



Policy Brief 12

February 2006

Inter-Regional Inequality Facility
sharing ideas and policies across Africa, Asia and Latin America

Health Insurance for the Poor

India

This series of Policy Briefs summarises the experiences of recent government initiatives aimed at addressing inequality in Africa, Asia and Latin America.

Current Policy Briefs in the series:

- Social grants, South Africa
- Familias en Acción, Colombia
- Red de Protección Social, Nicaragua
- Programme for Advancement through Health and Education, Jamaica
- Social safety nets, Indonesia
- Maharashtra Employment Guarantee Scheme, India
- National Employment Fund, Tunisia
- Youth Training, Argentina and Chile
- National Functional Literacy Program, Ghana
- Universal Primary Education, Uganda
- Upgrading educational opportunities for the poor, Sri Lanka
- Health insurance for the poor, India
- Affirmative action, Malaysia
- Affirmative action, India
- Affirmative action, Nigeria

The Inter-Regional Inequality Facility was initiated in 2004 to promote inter-regional dialogue and knowledge sharing on MDGs and inequality.

Institutions participating in the Inter-Regional Inequality Facility include:



African Development Bank



African Union Commission



Asian Development Bank



Inter-American Development Bank



New Partnership for Africa's Development



United Nations Economic Commission for Africa

Objectives

In India, individuals and families on low incomes face significant barriers to accessing quality healthcare. Public health facilities suffer from poor management, low service quality, and weak finances. On the other hand, private health facilities are expensive, so that households typically have to borrow or sell assets to meet hospitalisation costs. At the same time, insurance companies have until recently shown little interest in offering health insurance products to poor groups.

A search for alternative mechanisms for meeting the healthcare needs of the poor in India has given rise to a variety of new health insurance initiatives. This paper describes three such initiatives, namely micro-health insurance, the Yeshasvini scheme in Karnataka state, and the national Universal Health Insurance scheme. Each has the overriding objective of increasing the access of poor individuals and families to quality healthcare at an affordable cost.

Description

Micro-health insurance refers to the provision of tailor-made health insurance products, typically involving low premiums and modest benefits, by public and private insurance companies to poor or disadvantaged groups. A certain level of provision to such groups is now a regulatory requirement, imposed on insurance companies by the Indian Insurance Regulator.

The Yeshasvini scheme was introduced in 2002, and is available to members of Karnataka's state co-operative societies. It provides for free hospitalization for surgical procedures up to a cost of US\$ 4,444 per member per annum. The premium charged for membership in the programme in 2005 was US\$2.7 per adult per year, and US\$1.3 per individual below 18 years per year.

The Universal Health Insurance scheme was introduced in 2003, and is available to all individuals and families below the official poverty line. It provides hospitalisation expenses of up to US\$667 per family, and compensation for loss of wages in the case of illness or personal accident. The premium for joining the scheme varies between US\$8 and US\$16 per year.

Lessons learned

The three initiatives considered in this paper suggest that three conditions are essential for the success of health insurance for individuals and families on low-incomes. These are: the provision of healthcare services of a reasonable quality; the possibility of resource mobilization from the targeted population, so that part of the cost is recovered, and the presence of an intermediate agency to overcome the informational disadvantages and high transaction costs involved in providing insurance to low-income groups. The positive impacts of health insurance schemes for the poor can also be enhanced, by the strengthening of public health facilities through structural and institutional reforms, the provision of public subsidies to health insurance schemes in their initial years, and greater regulation of the growing number of micro-health insurance schemes.

Background

That low income people face financial barriers to healthcare is well documented in the literature (e.g. Peters et al. 2002, SHEPHERD 2003). For example, it is estimated that more than 40 per cent of hospitalised Indians have to borrow or sell assets to meet hospitalisation costs. Often they pay very high interest rates on the money they borrow: it is estimated that around 25 per cent of hospitalised Indians become poor in a single year as a result of hospitalisation expenses.

Moreover, access to both public and private hospitalisations is biased against the poor. On average, individuals in the poorest quintile of India are 2.6 times more likely than individuals in the richest quintile to forgo medical treatment when ill (National Sample Survey Organisation 1998). The fact that the poor have unequal access to healthcare, coupled with their low health status and the fact that labour is their main source of income, heightens the concern. The search for alternative financial mechanisms for addressing this need has given rise to health insurance initiatives in India.

This paper describes three recent initiatives aimed at providing health insurance to individuals and families on low-incomes. The first is micro-health insurance, which includes a variety of schemes across the country. The second is the Yeshasvini health insurance scheme, which is being tried in the state of Karnataka. The third is the Indian government's national Universal Health Insurance scheme. The overall objective in each case is to improve the access of the poor to quality healthcare at an affordable cost.

