

***Position paper on
Micro Health Insurance for the Poor in India***

***Submitted by the ECCP project
“Strengthening Micro Health insurance Units for the Poor in India”***

***to the
Parliament of India
Parliamentary Committee on Public Undertakings
Chairman: honorable Shri Rupchand Pal, MP***

Hearing on health insurance

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Table of Contents:

Executive Summary	2
Table 1: Summary presentation of Insurance Solutions.....	3
1. Brief:.....	3
2. Background on Some Cross-Cutting Issues:.....	4
3. The Main Issues of Health Insurance in India.....	5
4. Micro Health Insurance Units	8
5. Relative Advantages of Micro Health Insurance	9
6. Relative Disadvantages of Micro Health Insurance (And Possible Solutions).....	10
7. Regulatory Issues	11
8. Reinsurance and subsidies for Micro Health Insurance	13
9. Recommendations	14
Annex I: Invitation by the Parliamentary Committee on Public Undertakings	15
Annex II: Email communication regarding submission by the project of this position paper	16
Annex III: Four Incorporation Models for Micro Health Insurance Units	17
Annex IV: Position Paper Submitted by our Project on IRDA’s Concept Paper on Regulation of Micro Insurance.....	19
Annex V: Presentation of Micro Health Insurance and Social Re, Delivered At the Global Actuarial Conference, Delhi, February 2005	20
References	21

Executive Summary

The Parliamentary Committee on Public Undertakings invited submissions from the public related to its hearing to “evaluate current practices and mechanisms in health insurance in India, note inadequacies/shortcomings, explore viable alternatives and come out with a set of recommendations aimed at the promotion of Health Insurance in the country, with special emphasis on extending HI benefits to the poor, unorganized labor, women and children in the margins of society”. This Memorandum is submitted by the project “Strengthening Micro Health Insurance Units for the Poor in India” (www.microhealthinsurance-india.org), whose focus is to support the operation of micro health insurance units, because at present this seems the most promising option for pro-poor interventions.

With less than 2 percent of the population covered by health insurance in India, and with low public spending on health, most of the financial burden of illness falls on single individuals and households. Healthcare costs are thus the most serious cause of impoverishment in India today.

Commercial health insurance is expensive and responds to the needs of middle class urban clients. Consequently, most poor and rural segments of the population are unlikely to buy this health insurance. The government of India is unable to introduce safety net programmes for the poor, notably because income and morbidity data, which is needed for effective targeting of poor people and in rural areas, is lacking.

On the other hand, the micro health insurance sector had developed in India in the last few years faster than anywhere else. The initial drive for this development came from NGOs, but since IRDA issued regulations which require commercial insurers to fulfill a quota of “rural” and “social” clients, the Indian private insurance industry is showing some interest.

At the same time, there are many barriers in operating sustainable micro health insurance. These include a prohibitive level of surplus requirement, inability of micro schemes to transfer risks to reinsurance, lack of information, almost no support in raising technical and administrative skills at micro insurance level (and the funds to finance training), and complications in ensuring ample supply of medical services of good quality at affordable cost. Also, there is some (regulatory) pressure to limit microinsurers to the role of simple agents of commercial insurers. Such restriction could be devastating for micro health insurance.

We propose a four-pronged strategy to remove these constraints, with the view to enabling micro health insurance units to achieve the objectives of enhancing health insurance of underserved populations: (i) Flexible benefit package design, reflecting local priorities and ability to pay; (ii) Reinsurance of micro health insurance units; (iii) Subsidies to cover part of the cost of the insurance premium and/or the reinsurance premium; and (iv) Capacity building at micro insurance level. Implementing this four-pronged strategy requires government backing. Support for development of micro health insurance schemes can be more cost-effective than the realistic alternatives, can serve predominantly poor, rural, female and informal sector population segments, and does not challenge the basic construct of an open, multiple-player insurance market. Additionally, results can be achieved faster than through top-down health sector reforms. The proposed four-pronged strategy outlined here is based on ample research and positive experience in India and in other countries. Consequently, the Parliamentary Committee may wish to consider supporting this actionable plan.

Table 1: Summary presentation of Insurance Solutions

Comparative Advantage for Poor/ Rural Populations
 (based on arguments developed in this position paper)

Characteristic	Commercial insurer	Major insurer + MIUs as agents	MIUs stand alone	MIUs +SR
Knowledge of /Responsiveness to local priorities	none	+	++	+++
Knowledge of/ Adapting to local ability to pay	none	+	++	+++
Concern with equity/equality among all insured	+	+	+++	+++
Ability to gain trust of clients	+	++	++	+++
Keep administrative costs down	--	---	--	-
Mobilizing & training local talent	none	+	++	+++
Mobilizing social capital to get buy-in	none	++	+++	+++
Interaction with local providers	+	++	++	+++
Reserve capital needed for underwriting	-	-	---	-
Pooling of risks and resources	+++	+++	++	+++

Legend:

MIUs = Micro health insurance units

SR = Social Re (4-pronged strategy including reinsurance)

Values:

+ = good - = bad
 ++ = better -- = worse
 +++ = best --- = worst

1. Brief:

- 1.1. On May 12th 2005 the Parliamentary Committee on Public Undertakings, Parliament of India (PCPU), has issued a call for submissions of material pertinent to its detailed examination of health insurance. The deadline for submission has been set for 31 May 2005. (Annex I).

