



GENERAL ARTICLE

MICRO HEALTH INSURANCE-AN OVERVIEW OF INDIAN SCENARIO

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Abstract

The Indian health system is mainly funded by out-of-pocket payments. More than 80% of health care expenditure is borne by individual households. Only about 3% of the population, mostly those in the formal sector, benefit from some form of health insurance. Several Indian Non-Governmental Organisations (NGOs) have initiated Micro Health Insurance (MHI) schemes within their existing development programmes. This article describes the principal features of the design and functioning of few MHI schemes and presents a brief overview of the current landscape of MHI in India. The schemes explicitly target the poorest and most vulnerable households in Indian society—scheduled tribes, scheduled castes and poor women. Three MHI management models can be distinguished. The first model consists of local NGOs acting as both insurer and provider. In the second model, the NGO is the insurer but does not itself provide care, which is then purchased from a private provider. In the third model, the NGO neither does provide health care nor acts as an insurer: the NGO, on behalf of a community, links with an insurer and purchases health care from a provider.

Keywords: micro health insurance, Community Based Health Insurance

Introduction

Health is a human right. It's accessibility and affordability has to be ensured. The escalating cost of medical treatment is beyond the reach of common man. While well to do segment of the population both in Rural and Urban areas have accessibility and affordability towards medical care, the same cannot be said about the people who belong to the poor segment of the society¹. Despite a multitude of legislations having been enacted for the health sector, the providers of healthcare in India continue to be poorly regulated, with no checks on pricing and often no checks on service quality. It is often felt that poverty and insurance do not go together; and insurance is totally beyond the affordability of the poor.^{1,2} In a developing country like India, this statement would hold good - to a certain extent. However, measures

should be taken to ensure that it is not wished away as just that; and to bring as many under-privileged people as possible under the ambit of insurance.

Macro and micro studies on the use of healthcare services show that the poor, especially the scheduled castes and tribes are forced to spend a significantly higher proportion of their income on health care than those who are better off, pushing their families into further poverty and indebtedness. This is particularly high when availing 'in-patient' care, with 'out of pocket' expenditure being significant even when accessing public care³. Sustainable models of health insurance with poor people paying premiums and obtaining benefits were not considered as a viable option for equitable health distribution and insurance

was associated with the upper and middle class as a predominantly city centred facility⁴.

The low public investment in health and the absence of any form of national social insurance have heightened insecurities, which perhaps is an important reason for community initiatives for financial protection from ill health. In a context where more than 80% of health care expenditure is out of pocket and only 3% of the population is covered by any form of insurance, MHI in India definitely does respond to a need, especially for poor households in the informal sector. In India, while 5 per cent of GDP is spent on health, the government contributes only 0.9 per cent towards it or less than Rs 100 per capita per year. Internationally, this is one of the lowest health expenditures by any government^{5,6,7}. More than 80 per cent of most government budgets are earmarked for salaries. However, over the last few years, Health Insurance initiatives have been proliferating rapidly. The ILO estimates more than 7.5 million Indians benefit the number of Community Based Health Insurance (CBHI) programs which have shown how a replicable, sustainable and a scalable model of community health insurance may be implemented. This paper attempted to explore some of the most characteristic features of Micro Health Insurance (MHI) in India.

Micro Health insurance – A Historical Perspective

Micro Health insurance (MHI) is defined as ‘any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks. The community has a role in the management of the programme’. This definition includes mutual health organisations (MHOs), local health insurances and Community health insurances (MHI).

Micro Health insurance schemes have many aliases. In the anglophone literature, the terms Community Health Insurance and Community-Based Health Insurance are used most frequently. Less common is the descriptor Mutual Health Organisation, although its

