The ACCORD – AMS – ASHWINI Health Insurance.

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Introduction

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

The ACCORD – AMS – ASHWINI Health Insurance (AAA HI) is jointly managed by three organisations; ACCORD[1] - the NGO; AMS[2] - the tribal union and ASHWINI[3] – the health providers. It was initiated in 1992 and provides health insurance coverage to all the tribal members of the AMS living in Gudalur Taluk.

Its main objectives are:

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

The AAA Health Insurance scheme is nested within a comprehensive development programme. ACCORD the parent NGO was started in 1986 and works among the tribals of Gudalur. Its main objective is to empower the tribals to fight for their own rights. ACCORD also provides services like health, education, agricultural support, housing and animal husbandry. All this is done through the community based union of tribals called the AMS. ASHWINI, the sister NGO was started in 1990 to take over the health programme. The ACCORD / ASHWINI health programme consists of promotive, preventive and curative care.

Design

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

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[1] Action for Community Organisation, Rehabilitation and Development

[2] Adivasi Munnetra Sangam

[3] Association for Health Welfare in the Nilgiris

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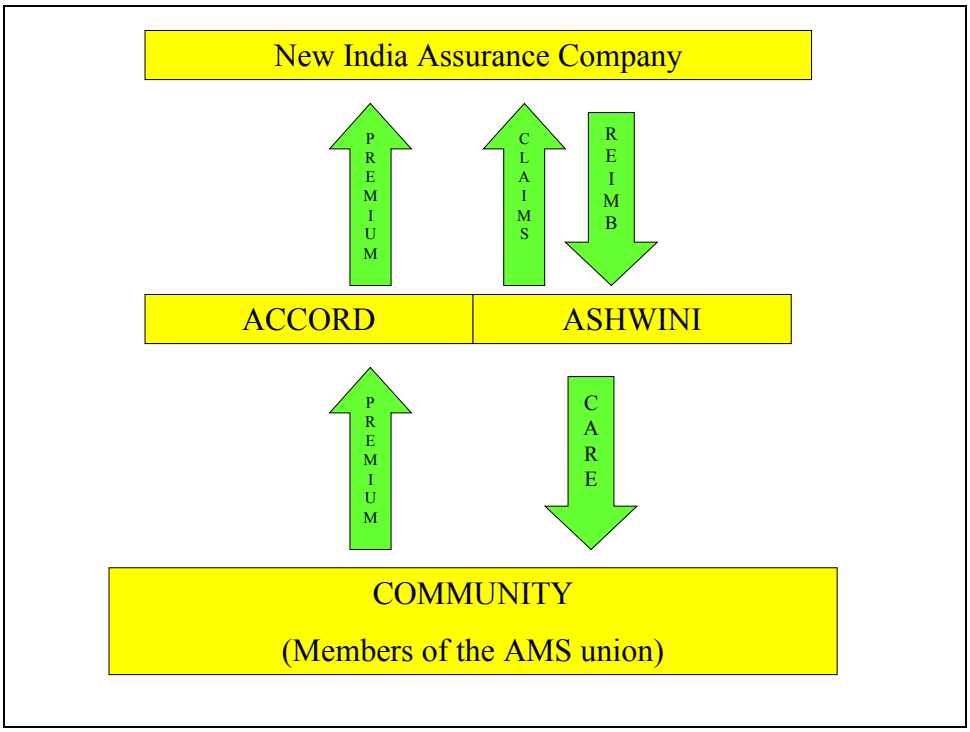
Figure 1: The design of the AAA Community Health Insurance Programme.