- 1.2. Since the announcement referred to a closed list of NGOs, and as our project is not an NGO, we inquired with the PCPU whether our project could nevertheless submit a position paper. In an e-mail reply (and telephone conversations) we were invited to submit a written contribution (Annex II). In view of the short time left between the reply and the deadline, we were granted leave to submit this position paper by 7 June 2005.

2. Background on Some Cross-Cutting Issues:

- 2.1. *Data for pro-poor policy choices:* Like many governments in developing countries, the government of India is increasingly considering introducing safety net programmes for the poor or those who face a probable risk of falling into poverty, in the absence of broad-based income redistribution programmes entailing cash or in-kind transfers. If the programmes should lead to the maximum reduction in poverty within the resources allocated, effective targeting of the poor is necessary, and the allocation of benefits should be proportional to the gap of individual income-shortfall from an official poverty benchmark. Implementing such a programme requires detailed information on people’s incomes and health consumption. Haddad and Haddad & Kanbur (1991) stated that ‘such detailed information, and the administrative ability to use it is not present in most developing countries’. Even today, it is generally accepted that information on health insurance coverage in India is insufficient at present, and in particular there is almost no income and morbidity data of people in poor and rural areas, which are the target population of micro health insurance schemes. Consequently, the government should actively support endeavors to establish the evidence-base (i.e. easily observable socioeconomic characteristics of households as well as morbidity indicators) which can be used in elaborating a programme to improve the access of poor people to low-cost health insurance.
- 2.2. *Equity:* Health insurance systems, be they public or private, must strike a balance between economic efficiency and equity. Equity in health has been the subject of enormous discussion and abundant literature. In public health finance, equity is usually defined in terms of the ratio of payments to income (rather than as the ratio of payments to the consumption of health services, as it is assumed that those who consume more health care are sicker and have greater need for health services). Equity in health care has also been conceived in terms of access, finance, expenditure, and outcomes, and additionally one can find reference to a distinction between horizontal and vertical equity. Horizontal equity generally refers to the distribution of costs and

Table 2: Definition of equity in health policy

		<i>Concept of equity</i>	
		<i>Horizontal</i>	<i>Vertical</i>
Dimensions of equity	Access	All those with similar needs have similar access to services	Those with greater need have access to more or more intensive care
	Finance	Those in equal socioeconomic positions pay the same for care	Wealthier households pay more than poorer households
	Expenditure	Those in equal socioeconomic positions, or those in similar health, receive the same value of publicly-funded services	Poorer households, and households with more illness, receive more than wealthier and healthier households.
	Outcomes	All households experience similar health outcomes, regardless of socioeconomic status.	

Source: Lundberg and Wang, 2005, p.4

benefits across groups of similar socioeconomic or health status; vertical equity refers to the distribution of costs and benefits across groups of differing status. The underlying assumptions are that unequal health outcomes are unjust, that health services should be provided (or guaranteed) socially, and that distribution of costs and benefits should somehow be related to health and wealth status.

- 2.3. *Women as consumers of care.* The PCPU has expressed special interest in elaborating recommendations on access of women to healthcare. The importance of looking at women’s health is linked to their role as the main health caregivers in the household, and the consequent impact on children’s health, particularly in rural areas and among the poor. The majority of studies on women have focused on the consequences of health systems on their reproductive health care needs, especially contraception and safe childbearing. These studies emphasize the importance of participation, openness and flexibility in the reform process and in the management of health care, especially at the local level, and the need to understand the constraints facing women and their consumption of health services (Lundberg & Wang, 2005, quoting Langer, Nigenda, and Catino 2000, Lakshminarayan 2003, POLICY Project, 2000). It should be pointed out that while many women share concerns and constraints in health care, there are also many differences in women’s health consumption according to health status, wealth, location of residence, caste and ethnicity.

There are few empirical studies of specific constraints on healthcare utilization by women and of solutions to these limitations in India. For example, poor women may have less disposable income and less control over purchasing decisions within households (Nanda 2002), and therefore the impact of user fees (imposed in many situations) will be more severe on them. Financial constraints are exacerbated where women do not have the right to travel alone; or where women may be forced to forego care if female health workers are unavailable, because of the custom disallowing women to be in the company of men (outside their immediate family) including health care providers. The evidence base for these problems, and possible solutions, is sorely missing at present.

3. *The Main Issues of Health Insurance in India*

- 3.1. *Barriers to entry into the market of insurance:* The most important legislation governing the insurance industry in India is the Insurance Act of 1938. This comprehensive law recognizes two categories: life and general (non-life) insurance. Health insurance is one of the sub-categories of general insurance. It is recalled that since in 1956 the Indian government nationalized the life insurance industry, and in 1973 did the same with general insurance. In the early 1990s, the Indian government established the Insurance Regulatory and Development Authority (IRDA), which has been responsible for developing the framework for de-monopolization of the insurance market. New companies have been licensed in the last few years, and foreign insurers can enter the market through joint ventures with Indian insurance companies. At the beginning of 2005 there were 16 life and non-life insurers operating in India and one reinsurer (GIC). Additionally, there were 25 licensed Third Party Administrators (TPAs) for health insurance (www.irdaindia.org). One of the severe barriers to entry into this market is the requirement to deposit Rs. 100 Crore as a precondition for being granted an insurance license (Ref: Article 10 (2) (b) of the

‘Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations, 2000’).

