The feasibility of a Community Based Health Insurance (CBHI) at Wayanad, Kerala.

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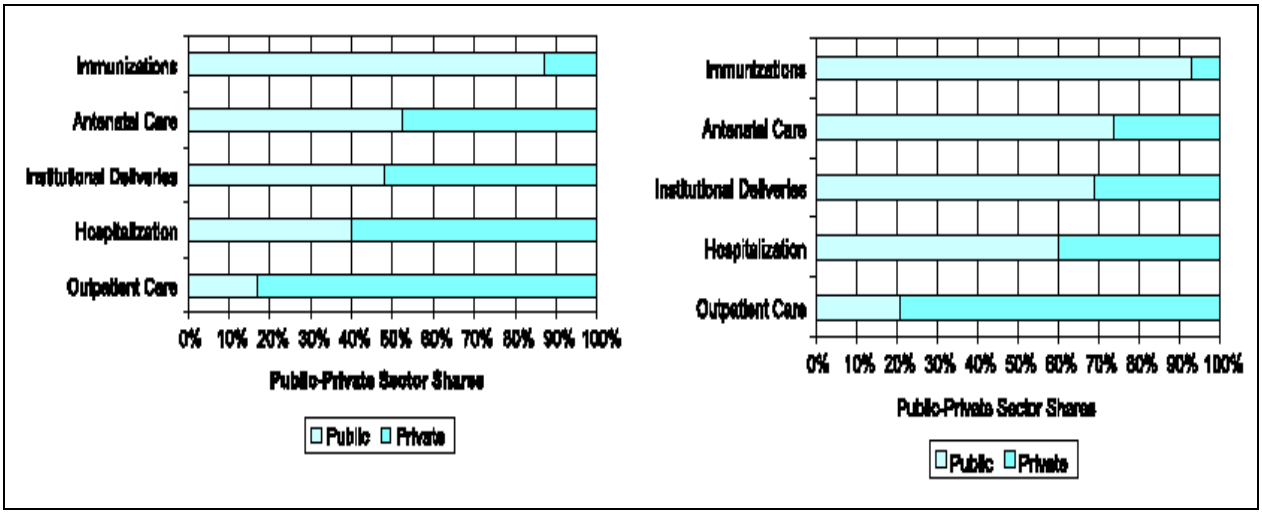
Introduction

India, though a socialist state and committed to providing health care for its citizens (Government of India 1950), has one of the lowest per capita public expenditures on health. The government spends just 0.9% of the GDP on health care – amounting to about US$4 per person per year. As 80% of this is on salaries, there is little for medicines. This results in poor quality of care in most of these government institutions (Gupte 1993). This pushes the patients to use the private sector to meet their health needs. Estimates show that about 80% of all outpatients and about 40-60% of all inpatients use the private health care facilities (Figure 1). At these facilities, the patients pay user fees for each service received and this is met from out of pocket. This places a large burden on the households, especially the poor and indigent. They are forced to borrow or sell their assets to meet medical expenses. Annually about 24% of those hospitalised are indebted because of hospitalisation expenses (Peters DH 2002). Thus the current methods of financing the health care, the under funded government health services and the fee for service private health services, are clearly unsatisfactory.

Figure 1: Utilisation of health services by above poverty line patients and below poverty line patients



Source: DH Peters et al: India Raising the Sights: Better Health Systems for India's Poor. 2002

Health insurance in India

One way out of this imbroglio is to introduce a risk sharing mechanism like a health insurance scheme. Currently there are three main categories of health insurance in India. The Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS) are social health insurance schemes for

the employees of the formal sector. The Mediclaim is a voluntary medical insurance policy provided by both the public and the private insurance companies. The government also actively promotes subsidised health insurance policies for the poor, along the lines of Mediclaim. These are recent interventions and have limited acceptance. And finally, for the informal sector, there are a few community health insurance schemes managed by NGOs.

The **CGHS** is a contributory health scheme to provide comprehensive medical care to the central government employees and their families. The staff contribute a tiny amount, on a monthly basis. This premium is income rated (Table 1). The benefit package includes both OP and IP care including medicines and diagnostics. It has its own dispensaries, 308 in 1993. It also uses the facilities of government and private hospitals to provide inpatient care. These bills are reimbursed later. In 1993, there were approximately 4.5 million beneficiaries (Ellis 2000). An evaluation in 1993 showed that there were problems with long waiting periods, significant out of pocket expenditures and inadequate supply of medicines and equipment.

Table 1: Rates of subscription of CGHS premiums

Rates of subscription in Rs. Per Month	Basic Pay/Pension.
15	Upto 3000
40	3001 to 6000
70	6001 to 10000
100	10001 to 15000
150	Above 15000

Source: [O.M. No. S-11011/7/0\98-CGHS (P) dated 27.5.1998]

The **ESIS** is also a contributory and mandatory health insurance scheme for workers of the factories employing ten or more employees. A total of 29 million employees and their dependents contributed towards this scheme in 1995. The contribution is paid through a payroll tax of 4.75 per cent and 1.75 per cent levied on the employer and the employee respectively. The state government also contributes 12.5% of the medical costs. Only those employees who earn less than Rs 6500 per month are eligible for benefits. The benefits include medical benefits and cash benefits for sickness, maternity, disability and funeral expenses. The ESIS has its own network of dispensaries (1427) and hospitals (118), all of them (except in Delhi) managed by the respective state governments. Some criticisms

about its functioning includes rude behaviour of its staff, inadequate medicines and supplies and inadequate information by the employers.

Both the above schemes are managed by the government and are exclusively for the workers in the formal sector (less than 10% of the labour force) (van Ginneken W 1998).

The **Mediclaim** is a medical insurance policy provided by both the public and private insurance companies in India. It is a voluntary medical insurance programme that provides for reimbursement of hospitalisation / domiciliary hospitalisation expenses for illness/diseases suffered or accidental injuries sustained during the policy period. The premium is calculated on the basis of the age and there is a maximum cap on the benefit. The benefits are only hospital treatment, with specific upper limits for each category of service. It also provides income tax benefits for those who subscribe to it. The premiums are relatively high and out of reach of majority of the population. This policy is usually used by the elite of Indian society, more as a tax benefit rather than as a medical insurance. In 1995 about 2 million people were covered under Mediclaim of which 95% were in the urban areas (R Bhat). Some of the details of Mediclaim are given in Table 2 below.

Health insurance for the poor – the government of India has been very keen to provide health insurance coverage for the poor. This intent is explicitly stated in the new National Health policy (Min of Health & FW 2002). The previous government launched various health insurance programmes for the poor. The details of some of these are given in Table 3. While the government explicitly subsidises the premium for the poor in the Universal health insurance scheme, there may be hidden subsidies in the other schemes. This is why only the national insurance companies offer these schemes.

Table 2: Details of the Mediclaim policy

Instituted in	1986. Is provided by the four national insurance companies plus six private insurance companies.
Eligibility criteria	5 to 80 years of age (Children between 3 months and 5 years can be covered provided one or both parents are insured)
Premium	Depends on age and sum insured (For sum insured of Rs. 15,000): < 25 years Rs. 201 36-45 years Rs. 219 46-55 years Rs. 312 56-65 years Rs. 358 66-70 years Rs. 403 71-75 years Rs. 429 76-80 years Rs. 520 Group discount available
Benefits	Hospitalisation benefits from 15000 to a maximum of Rs 500,000
Providers	Any hospital with 15 beds or more and registered with a local authority.
Exclusions	Any pre-existing illnesses; any disease contracted during the first thirty days. Cataract, BPH, Hysterectomy for fibroids or DUB, hernia, hydrocoele, fistula, piles, sinusitis not covered in the first year Cosmetic surgery, HIV-AIDS, Pregnancy related conditions, including caesarean sections
Payment mechanism	Indemnity – reimbursement of bills by company. Lead time is about 121 days. Third party payment through TPAs is also possible. This is especially used by corporate sector to process their claims, but the premium is loaded by 6% for this benefit.

Table 3: Details of some health insurance policies for the poor.