The Community

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

The Insurer

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

Provider

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

Premium

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

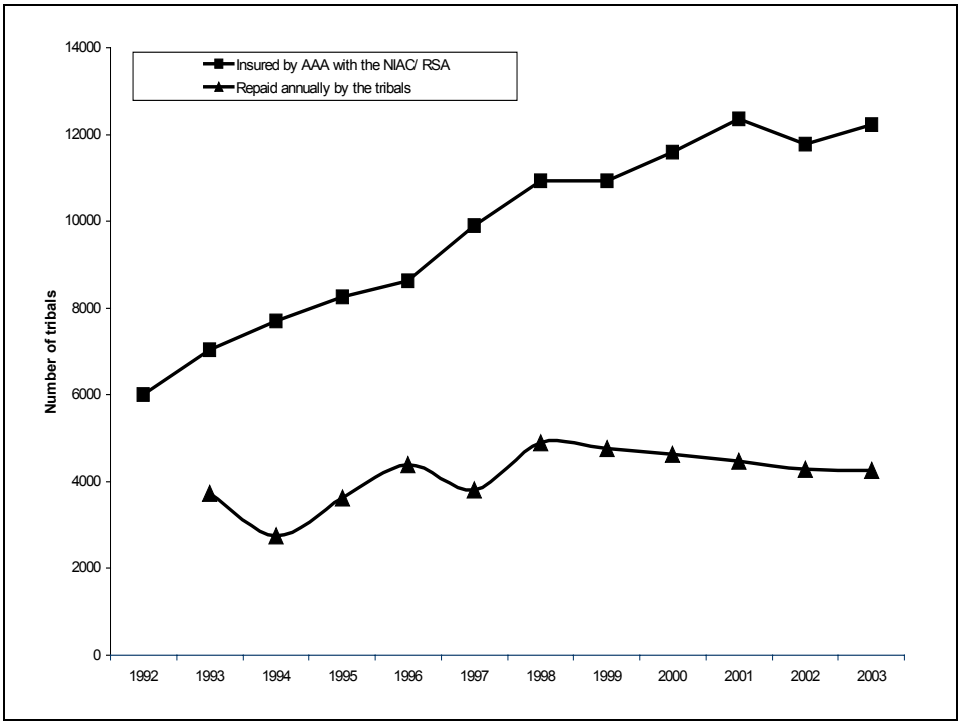
In 1992, ACCORD / ASHWINI / AMS negotiated with NIAC to insure ALL the AMS members for a period of five years. This enabled AAA to avail of the long-term discount as well as the group discount. This plus the fact that AAA limited the coverage to Rs 1,500 reduced the annual premium from Rs 48 to Rs 13 per person per year. ACCORD thus paid the premium of Rs 65 per tribal (Rs 13 per year for five years) and covered 6000 tribals in the first round. The lump sum amount of Rs 3,86318 was provided by CEBEMO, a Dutch agency. New members who joined subsequently were enrolled on a pro rata basis. The scheme was renewed in 1997 for another five-year period; the premium remained the same and once again CEBEMO/BILANCE helped meet the lump sum payment of Rs 4,83,000 to insure 9000 tribals for five years.

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

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

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

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



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

Benefit package

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

NIAC assures only hospital care with an upper limit of Rs 1500 per patient per year. It also has important exclusions – pre-existing illnesses, diseases due to substance abuse and self-inflicted illnesses. Deliveries and family planning operations were initially excluded, however, while renewing the policy in 1997, ACCORD managed to include the first two deliveries and family planning operations into the benefit package.

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

The current policy with RSAIC covers hospitalisation to Rs1000 and the first 2 deliveries to Rs500. There are no exclusions (except psychiatric illnessses)

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

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

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

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

As ASHWINI provides comprehensive care it encourages people to live a healthy life and to seek care at the earliest when ill so that problems are addressed close to home at the area centre or at the hospital. This cuts down morbidity and expenses- a truly win-win situation. This positive feedback loop is the greatest strength of the programme.

Claims and reimbursements

At the end of the hospitalisation, three copies of the hospital bill are made. One copy is handed over to the patient (but the patient does not pay any amount). One copy is kept for records and

the third copy is forwarded by ASHWINI to the insurance company (on a monthly basis). Any hospitalisation for an illness that is excluded is not claimed by ASHWINI – the expenses are met from ASHWINI's general funds. Similarly claims are made to a maximum of Rs 1500 only. Any excess of Rs 1500 is met from ASHWINI's general funds.