- 3.2. Not only is this amount out of reach for smaller insurers, but as this deposit does not bear a return, insurers must compensate for this lost yield by raising insurance premiums. Consequently, this measure may be interfering with the pro-poor policy objectives of the government at present. Unofficial information has it that within the government the idea has been floated of setting up a health insurance company, which would be required to deposit maximum 25 Crore. While this is certainly a welcome idea, which should be implemented as soon as possible, micro health insurance units will be unable to meet this capitalization amount, and therefore additional innovations will need to be considered.
- 3.3. *Insufficient pooling of healthcare expenditure:* The amount spent on all kinds of insurance is about 3.3% of GDP/capita, or about US\$ 16.90 per year (Swiss Re, Sigma 3-2004) which is considered very low indeed. The same source estimated that of this amount, only about US\$3.50 was spent on general (non-life) insurance, and only a small part of that was spent on health insurance. Stated simply, the vast majority of the population is still not covered under any form of health insurance. This low coverage under health insurance is a source of concern in view of the huge share of medical costs that users have to bear. According to WHO figures (2002 data), total health expenditures represent 6.1% of India’s GDP, but most of this amount, representing 4.8% of GDP is the share of private expenditures and only 1.3% of GDP is public expenditure. Of the 4.8% private expenditure, 98.5% are Out-of-Pocket-Spending of users (OOPS). In other words, 77.5% of total expenditure for healthcare costs must be paid by single individuals or households (WHO 2005, NHA Annexes 5 & 6) and this huge flow of funds does not pass through any pooling mechanism. Health insurance programmes should be designed to capture a considerable share of this huge amount. Without health insurance, and under the existing paradigm of (i) a very low share of public expenditure, and (ii) a very high share of unpooled expenditure, poor households are exposed to risk of impoverishment due to the cost of healthcare, and enjoy low access to healthcare due to its high cost. This conclusion has been corroborated by the World Bank; in 2001 it estimated that one quarter of all hospitalized Indians fell below the poverty line as a direct result of the related medical expenses of this single event (World Bank 2001). The same devastating effect occurs also in households that do not face a catastrophic hospitalization but must bear the aggregate cost of multiple episodes of less severe illnesses. This data suggests that healthcare costs are presently the single most serious cause of impoverishment in India among those whose income is close to the poverty line. Health insurance is therefore an urgent anti-poverty measure.
- 3.4. *Limited possibilities to buy health insurance:* Of those who do have health insurance in India at present, many (if not most) are covered by employer-sponsored schemes. This is a reflection of employer obligations in certain undertakings, but also of the most effective marketing of insurance products to an organized group, often under a collective policy, and with deduction of premiums at source from salaries. These insurance products are designed for those with a steady and relatively high income, namely mainly men in formal employment in large urban areas. People wishing to buy health insurance as individuals (outside the framework of group policies) may encounter difficulties in doing so. These difficulties are virtually insurmountable in

rural areas, or if the insurance product should be very cheap, both because the pure risk premiums are high and because there is insufficient pressure to reduce the administrative costs.

- 3.5. *Administrative loading to fees:* Some insurers use the services of intermediaries (TPAs), whose role is to administer claims and maintain business books. TPAs and other intermediaries do not influence the cost of underwriting the pure risk, but they add to the cost of premiums due to the higher transaction costs. These transaction costs are generated by search and information costs, negotiation and decision costs, monitoring and implementation costs on the market side, as well as increasing transaction costs inside the insurance company due to growing size and complexity (Ahuja/Juetting 2003). TPAs seem to grow in popularity because they reduce the effort of insurers to handle the volume of administrative work; also, it is claimed that the role of TPAs increases because they can operate for-profit activities, whereas health insurers are supposed to be not-for-profit. However, the fees of TPAs increase the administrative cost of the insurance, which translates to higher premiums. Higher premiums reduce the likelihood that poorer people would be willing or able to buy health insurance from commercial insurers. One can thus conclude that the present methods of administering insurance business interfere with extension of coverage to poor segments of the population.
- 3.6. *Insufficient supply of medical services:* On the service delivery side, it is self evident that health insurance can be attractive only if the insureds can access sufficient supply of good quality healthcare services. In India, most of the medical facilities are located in urban areas, and therefore the urban population has a better option to access good healthcare providers. This is all the more important since there is almost no regulatory control of the quality of care provided by medical providers. Insurers are also not very active in ensuring the quality of care that the insureds can get; in fact, there is relatively little information on links between providers of care and providers of insurance (the “managed care” model). And schemes like the Central Government’s health insurance and ESIS, which restrict free choice of providers, have been criticized that they offer insufficient quality of care under the insurance. Mediclaim, which offers mainly an indemnity product, has been criticized that its benefit package was not comprehensive enough, and that it was responsible for undue delays in claim settlements. In summary, health insurance is for the time being mainly sold in urban areas where there is ample supply of healthcare services. People living in rural areas have a more restricted choice, and often may be required to co-pay part of the cost even if they are insured. Therefore, poorer people, women, and those living further away from urban centers are much less likely to be interested in commercial health insurance.
- 3.7. *Low-cost (and low quality) services for the poor:* In 1983, India adopted the WHO “Health-for-all by the year 2000” declaration, also known as the Alma Ata Declaration of 1978 (Ashtekar 1999). In line with this commitment, the government offered basic health care services at very low cost to less-wealthy segments of the population. But persistent underfunding of these services led to worsening quality, especially in rural areas (Planning Commission 2002). And as in any case the concessionary prices of the “Health for All” initiative did not apply to consultations with specialists, many people prefer to buy such services from private providers who are reputed to give better quality care, even when prices are higher. Drugs are also not