Micro-health insurance

The term 'micro-insurance' refers to the provision of insurance services for the poor, delivered through an intermediate agency, involving modest premium and benefit levels. The objective is to provide protection against variety of risks faced by the poor, including health risks. At present, micro-insurance schemes cover between 5 and 7 million people in India, and their potential is viewed to be considerable (ILO 2004).

On the demand side, the increase in micro-insurance reflects attempts by micro-finance institutions (MFIs) and non-governmental organizations (NGOs), already involved in micro-credit activities, to provide their clients with insurance against risk, including health risks. It has been complemented, on the supply side, by the regulatory requirement of the Indian Insurance Regulator (IRDA) that all insurance companies supply insurance to rural households and to certain disadvantaged social groups (e.g. those below the poverty line, persons with disability, the informal sector) (IRDA 2000).

To fulfill their obligations to the IRDA, insurance companies have launched a range of micro-insurance products, including micro-health insurance. The products are tailor-made, and involve modest premiums, limited benefits and design and implementation features shaped according to context. A recent inventory (ILO 2005) lists 83 products designed for disadvantaged groups in India, of which 14 deal with health insurance. Nine products propose reimbursement of hospitalization expenses while 5 products cover specific critical illnesses such as cancer (Table 1). Most health insurance products specifically exclude common health risks however, including delivery

Table 1 Health insurance products for disadvantaged groups in India

	HE	CI
Private insurance companies		
Shakthi Health Scheme	×	
Health Insurance Policy	×	
Individual Medclaim Insurance	×	
Critical Illness Insurance		×
Advanced Medical Insurance	×	
Term Insurance Plan		×
Sudarshan Endowment Policy		×
MoneyBack Plan		×
Endowment Assurance Plan		×
Parivar Suraksha	×	
Public insurance companies		
Gram Arogya Yojana	×	
Universal Health Insurance Scheme	×	
Package Insurance for Credit Society	×	
Mother Theresa Women and Children Policy	×	

Notes: HE implies hospital expenses; CI implies critical illness covered.

Source: ILO (2005)

and pregnancy-related illnesses, and the specialized risk of HIV/AIDS. Thus coverage of health risks is still somewhat limited.

In extending insurance cover to the poor, insurance companies collaborate closely with civic society associations, including community-based organisations, women's groups, informal sector trade unions, MFIs, NGOs, and micro-entrepreneurs' associations. These intermediaries, also referred to as 'nodal agencies', help companies overcome the informational disadvantages and high transaction costs involved in providing insurance to low-income groups. Often, formal insurance providers lack information on what risks to insure, what benefits to provide, how much premium to charge, and how to go about settling claims. A nodal agency that is familiar with the target groups helps insurance companies both with product design and with programme implementation.

Micro-health insurance therefore combines the positive features of formal insurance with those of informal insurance. Two examples of a nodal agency providing considerable assistance to an insurance company in providing micro-health insurance are the Karuna Trust, based in T. Narsipura district in Karnataka (Karuna Trust 2003), and the health insurance scheme of the Self Employed Woman's Association (Chatterjee 2003). Overall, the intermediaries are considered to be essential in extending insurance cover to the poor (Ahuja 2004).

One major advantage of micro-insurance is that it allows considerable flexibility to the parties negotiating a contract, making it easier to replicate and scale-up the successful cases. They are also easier to introduce, and more successful in functioning, where the nodal agency is also helping the insured members generate income. On the disadvantages, micro-insurance has limited potential in regions where nodal agencies cannot be readily identified. More generally, health insurance is by its very nature a complex activity and therefore tends to get lower priority than other risks, even when other risks rank lower in the priority of beneficiaries. Moreover, micro-health insurance schemes do not receive any public subsidy, and to that extent their reach may remain limited.

The Yeshasvini Scheme, Karnataka

Karnataka is one of the four southern states of India, with a population of around 55 million. The Yeshasvini health insurance scheme was introduced in 2002 with the objective of making quality healthcare facilities available to members of Karnataka's state co-operative societies. There are currently about 30,000 co-operative societies in the state, with a total membership of around 19 million people, mainly small or marginal farmers and workers based in rural areas. The scheme is premised on the widespread belief that government health centres are able to address primary healthcare needs, but lack the facilities to provide satisfactory surgical treatment. Private surgical treatment is expensive, and is one of the main causes of indebtedness of Indian farmers.

The Yeshasvini scheme is a voluntary programme. It provides for free hospitalization for 1,600 predefined surgical procedures, subject to a maximum of US\$ 4,444 per member per annum, and US\$ 2,222 per hospitalization episode. Free hospitalization includes accommodation, operation charges, anesthesia, and professional charges. For outpatient care, consultations are free but treatment costs have to be borne by the patient. Diagnostic services must also be paid for, although at subsidised rates.

