards because of members’ attitudes can also be better dealt with by persuasion and questioning.

Yeshaswini has been criticised by some for being limited to co-operative members only. This means that a vast majority of the needy remain outside
its purview. Also, members usually belong to the middle class; the very poor are not part of this scheme. Yet, it still remains a very useful and relevant scheme for the members and an example of a successful health insurance scheme with wide coverage. Some role for the community might improve the viability and utility of the scheme.

**RASHTRIYA SWASTHYA BIMA YOJANA**

RSBY\(^2\) was launched by the Ministry of Labour and Employment, Government of India, to provide health insurance coverage for below poverty line (BPL) families. Beneficiaries under RSBY are entitled to hospitalisation coverage up to Rs. 30,000/- for most of the diseases that require hospitalisation. Pre-existing conditions are covered from day one and there is no age limit. Coverage extends to five members of the family, which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee, while the Central and State Government pay the premium to the insurer selected by the State Government.

**Unique Features of RSBY**

RSBY provides the participating BPL household with freedom of choice between public and private hospitals and makes him/her a potential client worth attracting on account of the significant revenues that hospitals stand to earn through the scheme.

The insurer is paid a premium for each household enrolled for RSBY. Therefore, the insurer has the motivation to enroll as many households as possible from the BPL list. This could result in better coverage of targeted beneficiaries. A hospital has the incentive to provide treatment to a large number of beneficiaries as it is paid per beneficiary treated. Insurers are to monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims.

By paying only a maximum sum up to Rs. 750/- per family per year, it is affordable for the Government to provide access to quality health care to the BPL population.

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. This makes the scheme truly unique and beneficial to the poor families who often migrate from one place to another.
A beneficiary of RSBY gets cashless benefit in any of the empanelled hospitals. The person only needs to carry the smart card and provide verification through his/her fingerprint. The participating providers send online claims to the insurer and get paid electronically.

The geographical coverage of RSBY is the largest among all the micro insurance programmes. It has already covered more than one crore BPL families; 1,39,80,036 families to be precise. It works in most states of India. So far 3,717 hospitals are empanelled for the scheme, out of which 897 are public hospitals and the rest are private.

**A Critique**

The above discussion shows that RSBY tries to cover the population that could have been left out by a scheme like Yeshaswini. Although the insurance coverage for expenses is much lower, it still provides considerable benefits to the members. Use of smart cards is an innovative feature added in implementing the scheme and could cut down corruption.

- Ironically, this same feature proves to be one of the major problems with RSBY. There is nobody to guide the beneficiaries on an ongoing basis regarding the ‘smart’ technology. The technology can intimidate them and they might not venture to use it at all. It has been found that many beneficiaries do not know what the card is for, and how to use it. Even when they know that the card helps them in covering hospitalisation expenses, the beneficiaries do not know to which hospitals they can go for getting free treatment. In short, general awareness about the scheme is quite low. It is felt that a massive awareness generation programme is needed to make this scheme successful, so that the beneficiaries learn the essentials about the scheme, the product, eligibility, premium cost, treatment options, and whom to approach in an emergency. The presence of a CBO or NGO in any micro finance model (including CMHI) ensures more capacity building measures. By involving the community in the implementation of the scheme, it can be ensured that the beneficiaries have full understanding of the scheme.

- Enrollment rates are quite low for RSBY mainly because the service providers do not make efforts to reach out to distant villages. Many villages thus remain completely uncovered. From the primary survey in Vidarbh conducted by Parikh and Shailabh (2011), it was found that even when the service provider company reaches a village, they go for
such a limited time (just a day or two) that it is not possible to issue cards to all the families in the village.

- If a community is involved in RSBY as in CMHI, they can ensure that the service providers come with an adequate notice and stay for the time required to cover everyone in the village. An aware leader can also direct the people to the district office of the service providers where they can get their cards made. Many problems at the ground level, such as issuing cards with wrong names or invalid cards can also be solved if the community leaders are involved with implementation.

- Often, the insurance companies harass the hospitals in the name of monitoring them and preventing frauds. In Amravati district of Maharashtra, no empanelled hospitals honour the RSBY card now, because ICICI Lombard makes it very difficult for the hospitals to get reimbursement (Parikh and Shailabh, 2011). In such a case, the insurance company benefits because it gets large income through premiums, but does not get any claims. The BPL families suffer because in spite of having a card, they have to seek paid medical help. Many families have thus become indebted due to hospitalisation last year in Amravati, even when they had the RSBY card. When communities are involved in implementation, such behaviour is easily brought to the notice of the authorities. As a result, the contract of the insurance company would not be renewed.