covered under the concessionary scheme, and people have to buy drugs at market prices. In most cases, 100% of these costs are borne by individuals as OOPS. The net impact of the low-cost services for the poor is thus quite limited at present.

4. *Micro Health Insurance Units*

- 4.1. *Definition:* The concept of micro insurance units is relatively new. The terminology is still confused, and one can find other terms used as well, e.g. “Community-based health financing (CBHF)”, “Mutual Health Insurance (MHI)” etc. Micro health insurance broadly covers financing schemes that have three key features: community control, voluntary membership, and prepayment for health care by community members (Hsiao 2004). Others have defined microinsurance as “a financial tool specifically designed for the market of low-income people (in terms of premiums, terms, coverage, and delivery) to protect against specific risks in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved” (CGAP Working Group on Microinsurance 2003). Micro insurance units are “micro” in two ways: their claim-load is small, and they are composed of groups that are relatively small in number of people and relatively marginal in terms of turnover compared to the financial volume of formal insurers in their country of reference. The PCPU may wish to peruse the presentation made by our project at the Global Actuarial Conference, Delhi, in February 2005. A copy of the presentation is attached as Annex III.
- 4.2. *Estimates of coverage by micro health insurance units in India:* The latest publication that contains an estimate of the number of schemes in operation and the number of persons covered in India dates to 2004. According to this source, the list included 12 of more than 20 schemes recorded (3 in Tamil Nadu, 3 in Maharashtra, 2 in Karnataka, 2 in Gujarat [of which one has several satellites], one in Chhattisgarh and one in West Bengal), with about 8 million individuals in the target population and many of them insured (Devadasan et al., 2004). A more recent inventory of micro health insurance units has identified a few more schemes, and the estimated number of insured individuals is somewhat higher than Devadasan’s estimate. These numbers need to be put in context. According to ILO, about 40 million persons are insured by microinsurance units worldwide, for all types of risk (both life and non-life). Therefore, one can assume that India has perhaps the most exciting and dynamic microinsurance sector in the world, particularly when it comes to health insurance. The other very important aspect is that if this form of health insurance can be scaled up, the target population counts many more millions.
- 4.3. *Corporate structure of micro health insurance units:* Four models have been identified: (i) Partner –Agent Model; (ii) Mutual model; (iii) Friendly Society model; and (iv) Provider-driven Schemes. A more detailed description of these models is provided in Annex IV. All four corporate formats have made positive contributions to widening the access to health insurance, and there is neither decisive evidence nor theoretical basis to determine which of the four types of incorporation is most suitable and most successful. Therefore, we submit that there is no reason or need to oblige all micro insurance initiatives to adapt one and the same mold. This point will be elaborated further under the section dealing with Regulations, below.

5. *Relative Advantages of Micro Health Insurance*

5.1. *Revenue collection and generation:* In India, like in most low-income countries, the scope for raising public revenue to finance health services through general taxation is narrow. As already shown, the amount that is allocated from the government budget to public health activities is very low, and certainly insufficient to provide more than a very limited range of basic care. If general government revenue is insufficient, other revenues must be raised. At present, most of the cost (on average 77.5%) is shifted to consumers through OOPS at the point of service. This is an inefficient and inequitable solution: It is inefficient because it entails handling many small transactions by people whose occupation is medical rather than financial or administrative; and when many people handle cash, there is a high likelihood that some of the money will leak from the system. It is inequitable because there is no guarantee that the fee-for-service will be adjusted to the income of the patient, and it is possible that poor people would pay much more than rich people for identical services. Consequently, they are likely to defer or forego care, with the resultant higher morbidity. A more efficient and equitable solution would be for people to pre-pay for services they would get through insurance. However, insurance companies do not evoke the trust of poor people. This is where micro health insurance units may have an important advantage: they are community-based and able to mobilize social interactions and social relationships to introduce a pre-payment scheme. Micro insurance units that emphasize as much the dialog among members of the scheme as the pure commercial transaction have been able to draw voluntary affiliation. People who join the scheme must pre-pay a premium, and this generates income for the micro insurance. Needless to say, those who pay the premium trust that the ‘insurer’ will be around to meet its part of the deal when the time comes. The community is less likely to disappear than an agent of a commercial insurance located far away. Hence the ability of community-based schemes to raise funds where others fail to do so.