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

The insurance company in turn reimburses ASHWINI on a regular basis, usually after a lag time of 3 – 6 months. The reimbursement rates have been in the range of 95 – 100%.

Reinsurance

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

Table 1 – Claims ratio of the AAA Health Insurance scheme.

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

Administration

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

Collection of premium

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

Claims and reimbursements

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

Risk Management

Measures to control adverse selection

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

Measures to control moral hazard

Provider induced moral hazard is negligible as the medical officers are paid a fixed salary. So there is no incentive for cost escalation. Most of the disease conditions are treated using a standard treatment protocol.

Patient moral hazard is minimised by the fact that patients have to incur all indirect costs e.g. transportation, food costs, loss of wages and cost of accompanying relatives. These are an effective deterrent to unnecessary hospitalisation.

Measures to control cost escalation

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

Achievements

Coverage

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

Utilisation

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

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

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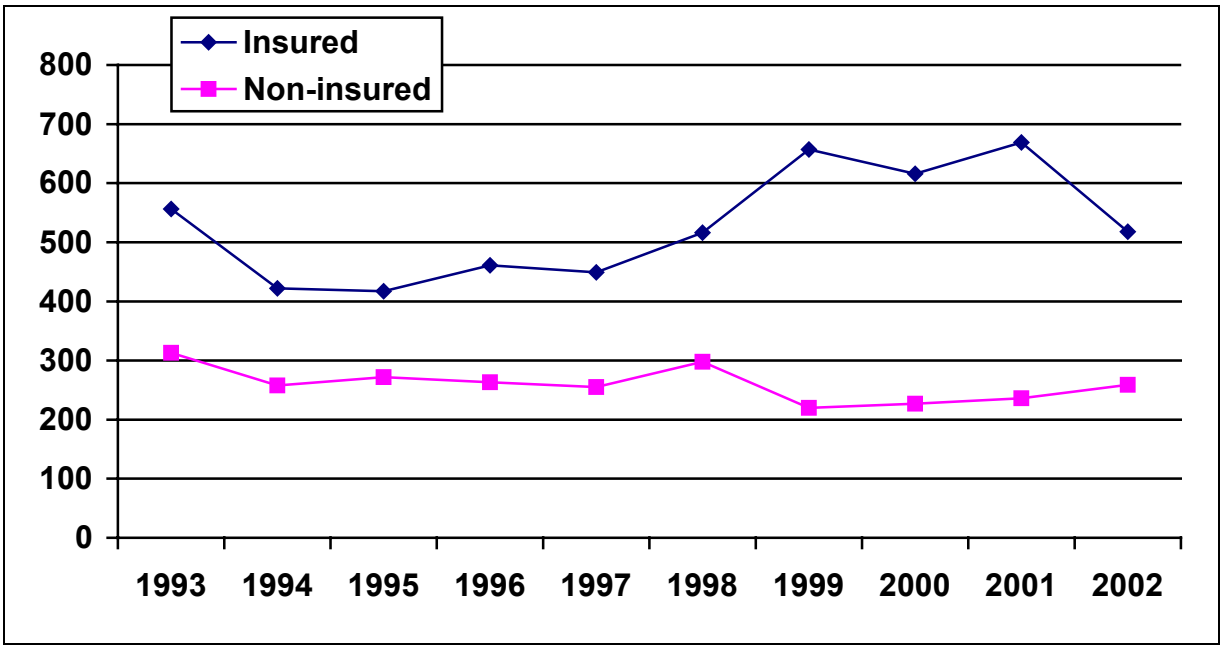

Cost recovery

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

Conclusions

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

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

	Amount paid to the Insurance companies as lump sum amounts	Amount repaid by the tribals on an annual basis
1992	386,318	
1993	44,296	14,904
1994	20,372	16,464
1995	10,513	28,992
1996	3,904	43,950
TOTAL	**465,403**	**104,310**

1997	523119	45,739
1998	36689	58,784
1999	18236	71,515
2000	11066	78,518
2001	34478	75,895
2002		85,820
Total	**623588**	**416,271**