

Community Insurance for Health

Background

India has one of the highest proportions of private health financing, almost 82%. It is ironical that in a developing country like India with over a quarter of the population still below the poverty line, the private sector expenditure dominates health spending. UNDP's global HDR 2004 ranks India with a public spending on health at 0.9 % of GDP, as 171 among the 175 countries a much lower rank than other poorer South Asian neighbours like Nepal and Pakistan. However, due to the predominance of private expenditures, the country's rank in terms of private health expenditure, as a proportion of GDP, is 18 among 175 countries.

Household survey of Health Care Utilization and Expenditure (NCAER 1995) indicates that on an average the households spend about 15 % of their income on curative health care and this percentage is marginally higher in case of rural households. Further this percentage is inversely proportionate to income. Both macro and micro studies on the use of healthcare services show that the poor and other disadvantaged sections are forced to spend a higher proportion of their income on healthcare than the better off. The burden of treatment is particularly high on them when seeking inpatient care. The high incidence of morbidity cuts their household budget both ways, i.e., not only do they have to spend a large amount of money and resources on medical care but are also unable to earn during the period of illness. Very often they have to borrow funds at very high interest rate to meet both medical expenditure and other household consumption needs. One possible consequence of this could be the pushing of these families into a zone of permanent poverty. In fact a single major episode of illness can topple families further into the poverty trap. Peters et al (2002) estimated that at least 24 per cent of all those hospitalized fall below the poverty line. Loss of wages during illness as well as the high cost of private health care contributes to this alarming situation.

Only about 10% of the population is in the organized sector and is covered by any kind of health security plans. Even those covered, experience growing inefficiencies and low quality of service. Further in an environment of fiscal constraint the already low public spending on healthy is further shrinking. There is an increasing demand for reviewing and revamping of the health sector so as to look at options for health financing. These innovations could be in form of health insurance schemes, strengthening public-private partnerships as also mainstreaming the indigenous systems of treatment. The Union Budget for the year 2003-2004 has announced a Universal Health Insurance package for the poor people. The premium i.e. Rs. 365 per person per annum will cover services upto Rs. 30,000 per year for inpatient expenses. The package however, is silent on the inclusion of people living with HIV & AIDS.

Health Insurance has often been suggested as an optimal solution as it minimizes the costs for the users as well as the providers. However, the fixation of the premium is problematic, as the low premiums require large numbers of people to enroll into the scheme, which leads proponents to suggest compulsory insurance. The insurance companies are reluctant to collect small amounts as transaction costs are high and they therefore, rely on several exclusion clauses to minimize their risk....these make the policies less attractive for the subscribers- for the very poor this could mean a choice between the next meal and an illness which is hypothetical. Also if the complexities and conditionalities of policy exclude more than they include the option is not very attractive.

UNDP supported initiative:

As part of UNDP's community Initiatives for Health project with the Ministry of Health & Family Welfare, **two models of health insurance are currently being implemented in select sites in West Bengal and Karnataka.** Both models are especially designed to offer a package of services for people living below the poverty line...people who are spending a very high percentage of their meager incomes on accessing health care. While in Karnataka the service provider is the public health system, West Bengal model was expected to include the private health care providers.

Karnataka experience is working much better and it has attracted attention of health researchers and practitioners alike. For a premium of Rs. 30 per person per year an individual is covered for hospitalization upto Rs. 2,500. The most distinguishing feature here is the compensation of wage loss at the rate of Rs. 50 per day for every day of hospitalization. This model is being undertaken with the help of a nodal NGO in the state, which is also providing preventive health services and promoting use of traditional medicines for curative care.

Karnataka experience

An innovative health insurance pilot supported by the United Nations Development Programme and the Ministry of Health, Government of India being implemented in Karnataka since 2002 could serve as a model- an experiment to draw lessons from. This pilot is based on the principles of community mobilization and comprehensive health care at public health centres involving a very low annual premium of Rs. 50 and a subsidized rate of Rs. 30 per person for SC/ST BPL families. In the third year now, the National Insurance Company has agreed to further lower the premium to Rs. 20.50 for BPL SC/ST subscribers. The most attractive feature of the scheme is that not only does it provide comprehensive health care –preventive and curative without any exclusions, it also compensates for wage loss. A unique feature unparalleled in the history of health insurance.