The scheme is open to state co-operative members and their dependent family members (i.e., spouse and children). The only restriction is that a person must have been a co-operative member for at least 6 months prior to joining the scheme. The premium for membership in the programme was initially fixed at US\$2 per annum per member, of which one third was subsidised by the state government. In the current enrollment year (2005), the government subsidy has been eliminated and the premium charged is US\$ 2.67 per adult and US\$ 1.33 per individual below 18 years.

The Yeshasvini scheme is managed by a trust, called the Yeshasvini Trust, which bears all the risks associated with the venture. The trust is in turn managed by representatives from the Government of Karnataka and the Karnataka State Co-operative Society. The trust has hired the services of Family Health Plan Limited (FHPL) for implementing the scheme. Currently, there are a total of 135 quality hospitals and nursing homes extending treatment to members of the scheme, spread over 26 districts across the state. The FHPL negotiates tariffs at these participating hospitals, arranges for cashless treatment to be provided to beneficiaries, issues photo identity cards to members, and provides overall programme coordination. In return, it receives a commission of 5.5 per cent of the total premium.

The Yeshasvini scheme has attracted a large number of members. From an initial target of 2.5 million members, around 1.6 million members were enrolled in the first year, which increased to 2.1 million in the second year and is set to increase to 3.5 million in the third year. Around 60 percent of members in the first year renewed their membership in the second year. There is no systematic analysis of the satisfaction of the insured members, but the high membership renewal rate suggests that members find it worthwhile to join and remain in the scheme. Some of the factors contributing to the scheme's success include: government support at a high level, the large group of potential beneficiaries, the existing administrative set up of the cooperative societies,

and the fact that the scheme is in a state that already has fairly well developed healthcare facilities.

In a nutshell, the Yeshasvini programme has shown the way to insuring a large group of low-income members who are already organized for some common purpose. If the group is large enough the in-house management of the scheme becomes cost-effective. Initially, such interventions may need the support of the government by way of subsidy, and also for using government administrative machinery. However, since the scheme does not cover all risks requiring hospitalisation, it remains to be seen to what extent it can continue to experience a high membership renewal rate in the coming years. The continuous success of the intervention also needs the support of leaders in the healthcare industry as well as in government.

The Universal Health Insurance scheme

The national Universal Health Insurance (UHI) scheme was launched by the Government of India in July 2003. It was designed to reduce the financial demands on state governments from providing health insurance schemes for the poor in their respective states. Although health in India is a state subject, and public healthcare facilities are managed by state governments, insurance (including health insurance) falls under the purview of central government.

The name of the scheme is in fact a misnomer. The term 'universal' comes from the Government's intention of eventually covering all low-income people in the country with health insurance, although subsequently, the scheme has been made available only to those below the official poverty line (BPL). The premium for joining the scheme varies according to family size: US\$8.1 for an individual, US\$12.2 for a family of up to five members, and US\$16.2 for a family of up to seven members. The benefit package includes medical expenses of up to US\$ 667 per family in the event of hospitalisation, compensation for loss of wages at the rate of US\$ 1.1 per day for a maximum of 15 days in the case of illness, and US\$556 in the case of death of the main family earner due to personal accident. The scheme is offered by the four non-life public insurance companies, and managed with the help of third party administrators (TPAs). TPAs are independent agencies that arrange for cashless hospitalisation by coordinating between insurance companies, customers, and healthcare providers (see Bhat and Babu 2004).

The scheme was targeted to cover 10 million poor families in the first year. However, in the first nine months the scheme was able to cover only about 417,000 families, 48% of whom were in rural areas. It not only fell short in terms of meeting the aggregate numbers, but also in terms of the population for whom it was intended, i.e. the BPL population. The BPL families who bought the policy numbered only about 9,300. In addition, less than 1 per cent of the members actually made claims.

Following the national elections in 2004, the new incoming Government of India introduced two changes to the scheme (Chidambaram 2004). First, it raised the subsidy amount, and second, it restricted the scheme to the BPL population only. With the hike in the subsidy amount, the coverage of BPL families increased. By March 2005 around 65,000 BPL families were insured, with 31,000 families joining in the first two months of the

financial year (2005–06) alone. The total is therefore likely to increase as the year progresses.

Table 2 Premium and subsidy levels for the UHI scheme in 2003–04 and 2004–05

Member type	2003–04 Premium (subsidy)	2004–05 Premium (subsidy)
Individual	8.1 (2.2)	8.1 (4.4)
5–member family	12.2 (2.2)	12.2 (6.7)
7–member family	16.2 (2.2)	16.2 (8.9)

Notes: Figures are in US\$.