	Jan Arogya	**Universal Health Insurance**	**Rural women's package**
Initiated in	Feb 2003	July 2003. Revised in 2004.	? 1998
Eligibility criteria	5 to 70 years of age (Children between 3 months and 5 years can be covered provided one or both parents are insured)	5 to 65 years of age (Children between 3 months and 5 years can be covered provided one or both parents are insured) **Only for BPL families**	Women of self help groups between 18 and 65 years. Their families (spouse + two children) can be covered but only if the woman member is covered.
Annual Premium	<46 years Rs. 70 per person 46 to 55 years Rs. 100 56 to 65 years Rs. 120 66-70 years Rs. 140 Dependant children (5-25 yrs) Rs. 50 • Special family rates are available	Rs 165 per person Rs 248 for a family of five Rs 330 for a family of seven **Explicit government subsidy**	Rs 93 for the individual woman member Rs 146 for woman plus family.
Benefits	Hospital benefit upto a max of Rs 5000 per patient per year.	Hospital benefits upto a max of Rs 15000 per illness episode or Rs 30,000 per family per year.	Hospital benefit upto a max of Rs 5000 per patient per year. Plus

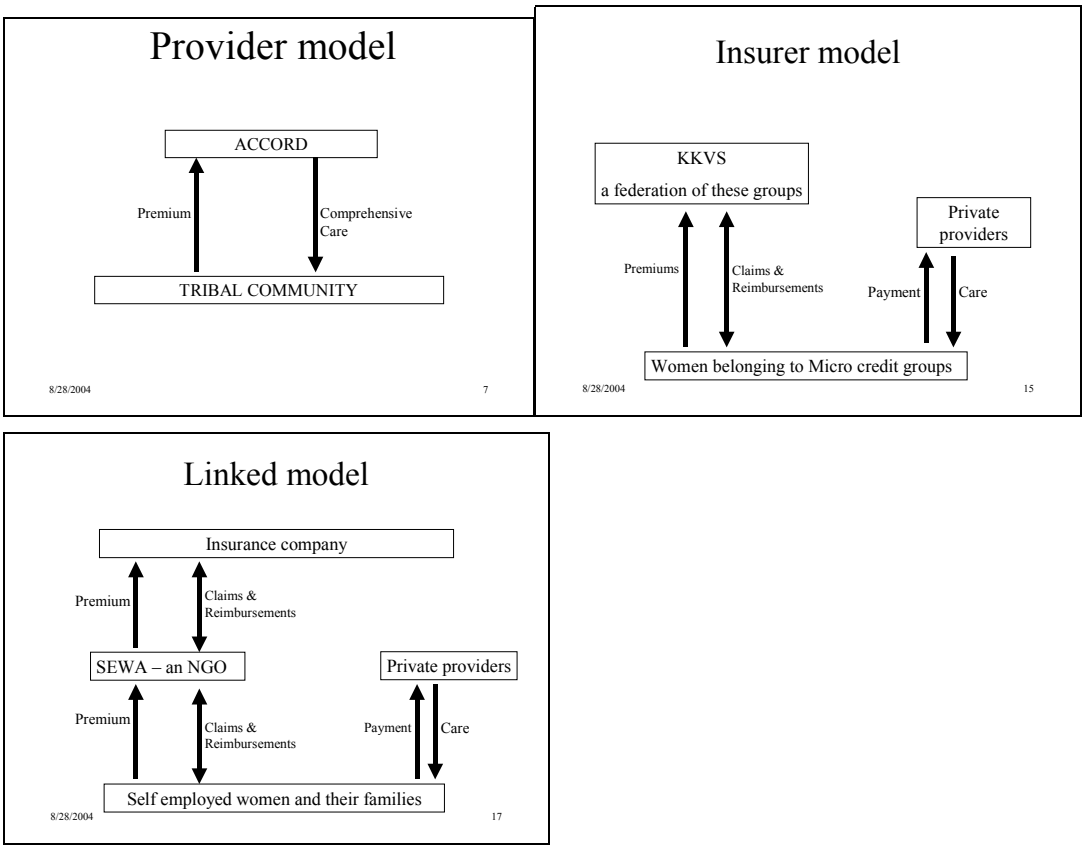
		Plus Rs 25000 life coverage for head of household in case of death due to accidental cause Plus Disability coverage for head of household @ Rs 50 per day for a maximum of 750 days.	Rs 15000 life coverage for woman in case of death due to accidental cause. Plus House cover upto a maximum of Rs 25000 against damage due to fire and allied perils.
Exclusions	Any pre-existing illnesses; any disease contracted during the first thirty days. Cataract, BPH, Hysterectomy for fibroids or DUB, hernia, hydrocoele, fistula, piles, sinusitis not covered in the first year Cosmetic surgery, HIV-AIDS, Pregnancy related conditions, including caesarean sections		
Providers	Any hospital with 15 beds or more. Hospitalisation period should be more than 24 hours, except for procedures like cataract surgery, dialysis, chemotherapy, lithotripsy etc.		
Mode of payment	Indemnity – patient gets bills reimbursed.		

Community based health insurance (CBHI) in India

Inspite of the above policies, there happens to be very few takers among the poor. As per the government of India, at the end of 9 months, there were only 11,048 families who had subscribed to the Universal Health Insurance Scheme (Deccan Herald). Obviously the insurance companies were pushing products rather than solutions. And this is precisely where the NGOs stepped in; by offering solutions to local problems. They initiated CBHI programmes that were able to meet the specific needs of local communities.

CBHI in India is still in a nascent stage. Various NGOs have initiated it as stand alone projects, mainly to allow the poor to access health care easily. Currently there are more than 30 such CBHIs in the country. These CBHIs can be divided into two broad categories – one that provide ambulatory care only and the other that provides both ambulatory and inpatient category. Among the latter (n=19), there are 3 basic models –

Fig: 2 The three models of CBHI in India



These models are depicted in Fig 2.

1. The provider model, where a provider (usually a NGO hospital) provides health insurance for the community around (6/19).
2. The insurer model, where an NGO takes the role of the insurer, collects money from the community and purchases health care for its members (5/19).
3. The linked model, where the NGO collects the premium, but passes it onto a formal insurance company. This company then takes the risk of running the insurance (8/19).

There are advantages and disadvantages with each of these models and these are highlighted in Table 4.

Table 4: Advantages and disadvantages of the three CBHI models

	Provider model	**Insurer model**	**Intermediary model**
Needs a community based organisation	Not necessary	Necessary	Is beneficial if one wants to negotiate an effective package with the insurance company.
Community awareness	Necessary		
Premium	Depends on the benefit package, usually lower than the other models	Depends on the benefit package.	Depends on the products available. Can be negotiated.
Benefit package	A very comprehensive package. Usually includes outreach activities, OP and IP	Limited and depends on the cost of treatment and the numbers insured	A standard package covering IP only. Certain aspects, e.g. the maximum limit and exclusions can be negotiated.
Fund management	Usually institutionalised and easy	Members have to be trained and supervised initially	Collection of premium needs to be supervised. Financial risk is with the company
Providers	The NGO hospital. A single provider usually.	Multiple private providers. Usually no control over them. Tendency for moral hazard is high, especially in the intermediary model.	

Administration	Simple and shared between the institution and the community.	Complicated and the sole responsibility of the community	Simple and shared between the NGO and the company
Enrolment into the scheme	Tends to be higher as compared to the other two models		
Utilisation of services	Higher as the package is more comprehensive.		Lowest among the three models.
Risk management	Is the lowest among the three models	Being flexible, they can introduce measures to control risk	Is already built into the model. But more can be done.
Cost recovery	The least among the three models	Usually meets moderate costs. However, the scheme is vulnerable as the risk pooling is small.	Is financially sustainable as the risk sharing is large. Administrative costs are subsidised by the NGO and the community.
Protection against catastrophic health expenditure	The most efficient, especially in those schemes where there is no upper limit	Depends on the upper limit. The higher the upper limit, the greater the protection.	
	Provider model	**Insurer model**	**Intermediary model**

The CDS project

1. Although Kerala is known for its achievements in health, poor and vulnerable populations are often excluded from accessing fair quality health care. High economic costs of health care often preclude those who do not have the ability to pay and the highly developed for-profit private health care system deters many who do not have the capacity to pay for accessing quality care. The India MAPHealth[1] study found that 10% of households spend more than their annual income on health care. Clear inequalities exist

[1] MAPHealth is a multi-country project coordinated by the principal investigators of the CDS-UDeM action research project, which evaluated the effects of macro-economic and sectoral reforms on health systems in eight countries.

as the burden of health care is three times higher for the poor (14.4% of their income) compared to the rich (4.4% of their income)[2]. In addition, Kerala faces a particular challenge due to its ageing population and shift from communicable diseases to chronic disease, both of which will generate additional financial burdens.