Besides the low premium of Rs. 30 per annum to cover the entire household, the scheme is available at all public health centres and involves the community at the village level. The involvement of Self Help groups is also encouraged to provide micro finance for outpatient care. The insurance cover of Rs. 2500/- that includes all in-patient – hospitalization cases as well as treatment including maternity care and deliveries. To provide drugs that may not be available at the primary health centres, a sum of Rs. 50 is given per patient per day directly to the primary health centre and a sum of Rs. 50 per day is provided to the patient to compensate for wage loss.

The pilot initiative is being implemented in T Narsipura taluka (Mysore district) and in Bailhongal taluka (Belgaum district).

The launch of the project was preceded by intensive campaigning through display of strategically placed public hoardings, display of posters and focused group discussions with a range of stakeholders. The skills of the village health workers, the aganwadi workers, panchayat leaders and most importantly the staff of the public health centres were strengthened to create awareness and promote health insurance; motivate members and villagers to utilize public health institutions and most importantly to involve them in health promotion and disease prevention. .

Though the project essentially meets the treatment costs and therefore, addresses the curative component, special efforts have been made to also include preventive health. This is done by promoting the use of traditional/herbal medicine through training for the members of the self help

groups by providing herbal saplings for plantation and to grow of herbal and kitchen gardens; and organizing workshops to train people in the use of herbal medicines.

The curative health component the pilot addresses both in-patient and outpatient health concerns. Self-help groups (SHGs) have been mobilized to set aside funds for health care. Dedicated savings for health care as well as micro-credits from these SHGs not only pay for the emergency outpatient health expenses but also pay for inpatient care medical bills where needed. 112 SHGs are on board and health loans have been provided to 202 members.

To enhance the referral services from the primary health centre to the community health care centre and further to the district hospital, the project has made special efforts to link all public health care centres in the pilot *talukas*. This connectivity not only helps in facilitating easy communication in case of emergency but also helps in maintaining client health history and claim settlement details.

Data upto late 2003 indicate that the project has so far reached out to a population of 241,052 persons with total premium amounting to Rs. 6,941,238 and has settled claims worth Rs. 1534500 for 2074 beneficiaries. Data also indicates that maximum of 45% patients in the age group of 15-35 years followed by 40% in the age group of 30-60 years age group sought health care. In a community where the inpatient rate is 6.5 per 1000 per annum, it is interesting to note that males account for 54% of the inpatients as against 46% females. The claim ratio has been about 23% of premium paid in T. Narsipura and 55% in Bailhongal possibly because of greater focus on preventive health care and use of traditional medicines promoted by the NGO in T. Narsipura.

This pilot clearly demonstrates that the health insurance companies can be motivated to provide low premium no exclusion health insurance coverage to the poor and the marginalized, that the use of public health systems can be enhanced, that women's access to health care can be enhanced if there is good community participation and mechanisms are put in place for fast claim settlement and re-imburements. Most important, of course, is the need to provide a comprehensive package of services, which go beyond the inpatient care to include outpatient care, preventive and promotive health care and compensation for loss of wages.

The success of this pilot lies in making health care affordable and accessible for the poor. The need, however, is to expand the coverage and to also explore options /alternatives to make such schemes more inclusive and to include (or reach out to?) those infected and affected by HIV/AIDS.

West Bengal Project Details

Pilot Project on Community Health Financing in West Bengal

The situation of the Mayapur (Nadia District, West Bengal) region is no different from the overall scenario in the country. The scarce health services are ineffectual, unattractive and often inaccessible to the poor rural communities of the region. The situation is further intensified with the absence of even a qualified private health service network compelling the people to be profusely dependent on local "quacks", no matter how unscientific their practices are.

In this context, the *Community Health Care Financing Project (CHCF)* project is playing a crucial role by addressing all these health issues of specific concern and cementing the loopholes for enhanced quality health service delivery by the government on one hand and empowering the local communities to better manage their own health care on the other.

Since September 2001, SMVS (an NGO) began the implementation of *Community Health Care Financing Project* under the auspices of UNDP, Govt. of India and Govt. of West Bengal. The project aims at a convergence of micro-credit, micro-enterprise and local self-governance initiatives in the Health sector covering four Gram Panchayats and 6,000 poor and marginalized families.