5.2. *Prioritizing local needs:* One of the problems associated with comprehensive social insurance on the one hand and private insurance on the other is that the benefit package is based on estimates of the needs of a large and heterogeneous population. Local needs may differ quite significantly. In countries that have National Health Insurance, rationing decisions are taken by politicians, who also allocate the funds. In the USA HMO system of managed care, rationing decisions are made by physicians, based on medical considerations. In India, rationing decisions are left mostly to single households (for the reasons discussed above), which is not optimal either. We think that community consultations can offer more reasoned rationing decisions, and people are likely to participate in this process provided that the community can ensure that its choices are taken up by the insurer. Additionally, the insurance premium needs to be low-cost. Hence, only the highest priority items will be included. As risks differ from one place to another, local dialog on local priorities is an effective way to raise the interest of the local population in the insurance scheme. The process of consultation and consensus building is managed best by local leadership, which is familiar with the indigenous *modus vivendi*, local perceptions of risk and specific customs and traditions.

5.3. *Increase utilization and play fair:* Furthermore, once community-based schemes start operating, they are more effective and more equal than the alternative. Evidence

suggests that micro health insurance units are effective in increasing utilization of insured members (Dror, Soriano et al. 2004) and that they perform very well in terms of equality of access among members of micro insurance (Dror, Steinberg & Koren 2005, forthcoming).

- 5.4. *Overcome (or reduce) market failure*: Insurance market failure stems from adverse selection and moral hazard. Adverse selection means that the client joins insurance only when there is a problem, and the insurer is unable to restrict this because of information asymmetry (the client knows something that s/he will not tell the insurer). Moral hazard means that clients will use services more than necessary because the services will be paid for by the insurance. One of the most powerful features of small communities is the free-&-frequent flow of information about people. Single individuals are unable to hide information about their condition or their conduct from their extended neighborhoods. So there is much less information asymmetry, and much less likelihood of adverse selection. Also, the more members of the group use healthcare services, the higher the cost of the premium will be. This is why small groups have a vested interest to disallow moral hazard by their members, because such behavior signifies shifting the cost of added care to other members of the group. Micro health insurance schemes can thus avoid, or at least reduce the failures of commercial insurance, and thus operate at lower premiums.

6. *Relative Disadvantages of Micro Health Insurance (And Possible Solutions)*

- 6.1. *Limited local capacity*: Running insurance requires a rather technical skill-mix that is often unavailable outside the insurance industry. Micro health insurance schemes need external support in building this capacity. Capacity-building entails training of a few people in each location in operating the administrative functions related to maintaining a membership register, collection of premiums, settling claims and producing reports for managerial and audit purposes. One of the objectives of the project “Strengthening micro health insurance units for the poor in India” is precisely to pilot-test a special computer application that has been developed for micro health insurance units, called “Social Re Data Template”. Once local persons are trained in operating the Data Template, it should be possible to resolve the main capacity deficit that prevails at present. In order to support development of the micro insurance sector in the long term, an institution capacity-building solution is required. One idea would be to establish a network of *microinsurance academies*, which would coordinate methods, tools and efforts to train the necessary skilled personnel for all functions (from first-line operators to supervisors and managers). The Indian Council of Social Science Research might be well placed to initiate and support this effort.
- 6.2. *Small group size*: Insurance is based on applying the Law of Large Numbers, which enables the insurer to diversify individual risks over a large number of similar risks; by collecting a premium based on the mean expected cost, the insurer can average out its above-mean losses with its below-mean losses. The larger the group, the more perfect the application of the Law of Large Numbers (a detailed discussion of the impact of small group size can be found in: Dror, 2001; Dror, 2002; Dror, Armstrong & Kalavakonda 2005). However, micro health insurance units are usually small groups, whose financing pool is too small to provide sufficient revenue to operate

independently. Additionally, the pool may be composed of mainly poor people, whose capacity to pay is very limited. This problem cannot be neglected, because it could lead to insolvency of the scheme (Bennett, Creese and Monash 1998).

Several solutions have been proposed to enhance sustainability and performance. These include (1) targeted subsidies for the poorest (Preker, Carrin, Dror et al. 2002); (2) re-insurance to enlarge the effective size of the risk pool (Dror 2001, Dror & Preker, 2002); and (3) strengthening links with formal financing and provider networks. In addition, Wiesmann and Jütting (2000) highlight (i) “covariant risk” (the phenomenon that health problems are correlated within a population); (ii) community participation; (iii) cultural concepts of illness; (iv) the quality of care; and (v) the referral system. Jakab and Krishnan (2001) added that successful schemes should allow members to pay premiums at irregular intervals, and even in kind.

6.3. *The reinsurance facility* that could offer the required financial and technical assistance does not yet exist. Such a facility, called “Social Reinsurance” by Dror et al. (2002) needs to be created, and government involvement in its creation is necessary and desirable.

6.4. *Coping with regular high-cost events*: Certain chronic conditions or diseases, e.g. HIV/AIDS, can generate costs that normally exceed the capacities of isolated micro health insurance units to bear. However, with adequate support, micro health insurers are probably the best close-to-client agents to offer assistance and care, in a holistic approach to coping with the situation and its cost. Institutions like The Global Fund could be invited to support these efforts; and one might well conceive that a reinsurance facility such as Social Re can be a preferred conduit linking single micro insurance units with international and national health initiatives.