2. As part of a broader action research project aiming at reducing social exclusion and improving access to basic services, the Centre for Development Studies and the University of Montreal are supporting the development of a community based health insurance (CBHI) in the district of Wayanad. Wayanad is located in Northern Kerala, and is one of the most backward districts in Kerala. It is a rural district, with an agriculture-based economy. Wayanad has also the highest percentage of Tribal populations in the State.
3. The idea of the CBHI originally emerged during discussions with community representatives and women engaged in self help groups. Discussions conducted with the women indicated that families were regularly confronted with various forms of temporary or permanent exclusion and they were willing to contribute additional funds to their weekly group savings towards developing a community insurance scheme. In fact, they had been thinking of proceeding towards achieving this goal.
4. Although the CDS-UdeM action research project is focusing its activities in one Panchayat[3], the CBHI will also cover three other neighbouring Panchayats. This is mainly to respond to the strong demand created by the project, and also to enlarge the pool and reduce fixed costs. The women's self-help groups are the pillars of the project. The basic idea is to draw on their existing networks to extend their income generating activities to health related activities. There are two networks of SHGs in these Panchayaths, those sponsored by the Local Self Government Institutions (LSGI), Kudumbasree, and those supported by NGOs. Membership of the two networks is not mutually exclusive; some women belong to both NGO SHG and Kudumbasree.
5. The CDS-UdeM Action research project is funded by the International Development Research Centre of Canada. It began in September 2002. The

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2 Uplekar & George (1994)

3 The Kottathara Panchayath is located within the Vythiri Taluk of Wayanad district, 20 km. North-West from Kalpetta, the only municipal town in the district. The total area of the Panchayath is 31.75 sq. km, with a population of about 17000.

CBHI component of the project aims at facilitating the development of the insurance scheme and resources are available to conduct reviews, field surveys and all community activities needed for the design of the scheme. Some limited resources are expected to be obtained to support the implementation of the CBHI.

Objectives

The main objectives of the feasibility study were

- To understand whether a community health insurance would be feasible in the four panchayats of Wayanad district
- To understand the conditions for a community health insurance to be feasible
- To determine the CBHI model that would be optimal for the given conditions

Methodology

To achieve the above objectives various methodologies were used, ranging from primary data collection to facilitating a seminar with the important stakeholders.

Primary data collection

Census

The CDS project team conducted a census among XXX families at Kottathara Panchayat during the year XXX. This was done as follows XXXX

FGD with SHGs

The CDS project team conducted four focus group discussions with SHG members at Kottathara Panchayat. A total of XXX meetings were held with XXX members. The author conducted a FGD with 10 SHG members at Nerachal village of Ambalavayal Panchayat.

Survey of providers

The author surveyed some of the private and government hospitals in Wayanad district to assess their willingness to take part in the community health insurance programme. Only those hospitals with > 15 beds (Insurance company norm) and with at least two or more specialists and with facilities like labour room, operation theatre and a laboratory were included in the survey. These were the minimum criteria required to service the hospitalisation needs of the patients of a CBHI.

The survey was conducted as follows – first of all a list of private hospitals was obtained from the Hospital owner's association – Wayanad. There were a total of 48 hospitals in that list. They were contacted over the phone. Of the 48, only 30 could be contacted. The other 18 were not available on the telephone directory, or the phone number that they provided was not correct. Of the 30 contacted, three refused to give information about their institution. Of the 27 who responded, only 12 met the above inclusion criteria. Of these the author visited nine and a

questionnaire (Annex1) was administered to a senior manager in the institution. While visiting these institutions, the author discovered two other hospitals that fitted the criteria and were included into the survey. Thus a total of 11 hospitals were surveyed.

The author also surveyed the district hospital at Mananthavady and a PHC at Ambalavayal.

Interviews

Interviews were conducted with member of the Insurance Regulatory and Development Authority (IRDA), with representatives of insurance companies (public and private sector) and with an Indian Medical Association (IMA) representative at Wayanad.

Secondary data collection

Data from the Census 2001 was used for getting the population data of the Panchayats.

A Seminar

The author facilitated a seminar of the important stakeholders – the representatives of the SHG federation; the providers, the CDS project staff and finally the representatives of the United India Insurance company. Discussions at this seminar helped finalise the findings and recommendations of the study.

Results

The various stakeholders for the Wayanad CBHI are the community (Self help group members and their families), SNEHA (a federation of the self help groups at Wayanad), the health care providers, the insurance company and the government, both local and national. The author presents here the views of each of the stakeholders.

The community

The essence of a community based health insurance is the community. In the case of the Wayanad CBHI, the community are the group members in the four panchayats (Kottathara, Meenangadi, Ambalavayal and Moopainadu). There are approximately about 750 groups in these four panchayats with an average membership of 15 to 20 individuals in each. This implies that there are about 11,000 to 15,000 group members in these four panchayats. Thus there is a potential of about 45,000 to 70,000 members (household size = 4.6 – Census 2001) who can join the CBHI.

At Kottathara, a census has been done. As the women in the other panchayats are also similar we are able to get a snapshot of the community involved. The details are given in the table below (Table 5).

Discussions with the Kottathara SHG members have been proceeding for over a year. They are aware about health insurance and its implications. There is also a considerable demand for health insurance. The main reason for wanting a health insurance programme is the high medical costs. People shared stories about how families were impoverished because of medical bills. They find the private health sector particularly expensive. Even in the government health sector, the patient is expected to purchase all consumables and medicines and this amounts to a considerable cost for the average poor family. The main reasons for joining a CBHI are the fact that it will protect them against the high hospitalisation bills, and that community ownership will protect them from

fraud. (They are wary about any insurance programme – having been at the receiving end of fraudulent companies who have collected premium and disappeared subsequently).

However, in the other three panchayats, discussions have started only since November 2003. And this is reflected in the limited knowledge of these members. Representatives from these panchayats still had basic doubts about health insurance in July 2004. Some of these are "*what are the "benefits" of this health insurance? Do we get the money back if we do not fall sick? Do we have to pay even if we do not fall sick? Should all the people pay or only those who are going to be sick? Why should the young adults insure, they do not fall sick?*" These questions reveal that basic issues about health insurance are not clear to majority of the community representatives.

Table 5: Details of the Kottathara community

Total population	XXX	Sex ratio	XXX
Percentage between 16 and 49	XXX	Literacy rate	XXX
Average annual income	XXX	Percentage who joined any group	XXX
Common illnesses in the community =			
Percentage who had major illness in the past one year	XXX	Median hospital bill paid	XXX
Percentage of hospitalised patients who went to a public provider	XXX	Percentage of hospitalised patients who went to a private provider	XXX
Percentage who have joined any health insurance prg.	XXX	Percentage who want to join a CBHI	XXX

However, many of the representatives of the SHGs were clear that they need to join a health insurance programme, especially one started by CDS and WWA (*credible organisations*). Also the fact that they were going to run it (under the banner of SNEHA) was an added incentive. *When we are running the health insurance, then why should we be afraid of being cheated? How can we cheat ourselves?*

This confidence is further enhanced by their capacity to manage finance. Most of the SHG representatives were clear that they could manage the finances of a health insurance programme with ease. *When we are able to handle lakhs worth of savings in our SHGs, then what is the problem with handling health insurance premiums?* This is a major advantage for any group starting a health insurance programme. So the women would be able to collect premiums, process the claims and disburse reimbursements. Book keeping and handling the receipts should not be much of a problem for the SHG members as they are familiar with similar activity. However, somebody (maybe CDS) would need to help them develop the management information system so that they are able monitor the activities.

This plus the fact that they are organised in groups helps in easy dissemination about the health insurance programme. Costs are minimal for creating awareness about health insurance among the members and their families. They can use the existing structure of the SHG and its federation to disseminate information. This is a major benefit, especially if one considers the costs involved normally. This same group structure will also help in collecting premiums. Very little effort is required to collect the premium from the members as this can be done through the existing infrastructure of the SHGs.

However, they were not confident about their role to collectively negotiate with the hospitals or with the insurance company. They felt the need for a professional to support them in this activity, and appealed to CDS for providing this.

Thus to summarise, some of the activities that the women of the SHG could do are

- Create awareness about health insurance among the SHG members
- Collecting premium from the members
- Basic accounting of funds
- Disbursing reimbursements (if necessary)
- Share the information about the CBHI performance with their community. This would require certain amount of training on monitoring indicators.