Project Objective

The final objective of the project is to empower communities to better manage their health care through establishing partnerships with the health service providers and thereby reduce burden of expenses on health care.

The interventions in West Bengal are two pronged- focussing on Community Mobilization and Health Services. Components in each area include:

a) Community Mobilization

- Promotion and formation of Self Help Groups (SHGs)
- Health surveys, disease mapping and analyse health expenses through PRA
- Capacity building of the SHGs on preventive health care
- Cooperation between panchayat, PHC and SHGs to enhance delivery of govt. primary health services
- Linkage between SHGs and LHPs
- Effective advocacy of ideas on issues related to gender inequity, domestic violence, wage disparity, web of indebtedness, deviant expenditures, income supplementation, migration etc

b) Health Services

- Community health financing
- Capacity building of Community Health Workers
- Integrating and capacity building of Local Private Health Practitioners
- SHG operated Drug Banks and referral transport
- Linkage with health centres, consultant doctors, hospitals for referral services
- Community centred diagnostic facility

Community Health Financing Products

1. Health Credit Fund (Out-patient) expenses

The purpose of this fund is to provide members of SHGs easy access to credit for health expenditures. This fund is initially provided to eligible groups as a long-term loan at low interest rates with certain restrictions governing its use. After 10 years the group owns the fund along with any additions they make to it. The fund may only be utilized to provide short-term loans to group members of up to Rs. 500 outstanding per family. These loans may be given at any time for any sort of preventive or curative medical expenditure including: Doctor's fees; Medicines; Diagnostic tests; Transport for medical purposes; Eyeglasses; Dentistry; Check-ups.

Eligibility

To be eligible to receive the Group Health Credit Fund a self-help group must meet be assessed in terms of its overall maturity through standard MFI indicators and undergo awareness and training in :

- Preventive health care and gender related health issues
- Assessing disease pattern and analyzing expenditure patterns
- Understanding local health providers

Operation

1. All group members must join with their family members
2. The ceiling for the fund is Rs. 100 per person (group members and their family members) and a maximum of 100 members per group.
3. The Fund must be deposited in the savings account of the group. Not more than Rs. 1000 of the fund should be kept in cash at any time.

2. Community Health Circle

This product covers a range of health services provided by the NGO either free of charge or with a co-payment. These are:

Free Services

- Preventive and promotive services provided by health workers
- Ante-natal clinics
- Health checkups

Co-Payment (40-75% of regular charge)

- Village health clinics
- Ambulance services
- Essential drugs from village drug banks
- Diagnostic facilities from community health center

Members are provided a special photo-id card to avail of these services.

Eligibility

1. Membership is open to all SHG members and their family members
2. At least parents and children under 12 must be enrolled, except in case of single persons without family.

Operations

1. Cost of membership will be Rs. 5 per person per year.
2. Membership fees are collected by the group and cards are issued by the NGO
3. Members present card at time of service. Non-members pay for all services.

3. Health Insurance Product (In –patient expenses)

The Health Insurance product is provided with certain facilities:

- Installment payment of premium facility
- Partial claim reimbursement during course of illness
- Advances against claim in certain cases
- Maternity Benefit for a special group

The insurer has two packages, Jana Arogya and Mediclaim. The projections here are based on getting 50% of the target population to purchase Jana Arogya and 20% to purchase Mediclaim.

Eligibility

1. Members of SHG's may obtain policies for themselves and family members under the plan.
2. It is not necessary for all group members to obtain policies, but all family members must be covered.
3. The group must have already obtained a Group Health Fund and have appointed a Fund Manager
4. Pre-existing conditions are excluded from the policy as per the terms of the insurance provider

Operations

1. Each member must make a monthly payment for the policy according to the schedule of premiums. There is a 10% discount for paying the full premium in advance.
2. Payments are collected by the group at its meeting and recorded by the Fund Manager.
3. On the onset of illness that may result in a claim the member must inform the Fund Manager who in turn informs the NGO Claims Adjuster
4. Claims against the policy are submitted directly to the NGO claims adjuster.
5. Claims may be submitted in part during the course of the illness.
6. Advances against claims may be obtained from the Claims Adjuster on meeting certain criteria.
7. Outstanding premium amounts are deducted from the claim reimbursement.