7. **Regulatory Issues**

7.1. *The role of regulations*: Regulation serves multiple goals: protecting the vulnerable, defining the “rules of the game”, and solving conflicts when they arise. Because the business cycle of insurance demands that clients pay a premium before they know if they will receive benefits or how much, the relationship is based on trust between the signatories of the insurance contract. The regulator thus intermediates to certify that the agreement is fair and valid (in conformity with civil law of contracts), but also that the insurance company takes certain measures to reduce its risk of becoming insolvent or bankrupt (in conformity with insurance supervision, e.g. solvency requirements, assets evaluations regulations, marketing, reporting and audit).

7.2. *Specific regulations for health insurance?* Under the prevailing Regulations, anyone wishing to offer health insurance must apply for a license for general (or life) insurance. Yet there is no dispute that health insurance is very different from other insurance products, requiring different expertise. The main limiting factor is that even a small operation of health insurance would require raising the enormous Rs. 100 Crore as a precondition to obtaining a license. Also, healthcare providers are not regulated in India, and it would be very difficult to expect small health insurers to deal with this complicated issue on their own. Consequently, for an orderly and sustainable development of health insurance, it may be useful to nominate a special

Council, and to consider various ways and means how the government can help this important sector to develop into sustainability. Until now, most of the impetus for innovation has come from scholars, NGOs and development agencies.

- 7.3. *Special regulations for micro insurance:* IRDA has been considering the possibility of issuing special regulations for micro insurance units. For this purpose, IRDA has issued a “Concept Paper on Need for Developing Micro-Insurance in India” in August 2004, and held a public conference on this draft once in October 2004, and another round-table (organized jointly with FICCI) in February 2005. The Concept Paper contains many commendable ideas, but it raises several concerns as well. The concerns revolve around the restriction of microinsurance to the partner-agent model, the lack of product flexibility, and the requirement to limit business relations to a single insurer. IRDA’s concept paper projects that most of the insurance business with rural and poor population segments should be conducted by commercial insurers. Consequently, the role of micro insurers is viewed in the Concept paper as that of agents, tasked with the distributional functions of insurance. This view has raised many reservations, notably from cooperatives, Mutuals and NGOs engaged in health insurance among the rural poor. Our project has had occasion to submit a Position Paper reacting to the Draft Concept Paper, attached as Annex V to this document. The idea of special regulations for Micro health insurance units is welcome. However, as already stated (para 4.3 above), all forms of incorporation have shown merit, and in health insurance the greatest success has been obtained by mutual organizations. Hence, these regulations should support all forms of incorporation of micro health insurance units, rather than merely relegating them to the role of agents of large commercial insurers whose interests may differ from those of the clients. For the time being, IRDA seems to have agreed not to proceed with regulation of micro health insurance units (verbal communication of IRDA representative at the Round Table convened on 19 February 2005), and this position seems very much in line with the pro-poor policies of the government.
- 7.4. *Rural and Social Insurance Regulation:* Microinsurance in India has been strengthened by IRDA’s regulation that requires private insurers to satisfy a quota of business in rural areas and among the poor. This “rural” and “social” obligation applies to all insurers who entered the Indian insurance after the liberalization, with different application to the older insurance companies (“not less than what had been recorded by them for the accounting year ended 31st March, 2002”). This regulation specifies that the clients must come from rural areas. The quota of the rural policies increases year-after-year, with a maximum of 16% of the total number of life policies sold for life insurance and 5% of premium income for other types of insurance (after 5 years). Incidentally, the quotas may be increased in the future.
- 7.5. *Impact of the “Rural and Social” Regulations:* On the one hand, the quota system has obliged insurers to seek innovative ways to reach their targets, and hence a new interest in working with the microinsurance sector, as agents who can sell insurance among the poor and rural populations. Formal insurers have developed new products and delivery channels, and they bring their considerable resources to this task. On the other hand, there have been unverified reports that as soon as they have met their targets, some insurers stop selling the low-cost “microinsurance products”, and that they service these products poorly. It would certainly be counter-productive and most unfortunate if the regulation resulted in a mass of poorly serviced products, sold at a

loss in order to enable insurers to concentrate on their more profitable products. One way of mitigating this undesirable consequence and enhancing the positive influence of the Regulation would be to strengthen competition on health insurance products that micro health insurance units can sell, either as risk underwriters or as low-level agents. The strengths of micro health insurance units could thus be mobilized toward a desirable deepening of financial protection of the poor and the rural populations. This is precisely the objective of our project.

8. Reinsurance and subsidies for Micro Health Insurance

Microinsurers’ financial instability stems from wide swings in both income and expenditures. Two key weaknesses of micro health insurance units relate to their small size (which limits the population across which risks can be spread), and their members’ low income (which limits the amount of financing that can be mobilized in poor communities). The solution to the first problem lies in reinsurance. The solution to the second problem lies in subsidies and strengthened links to national programs for health care financing and delivery.

Reinsurance is a way to transfer risks from one insurer to another insurer (with a bigger pool of clients). Sharing risks between insurance carriers is common practice in the insurance industry worldwide.