SNEHA – the insurers

SNEHA is a separate NGO that has been formed by the representatives of SHGs in the four panchayats of Wayanad District. This NGO has been formed recently, initiated by CDS and WWA, specifically to manage the CBHI. Four executive members represent each Panchayat. They are very enthusiastic about the CBHI and are keen to provide some service for their community. However, they are new at this activity; and coming from four different panchayats, the group is still to develop a working relationship. And most important, currently SNEHA does not have funds to manage the CBHI. Even simple activities like meetings need to be funded by somebody. SNEHA would also require regular staff to manage the CBHI. Somebody to interact regularly with the community, with the providers and with the insurance company (if relevant); somebody to maintain the books and manage the accounts. SNEHA would also need experts to negotiate with the providers and the insurance company (if necessary). Currently there is no provision for finances. It is not clear who will provide the funds – CDS or WWA or the SHG members? CDS and WWA (Women's Welfare Association – a local NGO supporting SHGs) have in principle agreed to support SNEHA technically. The availability of financial support is not clear and depends on the project funds.

The providers

Currently there are two broad categories of providers in Wayanad district, the Government providers and the Private providers. While traditionally one divides private providers into two subsections – "for profit" providers and "not for profit" providers; in practise there is no difference between the two. So they shall be considered here as a single entity.

Government hospitals – Like all districts in India, Wayanad also has its network of Primary Health Centres (PHCs), Community Health Centres (CHCs) and hospitals. The list of government hospitals in the district are given in Table 6. A visit to the district hospital Mananthavady and the PHC at Ambalavayal reveal a rather dismal picture. There is considerable overcrowding at the OP (200 out patients per day at Ambalavayal, to be examined by a single medical officer) and at the IP (1000 inpatients at DH – Mananthavady at any point in time, sharing 274 beds). The institutions are under staffed, 50% vacancy among the doctors and nurses in the DH – Mananthavady and under funded. Most patients are prescribed medicines that need to be purchased from the private pharmacies. In spite of having an operation theatre and a labour room, there are very few procedures being conducted at Ambalavayal PHC. In the previous month, there were only 5 sterilisation operations and 10 deliveries. This is probably due to a combination of lack of provisions and human resources.

Table 6: List of Government Hospitals in Wyanad

Number	GOVERNMENT HOSPITALS	Number of beds
1.	Manantavady district hospital	274
2.	Kalpetta Community Health Centre	14
3.	Meenangadi CHC	16
4.	Vythiri Taluk Hospital	XXX
5.	Thariyode CHC	40
6.	Porunnannoor CHC	XXX
7.	Cheeral Primary Health Centre	XXX
8.	Amabalavayal PHC	36
9.	Meppadi PHC	12
10.	Sugandagiri PHC	XXX
11.	Poothadi PHC	10
12.	S. Bathery Taluk Hospital	57
13.	Thirunelli PHC	20
14.	Vellamunda CHC	25

Source: http://www.ecostatkerala.org/html/panchayatstat.html Accessed on 18/8/04 at 8 pm IST.

Patients pay Rs 2 for admissions and buy the medicines prescribed. In the DH, Mananthavady, many of them had to share a bed. While the surroundings were clean, the crowd was disconcerting. Every department had long queues. Discussion with the women reveals that some of them are satisfied with the treatment at the government hospital. The main reasons for choosing a government hospital are credible caregivers (*these doctors are genuine doctors, not like the doctors in the private hospitals who may have got their degree from private capitation medical colleges. We know the quality of training there is very poor)*, safe drugs, no over-

prescription and finally the women felt that the providers had a service motive as opposed to a commercial motive in the private sector. Also most of the government doctors are Malayalis and can speak their language, unlike the doctors in the private sector who are from other states and do not understand the patients (*when we cannot communicate with them, how can they ever understand our illnesses and treat us correctly?).* They wondered whether they could be reimbursed the cost of medicines and diagnostics when hospitalised in a government hospital.

Private hospitals – There are many private hospitals in the district (Table 7), mostly concentrated in the towns of Sultan Battery, Kalpetta and Mananthavady.

Table 7: Categories of private hospitals* in Wayanad district

Number of beds	Number of hospitals in this category	General hospitals	Specialised hospitals
Less than 15	8	6	2 (Ent, Ophthalmic)
16 – 50 beds	11	10	1 (obstetrical cases)
51 – 99 beds	0	0	0
100 – 150 beds	6	6	0
Unknown	25	21	4 (2 dental and 2 ophthalmic hospitals)
Total	50	43	7

* Hospitals = health care institutions with inpatient facilities.

A visit to 10 of them (Table 8) shows that there are basically two categories of hospitals – the majority are small and usually managed by individual specialists. They call the other required specialists when needed. These hospitals have about 25 – 40 beds and have adequate facilities like fully equipped delivery room and operation theatre. They also have a few qualified nurses and a lot of locally trained nurses. All also have laboratory and radiological facilities and an in-house pharmacy. All of them also had ICU facilities with monitors and defibrillators and special nurses posted for ICU duty. These hospitals provided the services of a family doctor. Though the medical officers are specialists, they work as a generalist in the OP, providing polyvalent care – e.g. a paediatrician doubles up also as a physician; an obstetrician also examines children; a surgeon also treats fractures etc. However, they provide specialist care for their admitted patients, and if necessary call the appropriate specialist. E.g. a physician would admit a surgical patient and then request a surgeon to come and manage the case. Similarly a paediatrician would admit an obstetrical case and invite an obstetrician to manage. All the diagnostic tests are done locally and drugs dispensed from their own pharmacies. None of the pharmacies stock generic drugs and usually charge the patient at the MRP rates, which is considerably higher than the actual cost price.

There are 6 large hospitals, four with 100 beds and two with 150 beds. These usually have all the four basic specialists (physician, paediatrician, obstetrician and surgeon) as well as additional specialists like anaesthetist, orthopaedician etc. While in the 'mission hospitals' the staff are paid

a fixed salary, in the others, the specialists are paid a fee for service. All these hospitals have similar facilities like the smaller hospitals. The only difference is in the number of staff – more specialists, nurses and technicians. And because of this, they are able to provide specialist services both at the OP and the IP. They also have more extensive diagnostic facilities; most of the larger hospitals offer endoscopic facilities and one even had a CT scanner. The costs in these larger hospitals are higher as compared to the smaller hospitals. In smaller hospitals, the average cost of a caeserian section was Rs 6000 while in a larger hospital it was about Rs 9000.

None of the hospitals had any significant quality assurance mechanisms. Only one had a library and conducted regular doctors' meetings. Rounds were usually done on an individual basis, though in some hospitals, the doctors discussed 'interesting cases' informally. Journal clubs, mortality review and continuing medical education were rare. However, all the practitioners were members of the Indian Medical Association (IMA) and also of their speciality associations.

Table 8: Details of private hospitals visited.

Name and address of the hospitals	Owned by	Services provided	Specialities available as regular staff.	Availability of other staff
Leo Hospital Kalpetta	The Director (a MO)	OP, IP (100 beds), Emergency, Lab[4], Radiology (incl CT scan), Pharmacy, Maternity and surgical services.	Physician, Pediatrician, Obstetrician, Surgeon, Anesthetist, Orthopedician.	Qualified nurses, lab technicians, pharmacists and Xray technicians.
Fatima Hospital Kalpetta	The church	OP, IP (150 beds), Emergency, Lab, Radiology, Pharmacy, maternity and surgical services.	Physician, Pediatrician, Obstetrician, Surgeon, Anesthetist, Orthopedician.	Qualified nurses, lab technicians, pharmacists and Xray technicians.
Vinayaka Hospital (S. Battery)	The Director (MO)	OP, IP (100 beds), Emergency, Lab, Radiology, Pharmacy, Maternity and surgical services	Physician, Pediatrician, Obstetrician, Surgeon, Anesthetist, Orthopedician.	Qualified nurses, lab technicians, pharmacists and Xray technicians.
Assumption Hospital (S. Battery)	NGO	OP, IP (100 beds), Emergency, Lab, Radiology, Pharmacy, Maternity and surgical services	Physician, Pediatrician, Obstetrician, Surgeon, Anesthetist, Orthopedician.	Qualified nurses, lab technicians, pharmacists and Xray technicians.
St. Joseph's Hospital (Mananthavady)	NGO	OP, IP (100 beds), Emergency, Lab, Radiology, Pharmacy, Maternity and surgical services	Physician, Pediatrician, Obstetrician, Surgeon.	Qualified nurses, lab technicians, pharmacists and Xray technicians.

[4] Clinical pathology and clinical biochemistry. No blood banking. All labs have semi-auto analysers.