- RSBY often uses the BPL list that is old or incomplete. Many families are left out of RSBY because of such faulty lists. If a village community is involved in implementation, it would be easier to identify the BPL families and ensure that none of them are left out.

- The question of sustainability remains even for RSBY. As it becomes better known, the claims would rise exponentially. No insurance company would want to be involved with a health insurance programme where the claim premium ratio is less than one, that is, if the payments to be made to the insured by the insurance company is more than what the insurance company earns from the premiums, the income would be less than the payments. Hence, there would be losses, there would be no sustainability of this business venture. If the community is involved, enrollment ratio would be much higher. Such a large number would ensure that the probability of hospitalisation would be around 0.2 for a population and then the scheme would have more chances of becoming viable.
Vimo SEWA

The mission of SEWA Insurance is to provide social protection and security to SEWA members against various risks they face in their lives. SEWA believes in providing an integrated insurance package based on the needs of the members, which provides coverage against various risks like sickness, death, asset loss (assets include house), weather and accidents.

Vimo SEWA offers two types of payment schemes to its insurance members. Members can either pay their premium annually, or through a fixed deposit with SEWA Bank. Under the fixed deposit option, members deposit a lump sum in fixed deposits in the SEWA Bank. The interest accrued on this deposit goes towards annual premium. Thus, a woman gets continuous insurance coverage.

The premiums are understandably higher than for either Yeshaswini or RSBY because no state support is available. A woman pays a premium of Rs 125/-. She gets covered for a total of Rs 59,500/-. This includes the following risks: in case of death by natural causes (like disease, old age, and so on), the life insurance cover is Rs. 7,500/-. For loss of house, Rs. 10,000/- is reimbursed. In case of accidental death, Rs 40,000/- is paid. However, the cover provided is the least for health expenses—it is Rs. 2,000/-. If a higher premium of Rs. 275/- is paid, the health expenses are covered up to Rs. 6,000/-. Similarly, other coverage also increases.

Currently, 1,84,643 persons are covered under this scheme of which 1,01,681 are women.

A Critique

- The most important problem is that of coverage for hospitalisation risk. If a person is hospitalised, Rs. 2000/- is not enough for any treatment or operation. The purpose of having health insurance would not be achieved with this kind of reimbursement. The scheme can incorporate lessons from other organisations that are running the health insurance on better terms (for example, Uplift Mutuals covers Rs. 15,000/- of expenses for a premium of Rs. 100/-).

- The problem of complicated paper work remains, again discouraging the use of the scheme. In CMHI, paper work is usually looked after by some members or an insurance representative of the NGO.

- Most people seem to be members of the scheme through the fixed deposit scheme of SEWA bank. Many members are not aware of
the insurance scheme and thus do not avail of it at all. Communities manage the scheme by discussing the claims and balancing them with resources available. Hence, all members are aware of the features of health insurance.

- There is no attempt to cover the medicinal expenses; OPD charges are also not covered. Thus, the benefits of getting health care in time (before the problem gets aggravated and hospitalisation is needed) might not accrue to the members. It is noticed that most community managed programmes have realised the importance of covering OPD and other medical charges, as communities’ felt needs and inputs are conveyed regularly to the management.

**UPLIFT’S COMMUNITY MANAGED HEALTH INSURANCE SCHEME**

To contrast the experience of the above models with a community managed health insurance model, we illustrate the case of Uplift Mutuals. Ninety thousand persons in the state of Maharashtra are covered by Uplift.

Uplift works through Micro Finance Institutes (MFIs). When a person is sanctioned a loan from the MFI of more than Rs. 5000/-, premium for health insurance is deducted from the loan amount. When the loan is given, orientation about health insurance is simultaneously provided to the loanee by a full-time executive for micro insurance.

Uplift also designs health talks for client education. The insurance officer organises these talks for his groups. Additionally, Uplift arranges for discounts from OPD service providers for its clients. In the MFI meetings, members get to hear about other members’ experiences with health care services and hence get useful insights into the reliability of health care providers. Thus preventive health mechanisms are established and health care access intelligence (where to go, what is the right treatment and right cost) is enhanced.