Reinsurance activity covers four domains: (i) *Financing*: entails calculating and accumulating the reserves (surplus) an insurer must retain to guarantee its insurance risk. Small or newly established microinsurance units have no contingency reserves, and in any case it is dubious whether the use of own-funds to cover peaks in risk is more effective than financial reinsurance, which can be designed to cover actual costs and actuarial provisions; (ii) *Program-management capacity*: refers to the size of a single type of risk the insurer can accumulate; (iii) *Stabilization against fluctuations*: describes the ability to reduce year-to-year fluctuations in risk (or loss) exposure; and (iv) *Catastrophe protection* simply means insuring a microinsurer against a loss that might jeopardize its very existence (Outreville, 2002).

Reinsurance brings another very important advantage: checks and balances on the flow of funds. Health insurance involves large flows of funds (both when the cost of claims is compared to household income and in aggregate terms). Putting in place a system to avoid fraud or misuse of funds is by no means casting a doubt on the honesty or good intentions of micro insurers, but it offers a legitimate framework to reduce possible abuses of the system. Reinsurance is probably the most efficient and cost effective mechanism for this control, because the degree of analysis of the data, and the claims made to the reinsurance, surpasses other means of control. The government can encourage individual schemes to join microinsurance units by subsidizing part of the premium (or the reinsurance premium). This is perfectly justified because the poor and rural populations benefit much less than richer people who live in urban areas from other government subsidies (e.g. for building and maintaining the medical infrastructure). Operating reinsurance and collecting subsidies requires that the microinsurers would register, analyze, and transmit data to the reinsurer and the Regulator on an ongoing basis. The cost of developing and maintaining this knowledge-transfer and the necessary infrastructure to manage information would normally exceed the financial ability of microinsurers. Hence, someone else would have to bear the initial costs, and the reinsurer would provide underwriting, technical and IT assistance for this purpose.

9. *Recommendations*

This position paper can be summed up by saying that microinsurance units hold much promise in extending health insurance in India. Currently, we are engaged in collecting data to examine the impact of schemes that are already in operation, and we expect initial results to be available early in 2006.

Based on the evidence from the literature on micro health insurance in India, and in other countries, and extensive theoretical work, we submit that stabilizing microinsurance units is a justified and cost-effective policy for the government. The four components of this strategy are:

- (i) supporting flexible determination of the benefit package according to local priorities and ability to pay;
- (ii) building capacity at the local level to ensure inexpensive knowledge transfer (with on-going support to build the capacity of microinsurers to become full counterparts for reinsurance). For this purpose, our project will pilot test the Data Template that was developed for this purpose; other institutions could be invited to contribute to capacity-building according to their strengths
- (iii) setting up a reinsurance facility; and
- (iv) subsidies targeted to poor people who join the insurance.

This plan, which we call “*Social Re*”, promises many payoffs:

- With better knowledge of their health risks, microinsurance units can improve their capacity to plan healthcare services.
- More stable risk management can enhance members’ willingness to participate in voluntary health insurance, and thus more revenues will be diverted from OOPS to health insurance.
- Financially stable microinsurers could expand the supply of services and would improve their negotiating positions to obtain attractive prices from providers.
- Building local capacity for self-management is the first step toward a win-win linkage between grassroots communities and larger (national) health systems.
- Government lay-outs for this strategy will, most likely, be significantly cheaper than any alternative to offer an equivalent set of health insurance benefits to the underserved population segments.

We respectfully submit this Memorandum for the Parliamentary Committee’s consideration. We remain at the PCPU’s disposal for any additional information it may wish to solicit. And **we kindly request the Parliamentary Committee to accept our request to appear before it**, in order to present a more detailed implementation plan of the proposed strategy, and to respond to any questions that this strategy may raise.

For the project “Strengthening Micro Health Insurance Units for the Poor in India”

Prof. Dr. David Dror
Honorary professor of health insurance
Erasmus University Rotterdam
And
Lead expert, ECCP project for India.
daviddror@socialre.org

Annex I: Invitation by the Parliamentary Committee on Public Undertakings
to submit Memoranda on health insurance

Parliamentary Committee on Public Undertakings
Room 429
Parliament House Annex
New Delhi 110001
=====

No. 351/1-PU/2005 Dated 12th May, 2005

From J.P.Sharma, Director,

To General Director/ Director, All listed NGOs

Sir / Madam,

I am directed to state that the parliamentary Committee on Public Undertakings headed by Shri Rupchand Pal, MP have selected ‘Health Insurance’ as one of the subjects for detailed examination.

In this regard, comments / suggestions are invited from NGOs who are engaged in the field of Health Insurance. In case your organization is interested in sending any information/material pertaining to the subject, the same may be forwarded to the undersigned latest by 31st May, 2005 in the form of Memorandum for the consideration of the Committee.

The information can also be sent on E.mail – comm.pub@sansad.nic.in. if you desire to make personal appearance before the Committee, the same may be indicated.

Yours sincerely

DIRECTOR
Tel No. 23034403
23034428, 23034429
E.Mail – comm.pub@sansad.nic.in

Annex II: Email communication regarding submission by the project of this position paper

Thu, 26 May 2005 16:34:56 +0530 (IST)

Subject: Parliamentary Committee on Public Undertakings -hearing on health insurance

From: comm.pub@sansad.nic.in

Dear Sir,

Thank you for your e-mail and your keen interest and expertise in the subject will be immensely useful to the committee.