KJ Medical Trust Kalpetta	The Director (a MO)	OP, IP (50 beds), Emergency, Lab, Radiology, Pharmacy, maternity and surgical services.	Physician and Obstetrician	Qualified nurses and lab technician.
PBM Hospital (Meenangadi)	The Director (a MO)	OP, IP (40 beds), Emergency, Lab, Radiology, Pharmacy, maternity and surgical services.	Physician, Obstetrician and a general medical officer	Qualified nurse, lab technician and Xray technician.
Vinayaka Medical Mission Muttil	A charitable society	OP, IP (35 beds), Emergency, Lab, Radiology, Pharmacy, maternity and surgical services	General medical officers	Qualified nurses
Jyothi Hospial (Mananthavady)	Director (MO)	OP, IP (40 beds), Emergency, Lab, Radiology, Pharmacy, Maternity and surgical services	Physician, Pediatrician, Obstetrician, Surgeon.	Qualified nurses, lab technicians, pharmacists and Xray technicians.
Marina Hospital (Ambalavayal)	The Director (a MO)	OP, IP (25 beds), Emergency, Lab, Radiology, Pharmacy, Maternity services	Obstetrician and Paediatrician. Surgeon and Anaesthetist on call	Qualified nurse, lab technician and Xray technician.
Name and address of the hospitals	**Owned by**	**Services provided**	**Specialities available as regular staff.**	**Availability of other staff**

All the hospitals were keen on linking up with the health insurance programme. One of the reasons could be the low bed occupancy rate in these hospitals currently. The administrators are keen to have more patients. They have recognised the decline in the local economy and the inability of the patients to meet their costs. When this was raised at the seminar, the representatives of the hospitals qualified this willingness with the following statement – "*we are willing to join an insurance scheme and provide cashless service, only if it is linked with a credible government insurance company. Anything else is not acceptable. We have had bad experiences with previous insurance companies who have promised much, but ultimately the patient or we lose our money. We do not want to repeat such experiences."*

None of the administrators were familiar with flat rate fees, or essential drugs. All of them were unanimous in their condemnation of generic medicines – the reasons ranged from questionable quality, to same price as branded medicines to lack of liability of the pharmaceutical companies. One doctor stated that she preferred branded drugs as it provided employment for the medical representatives. At the seminar, the representatives of the hospitals were not too keen to introduce a flat fee; claiming that each individual patient required individualised billing. When the concept of a flat fee was explained, they were willing to accept it provided the medicines bills were excluded. Thus as per the providers, only hospital services (bed charges, nursing

charges) and doctors' fees could be included in a flat fee. Diagnostics and medicines should be charged on a fee for service basis.

All the all the hospital administrators were unanimous in their condemnation of fraudulent activities. Some of the common activities that they identified were

- Insured people coming and requesting them to give them false bills so that they can claim money from the insurance companies
- Insured and admitted patients requesting the doctors and staff to inflate the bills so that they get higher reimbursements
- Insured and admitted patients requesting the doctors to change the diagnosis so that they are able to overcome the exclusions e.g. women who are admitted for a delivery is given a discharge summary with a diagnosis of diarrhoea and dehydration.
- Insured and admitted patients requesting the administration to make changes in the bill, so that excluded items are included e.g. spectacles are billed under medicines.

The insurance companies shared their experiences about fraud. In addition to the above examples, they said that many of the hospitals included telephone bills and diet charges into the regular bills, sometimes disguised as hospital charges.

All the stakeholders, the providers, the community and the insurance companies were very vehement that they should not allow fraud to take place in the Wayanad CBHI. Some suggestions to check fraud were as follows

- Pre-authorisation: all admissions to be pre-authorised by the SNEHA insurance committee. This committee should have a doctor in it. This would ensure that only genuine cases were admitted. In the event of emergencies, the committee could authorise subsequent to the admission.
- One of the suggestions that most were open to was the independent verification by a "Panel doctor". SNEHA could employ a doctor or link up with the local Indian Medical Association (IMA), so that this doctor verifies every admission. Most of the hospitals found this measure acceptable. This could take care of most of the above fraudulent measures. It was made clear that this doctor would only ensure the presence of a patient and the diagnosis.
- A third suggestion that did not find much favour was for the admitting doctor to ring up a "panel doctor" and inform him / her about an admission, the probable diagnosis and the treatment plan. While this had the advantage of saving the time and effort of the panel doctor, the hospital representatives found it difficult to accept that the admitting doctor had to ring up a panel doctor. The real issue was about power, which was not stated openly but implied.

Another measure that was suggested to keep provider induced moral hazard down was 'standard treatment guidelines.' This was not well received and most of the representatives felt that doctors would not be open to such a suggestion. A suggestion by the IMA representative was for SNEHA to provide a list of medicines with their costs. He suggested that SNEHA should also

conduct an independent quality check on common medicines. This sort of information would be of great help for the hospitals and would go a long way in regulating unnecessary and costly prescriptions.

So to conclude, the providers were willing to link up with the SNEHA health insurance programme, provided it was linked up with a government insurance company. And they were willing to make some changes like introduce cashless payment for the insured patients, have a flat fee and introduce measures to control fraud.

Insurance companies

Interactions with two insurance companies – one private and one public received two different responses. The private insurance company, which is currently involved with a CBHI in south India was hesitant to get involved with health insurance. The executive was of the opinion that health insurance was too risky for insurance companies as the providers were currently unregulated. He felt that unless one knows the provider very well, it would lead to cost escalation and high claims ratios. Especially since there was very little information about morbidity, costs of treatment and risks involved.

On the other hand, the public sector insurance company was very open to collaboration with the SNEHA CBHI. The managers expressed interest in the fact that they would get at least 30,000 members (50% of the total members and their dependents) joining the scheme. And the fact that it was a group membership would limit adverse selection, which was one of their greatest fears. They were willing to pass on significant group membership discounts as well as some of the administrative overheads onto SNEHA; especially if SNEHA would take the responsibility of informing the community about the insurance programme and also collecting the premium. They were very impressed by SNEHA's attempts at curtailing fraud and were willing to provide the services of their panel doctor for SNEHA's insurance committee on a honorary basis. At the end of discounts, they were willing to offer a hospitalisation policy upto Rs 20,000 on a floater basis for a premium of Rs 250 for a family of 5. It would have the usual Mediclaim exclusions, but this was negotiable.

However, the SNEHA representatives were not too keen to link up with the insurance company. They felt that SNEHA's autonomy would be affected and that they would have listen to the insurance company. "*We will become like a post office – just collecting the premium and handing it over to the insurance company. We will not be able to decide what type of insurance we will need.*" The only concern was whether they would be able to provide similar benefits for Rs 250.

The Government

The Kerala Government is very keen on introducing health insurance. In its "Concept paper on Kerala Secondary Health System Project (Aug 2003)" the government has specifically mentioned the role of health insurance to generate finances for the health sector. The 2003-04 Budget had allocated Rs 10 crores towards health insurance premiums for the poor tribal families. This is an indication of the government's commitment towards health insurance.

This is reflected also in the stance national government. The National Health Policy – 2002 has specifically mentioned that the government of India will promote health insurance in the country (Min of Health & FW 2002). The previous government and the newly elected UPA government

have also promoted health insurance in a big way. They have made provisions for a subsidised health insurance policy for the poor (The Times of India 2003).

However, the Insurance Regulatory and Development Authority – the main regulatory authority has not recognised CBHI as a legal entity. An interview with one of the members revealed the IRDA position on CBHI. The member was of the opinion that NGOs should not organise health insurance by themselves. He felt that first of all it was illegal to do so under the IRDA Act. Secondly he was of the opinion that most NGOs did not have the capacity to manage health insurance by themselves, especially the actuarial aspects of it. And finally there are no redressal mechanisms available for members of the CBHI. So keeping in mind all these reasons, he was of the opinion that the NGOs should link up with existing insurance companies and their products. He hinted about the introduction of a secondary legislation soon that will allow insurance companies to approach NGOs directly without the burden of enrolling them as agents. This would allow NGOs to solicit policies directly from their community. Moreover the insurance companies could pass on upto 15% of the premium as administrative costs directly to the NGOs.

Thus to summarise, while the government is keen to insure its subject, they would like to promote the intermediate model of health insurance, wherein the NGOs link up with the existing health insurance companies and their products.