If the need for hospitalisation arises, the member first takes a referral letter from the micro insurance executive who is available in the MFI office full-time. In case the emergency arises at night, the person attending the 24-hour helpline (run by Uplift) issues the referral letter. When the patient comes to get the referral letter, she is told about the expenditure involved in going to a private versus public hospital and how much money she will have to pay out of her pocket. After that, the patient can decide where to go. Uplift does not take this decision for them.
Once in hospital, the patient takes the referral letter to the social worker who guides her through the often complicated admission process. This prevents patients from feeling lost in the hospital.

Once the treatment is over, Uplift organises validation of the claim medically (for example, does it usually cost this much for a heart operation). Then the claim is sent to the area’s claims committee which evaluates the validity of the claim in a monthly meeting of all members, guarding against frauds as well as instances of moral hazard. The valid claims are then compared with the premiums collected from the area, and the amount to be reimbursed is decided. In case claims exceed the premium collection, other area committees are requested to cover the shortfall.

As the micro insurance business in each area grew, it was found that there were too many claims for an area committee to handle, mainly because it had to manage its credit business as well. Hence, a separate claims committee covering many slum areas was formed. This has representatives from each area. Each representative is aware of the claims made by her area members.

The claim ratios have been increasing, they have reached about 53 percent by now, showing proper utilisation of the scheme. At the same time, the claims are not so high as to make the insurance operations unviable. Also, many have benefited from the discounts given on OPD. In short, just as SHGs made banking viable for the poor, health mutuals can make micro health insurance a viable business.

**Comparative Analysis of Micro Health Insurance Models**

Michielsen and others (2011) rigorously reviewed 25 papers for case studies of eight micro health insurance schemes. Using the criteria of whether the users of the health service can exit one provider and access another one and can voice their grievances effectively, and studying the power equations between the providers and patients, they report that poor people’s freedom of choice is limited even with the insurance, because of health facilities of good quality are unknown, or not located close to the beneficiaries or they do not adhere to the defined quality standards. The examples cited are Yashswini and SEWA. Regarding consumer empowerment and accountability, the study states that in Uplift a social worker accompanies the patient to the hospital and thus ensures good medical treatment. Because the Uplift model is participatory, the members can negotiate with the company what they expect to receive as services. The study concludes by saying that CBHI holds strong potential to
improve financial protection and enhance utilisation among the enrolled populations.

The study by Matul and others (2011) systematically analyses client value emerging from indicators related with product (the design of the product), access, cost of the scheme and the experience of the clients. It reports that Uplift has the “most balanced” client value because of value added services, quality care management, systematic client education efforts and outstanding customer care. SEWA comes close to Uplift but loses out on the product as the benefits offered are the lowest compared to any other micro health insurance scheme in India. However, SEWA has been more viable than others because of this same reason.

Yashswini provides decent value at a fair price, but adds lesser client value than Uplift and SEWA because of access issues. It recommends that NGOs should align their products with large public schemes like RSBY through integration or by targeting different market groups.

CONCLUSION

In this paper, the authors have looked into the concept of micro health insurance, and how it is taking shape in India. Although numerous micro health insurance programmes have been introduced, utilisation rates remain low. This has happened mainly because people have either not understood the concept of health insurance or they are not aware that they are insured. The political economy of health provision comes into play here. Insurance companies would always be interested in keeping the insured less informed so that the number of claims are lesser and the company can make sizeable profits from premium earnings. It is not in their interest to bring about awareness among the users.

The hospitals on the contrary want more and more insured to know about the scheme so that the patients come to them for treatment, increasing their business. Some hospitals actually send out vans and buses to bring insured patients to their hospitals. Many hospitals make the patients go through unnecessary advanced treatment (like going for operation when simple medicines would have been enough) to get more income. The SHGs offering CMHI will have to face these challenges and arrive at a balance.

An innovative model to make micro health insurance available to the poor is required—it is argued in this paper that community managed health insurance schemes might alleviate the problems prevailing in the sector. However, this is mainly a theoretical assessment. There have been
very few experiments with CMHI models. Their scalability and associated challenges need to be examined to establish their relevance. More innovative versions of the CMHI models also need to be devised. Much more research and experiments are required for this field that is growing fast, but has not been able to generate wide spread impact.

NOTES
1. Based on Radermacher and others, 2005
2. Based on www.rsby.com
3. Based on Ranson and others, and Presentation on VimoSEWA, 2007

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