Nevertheless, the UHI scheme has still had rather limited coverage. This reflects a variety of problems, including:

- *incentive and ownership problems*: a low-value, subsidised product such as the UHI has the inherent problem of receiving lackadaisical response from insurance agents. Unless the interest of both the insurers and insurance agents is taken into account, the scheme is unlikely to get a significant boost from the supply-side;
- *product and insurer options*: in its current form, the scheme does not allow for any product variation, and is open only to public insurance companies. Product variation, with respect to the premium and benefits package, could make the insurance better suited to the needs of the low-income people. In this respect, the government should take advantage of the competitive insurance market and allow private insurers also to partake in UHI and receive the public subsidy;
- *streamlining healthcare provision*: in regions where healthcare provision is already weak, the introduction of health insurance must necessarily be accompanied by the strengthening of healthcare itself, which is the responsibility of state government.

The UHI scheme is still in experimentation. As a subsidised scheme it is attractive to the poor, but it lacks a nodal agency who can tap large groups. If state and local governments can get actively involved and act as a nodal agency, the scheme has a greater chance to succeed.

Lessons learned

From the three major initiatives considered in this paper, it appears that three conditions are essential for the success of health insurance for low-income people. These are:

- the provision of a certain minimum level of healthcare services of reasonable quality;
- the possibility of resource mobilisation from the targeted population so that part of the cost is recovered, and
- the presence of an intermediate or nodal agency, which could be a public agency or a civic society association.

The role of the nodal agency is particularly crucial in lowering transaction costs, through for example providing ready access to a group of potential customers, educating the poor, collecting premiums in a flexible manner, and ensuring that the benefits actually reach the target community. There is no presumption that these conditions would hold good in all contexts. Yet they provide

important insights into the design and implementation of health insurance programmes. Given that this field is relatively new and evolving in India, the constant evaluation of existing and emerging programmes is critical.

Another lesson that emerges from the above initiatives is the importance of public subsidies in providing health insurance to the poor, at least in the initial years. Given that some health insurance programmes have access to subsidies and some do not, a case can be made for the provision of subsidies with sunset clauses (as with the Yeshasvini scheme) to all health insurance products, below some minimum premium and benefit threshold, so as to put all health insurance initiatives on an equal footing.

Finally, there is a need for greater co-ordination between the different levels of government, as well as between different departments at the same level of government, and greater regulation of micro-health insurance schemes, to ensure that a meaningful level of benefits are available to the poor.

References and further reading

- Ahuja, R. (2004). Health Insurance for the Poor, *Economic and Political Weekly*, Vol. 34, No. 28.
- Bhat, R., and Babu, S.K. (2004). Health Insurance and Third Party Administrators: Issues and Challenges, *Economic and Political Weekly*, July.
- Chatterjee, M. (2003). *Strength in Solidarity: Experiences of SEWA Insurance*. VimoSEWA, Ahmedabad, Gujarat.
- Chidambaram, P. (2004). 2004–05 Budget Speech, Ministry of Finance, Government of India, Delhi.
- Devadasan, N. (2005). *Community Health Insurance in India*, Friends of Women World Banking, India.
- ILO (2004). *India: An Inventory of Community-based Micro-insurance Schemes. Strategies and Tools Against Social Exclusion and Poverty (STEP)*, February 2004.
- ILO (2005). *India: Insurance Products Provided by Insurance Companies to the Disadvantaged Groups in India, Strategies and Tools Against Social Exclusion and Poverty (STEP)*, March 2004.
- IRDA (2004). *Concept Paper on Need for Developing Micro-Insurance in India*, downloaded from: <http://www.irdaindia.org/>
- Karuna Trust (2003). *A Draft Report on Community Health Insurance, Karnataka Experience*, Mysore.
- Peters, D. et al. (2002). *Better Health Systems for India's Poor: Findings, Analysis, and Options*, The World Bank: Washington D.C.
- SHEPHERD (2003). *Insurance—A Safety Net to Poor, Self-Help Promotion for Health and Rural Development (SHEPHERD)*, Trichy, Tamil Nadu. See also: www.yeshasvini.org and www.sewainurance.org.

This paper was written by Rajeev Ahuja, Senior Fellow, Indian Council for Research on International Economic Relations (ICRIER), Core 6A, Fourth Floor, India Habitat Centre, Lodi Road, N. Delhi 110003, India. For more information please contact: ahujaahuja@yahoo.com. The author is grateful to Mr. K.V. Krishna for giving the latest statistics on universal health insurance scheme, and to Dr. Nandini Ali for furnishing the latest information on Yeshasvini scheme. It was edited by Edward Anderson of the Overseas Development Institute.

©Overseas Development Institute 2005

This and other papers are on our website: www.odi.org.uk/inter-regional_inequality

This Policy Brief has been produced by the Secretariat of the Inter-Regional Inequality Facility at the Overseas Development Institute, London. Initial sponsorship for the Facility has been provided by the UK Department for International Development.



The views in the paper are those of the author(s) and do not represent the official position of the institutions participating in the Inter-Regional Inequality Facility.