Membership to the CBHI

It was clear from the discussions both with the SHG members at Kottathare, Ambalavayal and with the SNEHA representatives, that members of SHGs and their family were eligible for enrolment to the CBHI scheme. By family they included dependent children and parents. This was in keeping with the insurance company's definition of family, though they had a limit of only three children and two parents. As the SHG members are women, it would mean that only parent-in-laws could be insured.

While the insurance company products allowed for individual enrolment, SNEHA was very clear that the unit of enrolment would be the family. The reason behind this was to protect the entire family. While there was some discussion on the SHG being the unit of enrolment, this was categorically rejected, because the SNEHA representatives felt that it would be difficult to convince all 20 members in a SHG to join. And if even one member refused, the other 19 members and their families would suffer. Hence they preferred to have the family as the unit.

SNEHA preferred to allow all the eligible people to join, though the insurance companies had a specific age bar. Any child below three months and an adult above 70 years could not be insured under their policies.

Strategies to include the poorest, the destitute and the scheduled tribes were discussed, but SNEHA representatives felt that currently they had to concentrate on the existing members. Once the CBHI was functioning well, they could think of measures to include them. But this was at a later stage.

There was unanimous approval to the suggestion that there be a definite enrolment period. A suggestion was to have it in January when apparently the cash income to the household is high. However, this was left to SNEHA to decide. However, a minority group felt that in the initial years, it would be better to have at least two enrolment periods a year, so that those who did not join in the initial period was given another chance.

SNEHA agreed that its members would take the responsibility of enrolling members into the CBHI. Each member and their family would be given an insurance card, with the family details. They were emphatic that it was not necessary to have a photo identity card (to prevent fraud). *"we know each and every one and what is happening. If anybody tries to cheat, the SHG members will easily catch them. We will not allow this to happen."*

Premium

This was a crucial element in the discussion. The members were willing to pay a maximum of Rs 200 to 250 for a family. Anything above this would be unaffordable, according to them. Some suggested different products with different premiums so that those who can afford can pay more and purchase a higher end product with a more generous benefit package. Also there was discussion about whether the premiums could be stratified according to family size, less than 5 and more than 5. However, no decision on this was made.

The insurance companies were willing to provide a new policy with a premium of Rs 250 for a family of five (for a hospitalisation package for the family with a maximum limit of Rs 20,000). The current insurance company products are priced as follows (Table 9):

Table 9: Premiums and benefits in the existing public sector insurance policies

Name of product	Premium	Benefit
Mediclaim (for person aged < 45)	Rs 219 per person per year. Group discount available.	Hospitalisation benefit upto Rs 15000 per patient per year.
Jan Arogya	Rs 70 per person per year. Family rates available.	Hospitalisation benefit upto Rs 5000 per patient per year.
Universal Health Insurance	Rs 248 per family (5) per year (for BPL families only)	Hospitalisation benefit upto Rs 30,000 per family per year.
Rural Women's package	Rs 146 for women member plus family (5) per year.	Hospitalisation benefit upto Rs 5000 per patient per year.

SNEHA desired to know the premium if they offered a similar package to their members without an insurance company. Unfortunately as the requisite data (morbidity pattern, hospitalisation rates, hospitalisation costs) were not easily available, it was not possible to calculate the premium. CDS has promised to get back to SNEHA with the figures.

Benefit package

Both the Ambalavayal SHG members and the SNEHA representatives were clear that the premium and the benefit package were related. The bigger the benefit package they ask for, the higher the premium that they would have to pay. This helped when we discussed the details of the benefit package. The women wanted hospitalisation expenses to be the core of the benefit package. They were uncomfortable with exclusions and felt that this should be limited to self inflicted injuries or illnesses due to substance abuse. They were clear that if one excluded pre-existing illnesses, then a majority of the members might not find the insurance scheme appealing. Especially since many of the parents had lifestyle disorders like diabetes mellitus or hypertension.

What they did not want was domiciliary care. They felt that the individual households could manage this through out-of-pocket payments. Similarly they were not too keen to have life or asset cover included into the benefit package. However, they did recognise the need to insure some specific conditions that were costly but did not require hospitalisation, e.g. anti rabies injections, road traffic accidents resulting in simple fractures, dialysis, etc.

The insurance company was insistent that it could not do away with exclusions of certain conditions. The most contentious was pre-existing diseases. They shared how all their products has excluded this and they could not change it.

The SNEHA representatives were also not in favour of any co-payments. Even when it was explained to them that co-payments were a mechanism to control for unnecessary hospitalisations, they were of the opinion that this was not necessary. In fact the representatives were sceptical whether anybody would get hospitalised unnecessarily. *A hospital is not a nice place to go. Also when a person is hospitalised, the whole family is affected. And there are a lot of expenses that are not met by the insurance, e.g. food, travel, loss of wages. Do you think that anybody will be so foolish as to get hospitalised without any disease?* The idea of maximum limits was acceptable to them and they felt that this was necessary, else there would be no control over the costs.

SNEHA representatives also strongly favoured a third party payment. They felt that the purpose of insurance would be lost if the patient had to pay and get it reimbursed later. The relatives would have to run from pillar to post just to get the money and then there would be no difference between an insured family and a non insured family. When reminded that the SHG members could avail of loans from the SHGs, the women retorted that most of the members are so deep in credit already that it would be difficult for them to take another loan. And there was very little ready cash available in the SHGs to pay for hospitalisation bills, which are relatively big.

Administration of the scheme

It was clear that SNEHA would administer the scheme. However, there were members in the Ambalavayal SHG who were not clear who or what SNEHA was. SNEHA representatives agreed to develop mechanisms for creating awareness, collecting premium, monitoring fraud, administering claims and reimbursements and managing the fund. They were not very confident about negotiating with either the insurance company or with the providers and felt that CDS should help them in this. Issues like cost containment, quality assurance, moral hazard and adverse selection were not familiar and they were unsure on how to tackle them. They did not see the need for specific training inputs and felt that if CDS helped SNEHA during the initial phase, they would pick up the lessons on the job.

Discussion

This feasibility study was undertaken on behalf of CDS to understand whether a CBHI would be possible in Wayanad District of Kerala, India. The study also tried to understand the conditions under which it would be possible. The research questions were

- Who would organise the CBHI?
- Who would enrol in the CBHI?

- Who would provide the health care?
- What would be the benefit package?
- What would be the premium?
- Does the organisers have the financial and techno-managerial capacity to manage the CBHI?
- What model of CBHI would it be?

It is clear from discussions with the SHG members that there is a need for CBHI in Wayanad and they are willing to join it. They are also confident that they will be able to manage it, given their past experience with micro-credit. However, they have specifically sought the help of CDS for more technical matters. Also since the members are already organised in micro-credit groups, it would be easy to create awareness, collect premium, administer the claims and reimbursements and monitor fraud. Just a word of caution – monitoring fraud is a double edge sword as social control may impinge on individual patient privacy and confidentiality. This needs to be developed with much thought.

From discussions with the CDS researchers it was clear that SNEHA would be the organiser of the CBHI. This is a federation of SHG members from the four panchayats and so has a representative and legal nature. Most of the women are senior SHG members and have considerable experience in managing a group. They also appeared to be enthusiastic about the CBHI. However, while some of them had considerable insights, others had some basic doubts about a CBHI. This is something that needs to be looked into both by SNEHA and CDS. It is essential that the leaders are aware about the essential concepts of CBHI, without which, it would be difficult to convince the members. The training inputs could include specifics on concepts in insurance (risk pooling, adverse selection, moral hazard); quality of care, health insurance products in the country and negotiation strategies. They would also need inputs on monitoring a CBHI, the indicators that need to be scrutinised and handling a MIS. This is all the more important, considering the negative experience that some members have had with insurance organised by unscrupulous entrepreneurs.

Other than this, there is the issue of funding SNEHA. Currently there are no funds to finance the organisational activities of SNEHA. Expecting the federation of SHGs to contribute to its working capital is a good idea. However this may take some time, as the concept itself is new and the women may want results before paying. In this context, it maybe advisable for CDS / WWA to provide an initial working capital to SNEHA. This would allow SNEHA to open an office, hire necessary staff to take care of day-to-day management and contract experts to help them implement the CBHI. This would help in establishing SNEHA's credibility and also give time for developing a long term funding strategy.