The broad terms of reference, rather the task the committee has set before itself is to evaluate current practice and existing mechanisms in the health insurance sector in India, note inadequacies/shortcomings, explore viable alternatives and come out with a set of recommendations aimed at the promotion of Health Insurance in the country-with a special emphasis on extending HI benefits to the poor, the unorganized labour, women and children in the margins of society.

The Parliamentary committee is headed by hon'ble MP Shri Rupchand Pal and consists of 15 members of parliament from the Lok Sabha and 7 from the Rajya Sabha.

Looking forward to your informed contribution in this regard.

With Regards

P. Haokip
Committee Officer
Committee on Public Undertakings
Lok Sabha Secretariat
Parliament of India
429 PHA
Sansad Marg
New Delhi-1

Annex III: Four Incorporation Models for Micro Health Insurance Units

Typology: At present one can identify four distinct forms of incorporation:

1. *Partner-agent model:* The most prevalent model among micro insurers in India at present; the “partner” is a commercial enterprise that underwrites and bears the insurance risk, meets regulatory requirements for surplus and, as relevant, reinsurance, and retains profits and losses of the insurance business. The “agent” is the grassroots organization which holds a “super policy” and performs other roles, e.g. flow of information between clients and insurance company, recruiting the individual insureds, collecting contributions and providing financial help to do so, pre-screening claims, collecting benefits from the insurer and distributing them among the insureds etc. In some instances, Partner and Agent also collaborate in adapting the insurance product to local needs, or design more suitable products for the particular market segment. This option is of course linked to the micro insurer’s role of “super policy-holder”, which distinguishes it clearly from the classical definition of an agent. Incidentally, under this model, the agent intermediates between the Partner and the insured (normally known in insurance jargon as “the Principal”).

Unlike the commission-based relationship between agent and insurance company, the insurance company does not compensate the micro insurer for services rendered, but grants a reduction in the premium charged for the insurance, which is thus passed on to the insured principals.

The role of the micro insurance under this type is mainly in the distributive phase of the product cycle. Unlike commercial insurance agents who are external to the group of insureds, the micro insurance unit can interact with the local community in rural and semi-urban locations due to complex relations, which are often of a non-commercial nature.

2. *Mutual/Cooperative model:* These are cooperative schemes which are launched by members who may associate for this purpose only, or may associate for other purposes as well, e.g. through a trade organization, village committee, membership in a micro-finance institution, etc. Members of mutual schemes are both insured and insurers, as the group underwrites the risk collectively. Profits and losses remain within the community. Mutual insurance schemes function on a democratic basis: all members have the same rights to formulate their needs and to influence the design of the benefit package as well as the level of contributions and other conditions, and usually also elect the managers of the scheme from among the membership.

When these schemes are operated in small communities, they usually lower the costs associated with administration and those stemming from fraud, moral hazard and adverse selection. This is usually due to informal and frequent flow of information. These schemes can retain the benefits derived from their ‘social-capital’ for as long as the members share a feeling of ownership.

3. *“Friendly Society” model:* Schemes established and operated by an external body, e.g. a church, a development project, a health NGO etc. These schemes often enjoy financial support from the external body. The Friendly Society model is sometimes referred to as a ‘full service model’, because it assumes responsibility for supplying all aspects of the

insurance product, including designing, distributing and servicing the product, and ensuring long term stability. The insurance risk is borne by the scheme, with financial backing from the external institution as necessary. A Friendly Society often has good access to the target group, which can be enhanced if the external supporter engages more funds for this purpose. On the other hand, operational knowledge of insurance processes may be rudimentary. If the external support diminishes or stops, the micro insurer may be unable to maintain its financial stability independently. Additionally, in years in which actual claim experience is lower than expected (“good years”), surpluses that are created may generate pressures from the membership to increase the benefits. There may also be operational problems in managing the investment of contingency reserves. If such schemes are required to deposit large amounts of capital as a condition to being allowed to operate, they may well disappear.

4. *Provider-driven micro insurers*: This type of incorporation is usually limited to health insurance. Providers of care (e.g. hospitals) may launch an insurance scheme which is intended to generate larger volumes of business in dedicated facilities, as well as to open up access to healthcare at different unit prices for different segments in the catchment population. The first objective explains why many provider-driven schemes restrict clients’ choice to the provider’s facility, or to the providers’ health professionals. The clients pay their premium to the health care provider. The provider offers the patients a financing mechanism that enables them to use services. The provider benefits from this arrangement in several ways: a) it increases its potential market by enabling more people to demand services; b) the provider restricts the choice of his customers to its facility; and c) the provider receives revenue from those who would otherwise have not treated, or done so elsewhere (and perhaps also for lower prices). Customers draw similar advantages from this arrangement. Consequently, a mutually-beneficial system can evolve.

Position paper submitted by the ECCP project
“Strengthening Micro Health insurance Units for the Poor in India”

***Annex IV: Position Paper Submitted by our Project on IRDA’s Concept Paper
on Regulation of Micro Insurance***

Position paper submitted by the ECCP project
“Strengthening Micro Health insurance Units for the Poor in India”

***Annex V: Presentation of Micro Health Insurance and Social Re, Delivered
At the Global Actuarial Conference, Delhi, February 2005***

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