Thus to conclude, a legal entity has been developed to organise and manage the CBHI. Given its embryonic status, one feels that SNEHA would need a lot of support, especially initially to commence operations. However, given that similar groups elsewhere have successfully managed CBHIs (KKVS at Theni, TN and BAIF at Pune, Maharashtra); history is on their side. One recommendation is that CDS shares the administration in the beginning, but takes specific measures to hand over to the women in a phased manner. Some of the functions that could be shared are as follows (Table 10)

While most of the women were keen on private providers, there were some who wanted to keep the option of government providers open. This should be respected and the members to the CBHI scheme should be allowed to use either the private or the public sector. The expenses incurred in the public hospitals (like purchase of medicines and diagnostics) could be reimbursed, provided that it is above a minimum amount to minimise the workload on the SNEHA administration. However, given the conditions that I saw in the government hospitals, it may not be feasible to expect the doctors to be actively involved in a health insurance programme. They just will not have the time and the energy to cope with the extra demand. Moreover, there is no direct incentive for them to be involved with the scheme. Hence they would not be interested in making changes to the operations of the hospital to facilitate the health insurance programme. This last is my opinion and not based on any indications given by the government doctors.

Table 10: Distribution of functions between the stakeholders

SNEHA	CDS
Creating awareness in the community	Negotiating with the insurance company
Collecting premium	Actuarial calculations
Monitoring fraud	Negotiations with the health care providers
Administering claims and reimbursements	Ensuring quality
	Cost containment measures
	Managing the risks – adverse selection and moral hazard
	Training the SNEHA representatives
Monitoring the programme	

Most of the private providers interviewed (11 out of 12) were willing to link up with the insurance programme. Given this acceptance and the fact that SNEHA would provide a large number of patients to the selected hospitals, SNEHA is in the driver's seat. It should identify select hospitals in the four panchayats and then it needs to negotiate for getting more benefits from the providers. This would include measures like:

- Regular meetings with the empanelled hospitals to share experiences and make mid term corrections if necessary.
- Contractual agreements for deliverables like third party payment, minimum quality of care, a capitation fee system and anti fraud measures.
- Standard treatment guidelines and use of essential and generic medicines

SNEHA with suitable expertise could also use this opportunity to locally develop standard treatment protocols. This would be acceptable to the providers as well as will provide a win win situation for all concerned.

Some of the criteria for selecting the hospitals could be –

- A minimum of 15 beds.
- At least two or more specialists available round the clock.
- At least three qualified nurses.
- A functional operation theatre, labour room, a laboratory and a pharmacy also available.
- List of on call specialists available
- The hospital agreeing to the above demands.

While the providers were open to a suggestion for having an empanelled doctor visit them to check on admissions, this may not be practically possible, because of the large number of admissions in a day. One possibility would be to ensure that the hospital informs an empanelled doctor (telephonically) and s/he subsequently discusses the case with the concerned doctor. This would minimise costs and also be useful in keeping a check on the doctor / hospital.

The other option is to institute pre-authorisation for every hospitalisation. This would be a bureaucratic measure that may not be appealing to the members. Either way, SNEHA would need the services of a doctor to control for fraud and ensure quality. While the insurance company has promised the services of their doctor, at the most, this would be part time services which may not be sufficient.

Thus, unlike in most other settings, Wayanad has a plethora of providers and who are willing to link up with the CBHI. With astute negotiations, the CBHI can assure good quality care at reasonable costs for their members.

It was heartening to note the positive note struck by the public sector insurance company. The managers are aware of the benefit of enrolling large numbers of individuals with minimum administrative burden on the company. They do not have to spend on promotional efforts, collection of the premium and controlling fraud. There would be minimum expenses for administering claims and reimbursements. Most important, being a group insurance, they would be able to minimise adverse selection, the bane of Indian health insurance. And if SNEHA's efforts to control the providers succeeds, they also have inbuilt measures to control moral hazard and costs without any extra expenditure. All this explains the enthusiasm of the insurance company. This also means that SNEHA is again in the driver's seat and can negotiate a favourable benefit package for its members. This would include lower premiums, minimum exclusions and support for training the insurance committee. It would also include financial benefits from the insurance company by way of administrative charges. And finally, most important, there would be a larger risk pooling and the financial risk of the insurance would be with the insurance company. However, this would also mean that SNEHA would not have total control over the insurance programme and would have to abide by some of the rules and regulations of the company. But given the "illegal" status of the insurer model, and given the providers' preference to be linked up with genuine insurance companies, the intermediate model may be a more favourable option.

Strategies like family as the unit and a definite enrolment period are good measures to control for adverse selection. These should be encouraged. The numbers who enrol will depend on a lot of factors, ranging from awareness about the scheme, ownership of the scheme, the pricing of the premium, the suitability of the benefit package, the administrative load, the transparency of the programme and last but not the least, the credibility of the organisers. It may be expected that in

the initial years, the enrolment may be low but will increase if the CBHI is perceived to be functioning well and meeting the needs of its members.

One of the crucial factors in this is the affordability of the premium. The figure of Rs 200 for a family of five came from independent quarters, indicating that this is the amount that the community can afford at this point in time. SNEHA has a challenge ahead to devise a scheme that will meet the needs of the members while being affordable. This balancing act may be difficult in the initial years. Elementary calculations with crude figures available threw up premiums that were definitely outside the affordable range. This of course needs to be confirmed by actuarial calculations. However, it appears that SNEHA would find it difficult to match the subsidised premiums of the insurance companies.

The SNEHA representatives understood the linkage between the premium and the benefit package. This is crucial to the successful functioning of any CBHI. Many CBHIs have collapsed due to the unrealistic demands by the community for having a very extensive benefit package with no proportional increase in premium. They have also decided to insure only low risk but high cost events, and this is in keeping with their need for CBHI to protect the households from high expenses.

The administration of the scheme needs to be kept minimal if one wants to enhance the enrolment rates. Too much paperwork, either for the patient or for the hospitals will be seen as a negative aspect and may cause the stakeholders to opt out of the scheme. SNEHA needs to be aware of this and monitor it closely. At the same time, CDS / WWA needs to provide SNEHA with the technical and financial support required to administer the scheme, especially in the initial stages. Without this support, SNEHA and the Wayanad CBHI would have problems in taking off.

While there are at least 3 distinct kinds of CBHI in India (with individual variations); as SNEHA does not have a hospital or a health programme, the provider model is out of question. So that leaves either the insurer or agent model.

SNEHA representatives were more in favour of the insurer model, because they felt that they could have total control over the health insurance programme. And then they could design the health insurance, especially the benefit package and the premium according to the needs of the community. While impressed with the insurance companies' products, they were concerned about the exclusions and the administrative hurdles in insuring their community. However, they were hesitant when elementary calculations indicated that the insurer model might not be financially sustainable. Moreover, they realised that they would need some technical expertise and initial financial assistance in managing the CBHI and expected CDS to provide them with this.

The insurance companies were in favour of an intermediate design, and promised to develop a favourable product, in keeping with the needs of the community. Provided that SNEHA would take on some responsibilities like creating awareness, enrolling members and administering the claims. The providers were also in favour of a linkage with a formal and registered insurance company, as they felt that this would be a credible venture rather than SNEHA managing it on its own. As stated earlier, the IRDA supported an intermediate model.

And finally what is the model of the scheme that one needs to choose? Based on the findings, the options are shown in Table 11.

Table 11: Options with the two different models.

	Insurer model	Intermediate model
Only SHG members are eligible	Possible to limit this in both the models	
Enrolment unit	The family as desired by the community	Usually is the individual
Creating awareness	SNEHA would be the main player in both the models	
Premium	Maybe at least more than Rs 500 per family for the package of benefits	Has agreed to develop a product that costs Rs 250 for a family of five
Flat rate premium	Possible in both the models	
Enrolment period	When SNEHA decides	Only after the insurance company clears the policy
Waiting time	Longer waiting time can be prescribed	Usually only one month waiting time.
Administration of the premium collected	Managed by SNEHA	Managed by the insurance company.
Interest on the premium collected	Goes to SNEHA	To the Insurance company
Benefit package	Hospitalisation benefits, upto a max of Rs 20,000; plus limited day surgery benefits.	
	Details can be decided by SNEHA	Will be decided by the insurance company.
Exclusions	Limited	Wider range of exclusions
Co-payments	No co-payments possible in both the models	
Referral system	No referral system in both the models is possible	
Third party payment	Feasible	Maybe more difficult to organise.
Providers	Can be decided by SNEHA	Usually has very broad guidelines. SNEHA can decide.
Payment of providers	Flat fee for cost containment is possible	Fee for service usually
Review of claims	Responsibility is with SNEHA	Final responsibility is with the insurance company

	SNEHA	insurance company
SNEHA will manage the scheme	SNEHA will have to manage it totally	SNEHA can share the responsibilities, with the insurance company.
Administrative costs	High for SNEHA	Lower for SNEHA. Insurance company will also pay SNEHA some money to meet the administrative costs.
Cost of initiating the programme	Initial costs very high for SNEHA	Initial costs can be minimal for SNEHA. Depends on SNEHA's involvement.
Financial risk	SNEHA would be shouldering all the risk	Risk would be sharing the risk with a larger pool.
Quality of care	SNEHA can negotiate for better quality in both the models	
Cost containment	SNEHA can negotiate for measures to maintain costs	Same here, but the motivation would be less.
Control of fraud	SNEHA can develop measures to control fraud.	Same here, but the motivation would be less.
Financial protection	Depends on the upper limit in the benefit package. The higher the limit, the more the protection.	
Financially sustainable	Both are sustainable, but the risk in more in the insurer model.	
Acceptability to the community	Currently this is more acceptable	
Acceptability to the providers		They prefer an intermediate model
Acceptability to the government		They prefer an intermediate model.
	Insurer model	**Intermediate model**

From the above table it is clear that there are pros and cons in both the models. Essentially in the insurer model, SNEHA has total control. But with control comes risks. And given the conditions currently existing, it may be too early to expose SNEHA to risks. This and the fact that in the intermediate model, the insurance company is able to provide a product at much lower costs is an incentive for SNEHA to adopt the intermediate model. This does not mean however, that they relinquish all control. SNEHA could act as the main insurer and just use the insurance company to share the financial risk. This would have two advantages. The most obvious is the fact that SNEHA could tap into the larger risk pool of the insurance company. Secondly, SNEHA could use this period for capacity building so that it can manage the CBHI on its own if necessary at a later stage. So the intermediate model is a win win situation for SNEHA where it can maintain control but give up the headache of financial risk management. Of course there will be some

hurdles e.g. exclusions, third party payment and negotiations with the insurance company. But given the benefits, SNEHA needs to take it into its stride.

Recommendations and conclusions

To conclude, the author is of the opinion that a CBHI is possible at Wayanad district, Kerala, India. The main factors in support of this statement are

- An organised and capable community that needs some form of health insurance coverage to protect them from high medical costs.
- A legal and representative body, SNEHA, that will manage the CBHI.
- A network of providers who are willing to link up with the insurance scheme and can be contracted to provide quality health care at reasonable costs.
- A supportive government policy
- Insurance policies that are pro poor and can be used by the women to reduce the risk of a CBHI

To succeed however, some enabling factors need to be in place:

- More awareness among the community
- A product that is affordable and acceptable to the community
- A technically and financially sound SNEHA that can administer the CBHI as well negotiate effectively with the providers and the insurance companies.
- Technical and financial support to SNEHA through CDS / WWA especially in the initial few years. For this CDS would need to establish a project team locally to support SNEHA.
- An effective MIS that monitors the programme closely and makes mid term corrections where necessary
- Transparent transactions, especially financial ones.
- An intermediate model of CBHI. The last is for the following reasons:
    - Given the promise of the insurance company, the author feels that their product would be more affordable than the one developed by the insurer model.
    - Given the current level of understanding that SNEHA leaders have about health insurance, it is better that they are supported in the initial phase
    - Given the general suspicion about health insurance, it would be better to link up with a credible insurance company, till SNEHA is able to prove its mettle.
    - Given the political climate in Kerala, it may not be advisable to do anything “illegal” even if the risk from the IRDA is marginal.

Of course, this can change with time as SNEHA gains more expertise and is more confident about managing the CBHI.

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Annex 1

INTERVIEW SCHEDULE FOR THE DOCTORS – WAYANAD

Objectives:

1. To understand the needs of the community
2. To understand the facilities that are available to meet these needs
3. To understand the costs involved
4. To understand their impression about community health insurance
5. To understand what they are willing to give:
6. What are their expectations as partners in a community health insurance programme?

CDS – Trivandrum

Health care providers study

Questionnaire

Name of the hospital:

Town:

Address:

Tel No:

Contact person:

Email id:

What are the common health problems that you see as a doctor here?

What are the common reasons for admissions in your hospital?

What are the facilities that are available in your hospital?

OP	**Yes / No**
If yes, how many doctors are available in the morning?	
How many doctors are available in the afternoon?	
What are the OP timings?	
Average OP load in a day?	

IP	**Yes / No**
How many beds are there?	
Is there any ICU?	Yes / No
Is there a resident doctor at night for the wards?	Yes / No
Total number of inpatients seen in year?	
Number of surgeries done in a year?	
Number of deliveries conducted in a year?	

Emergency	**Yes / No**
If yes, is it available round the clock?	Yes / No
If yes, is there a resident doctor available round the clock?	Yes / No

Laboratory	**Yes / No**
Do you conduct clinical pathology tests?	Yes / No
Do you conduct biochemistry tests?	Yes / No
Do you conduct microbiology tests?	Yes / No
Do you have a regd. blood banking facilities?	Yes / No

Radiology	**Yes / No**
Do you perform Xrays	Yes / No
ECGs	Yes / No
Ultrasound scans	Yes / No
Echo cardiography	Yes / No
CT / MRI scans	Yes / No

Pharmacy	**Yes / No**
For OP / IP / Both	
Available round the clock	Yes / No
Has most essential medicines	Yes / No

Staffing pattern in the institution:

Specialities	**Full time**	**Part time**	**On call**	**Others**
RMOs				
Physicians				
Surgeons				
Anaesthetists				
Paediatricians				
Obstetricians				
Orthopaedicians				
Qualified Nurses				
Unqualified Nurses				
Hospital administrator				
Pharmacist				
Radiographer				
Lab technician				

Which hospital / Doctor would you recommend in _____ for the following speciality

Speciality	**Hospital / Doctor**
General Medicine	
General Surgery (with anaesthesia).	
Paediatrics	
Obstetrics	
Gynaecology	
Orthopaedics	
Laboratory	
Others	

What would be the approximate costs for the following conditions in your hospital

Condition	Costs
An acute medical admission e.g. typhoid fever	
A chronic medical admission e.g. control of DM	
An acute surgical admission e.g. appendicitis or intestinal obstruction	
A DU with perforation	
A normal delivery	
A Caesarian section	
An abdominal hysterectomy	
An uncomplicated fracture	
A paediatric admission e.g. bronchopneumonia	
OP conditions Consultation Medicines Diagnostics	

Quality of care

Do you have the following activities?

- Chart audits? Yes / No
- Death reviews? Yes / No
- Infection reviews? Yes / No
- Surgical reviews? Yes / No
- Journal Clubs? Yes / No
- CME? Yes / No
- IMA membership? Yes / No

Involvement with the Insurance programme

We are planning to introduce a community health insurance scheme among the Kudumbashree women here in Kalpetta. Explain broad outline about the scheme. Then ask the following

- **Would you be willing to be part of such a scheme? Yes / No**
- **Would you be willing to bill the patients on a capitation fee / DRG basis?**
- **There may be a need for introducing standard treatment guidelines – would that be acceptable to your hospital?**
- **Currently generic drugs are available in the market, that are much less costly. Would you be willing to prescribe such medicines in your hospital?**
- **Would you be prepared to be part of a committee that reviews health care, costs of treatment and other related issues?**
- **Would you be willing to share some key information with this committee e.g. surgical complication rate, Caesarian rate, average length of stay, average cost for common admissions?**
- **Are you willing to make organizational changes like**
    - **Special queues for insured patients?**
    - **Cashless discharges?**
    - **Billing / Certification as required by the company?**

If you would like to link up with such a CHI, what would you expect from them (the organizers / community) in return?

Observation

Is the building new? **Yes / No**

Clean surroundings? **Yes / No**

Spacious Waiting area? **Yes / No**

Separate casualty entrance? **Yes / No**

Wheelchair? **Yes / No**

Trolley? **Yes / No**

Spacious OT **Yes / No**

Boyle's Apparatus / Resuscitation set / Oxygen

Spacious labour room **Yes / No**

Forceps / Vacuum extractor / Oxygen / Paediatric resuscitation set

Spacious and well light wards **Yes / No**

Emergency medicines available in the wards **Yes / No**

Nursing station in the ward **Yes / No**

Nurse available in the ward – 24 X 7 **Yes / No**

Resident Doctor's room **Yes / No**

Records? **OP / IP**

Registers **OP / IP / Surgical / Delivery**

Discharge summary **Yes / No**

Hospital bills – itemized / consolidated