French equivalent Mutuelle de Santé is widely employed in francophone Africa, thereby emphasising an underlying social dynamic^{2,6}. In West Africa especially, scheme management relies considerably on community participation. In East Africa, where provider-driven schemes are encountered more frequently, the financial dimensions of CHI attract more attention. This latter approach to CHI is reflected in the use of the term Health micro-Insurance (HMI). The International Labour Organisation prefers to call them micro-health insurance. The main characteristics of micro-health insurance (MHI) are that they target the informal sector, farmers, labourers, vendors, housewives, etc. Secondly, they are usually not-for-profit enterprises, that plough any excess money back into the fund. And finally, the community usually has a role in initiating, implementing and managing the insurance funds. MHIs are not a new phenomenon. Way back in the 19th century, at the peak of the industrial revolution in Europe, labourers had no social security measures. To protect themselves from the hardships of illness and death, these labourers instituted local “sickness funds” that collected money for future contingencies. Over years, these sickness funds have federated and merged to form the large health insurance companies that exist today in many European countries. Again, this is not limited to Europe. In Asia, the jyorei scheme in Japan has a similar history. Then of course, there is the famous Chinese Rural Cooperative Medical System (RCMS), where the farmers contributed annually towards a common health fund that was used to finance the health services in the region.

Underlying Objectives of Micro insurance schemes

Most of the insurance programmes have been started as a reaction to the high health care costs and the failure of the government machinery to provide good quality care. The objectives range from “providing low cost health care” to “protecting the households from high hospitalisation costs.” BAIF, DHAN, and RAHA explicitly state that the

health insurance scheme was developed to prevent the individual member from bearing the financial burden of hospitalisation. Health insurance was also seen by some organisations as a method of encouraging participation by the community in their own health care. And finally, especially the more activist organisations (ACCORD, RAHA) used community health insurance as a measure to increase solidarity among its members – “one for all and all for one.

Scheme Design and Management

While the MHI movement is vibrant in Africa, it is slowly picking up momentum in India. Currently there are about 100+ MHIs in the country, many of which have begun operations in the past few years. ILO estimates that more than 1 crore individuals are members of CHI schemes in India⁷. Figure 1 MHI schemes in India can be broadly grouped into three type's .Type I or Provider model; Type II or Mutual model; Type III or Linked model^{8,9}. The first and the oldest type is the 'Provider or Direct' Model, where a hospital has initiated a health insurance product. Type I is the provider model where the hospital is both the provider of care as well as the insurer for the scheme. The classical example is the Medical Aid Programme by the Voluntary Health Services Only three schemes had premiums larger than Rs 100.for Community Organisation, Rehabilitation and Development) ,DHAN (Development of Humane Action), SEWA (Self Employed Women's Association), BAIF (Bhartiya Agro Industries Foundation), YESHASVINI, RAHA (Raigarh Ambikapur Health Association), SHH (Students Health Home), MGIMS (Mahatma Gandhi Institute of Medical Science), KARUNA, VHS (Voluntary Health Services).

Some Common Problems With Micro Health Insurance Schemes (MHI)

While there are many advantages of health insurance, there are some characteristic problems with health insurance that needs to be aware of which envisages adverse selection, moral hazard, cost escalation, administrative costs^{2,9}. Table 2 lists some of the provisions to

(VHS), Chennai. Here the VHS has organised the programme and its field workers collect an annual income-rated premium ranging from Rs 75 – to Rs 400. The insured is given a card which they can use in the VHS hospital only. When they fall sick, they go to the VHS hospital and get both outpatient and inpatient care. They have to pay a nominal amount; the rest is reimbursed from the insurance fund.

The second type is the 'Insurer Model' or 'Mutual' Model, where the NGO organises and implements the insurance scheme and purchases care from various providers. There are very few examples of this, the most famous being the Yeshasvini model. And finally, the most common type is the 'linked' model, where the NGO collects premium from the community and purchases insurance from a formal insurance company and healthcare from providers. The membership to these CHIs varies from 1000+ to more than 2 million. Most of these schemes operate in rural areas and cover people from the informal sector. Enrolment is usually facilitated by membership organisations, e.g. micro finance groups, cooperatives, trade unions. The premium ranges from Rs 20 to Rs 60 per individual per year.

mitigate adverse selection and moral hazard in Indian MHI schemes. Adverse selection occurs when those who anticipate needing healthcare choose to buy insurance more often than others. This happens when insurers lack full information about the risk of individual insured persons and there is an asymmetry of information. This will mean that an insurance scheme with adverse selection will be full of people with high risk of illness. This in turn results in a financial drain on the scheme and may challenge the viability of the scheme. However, in terms of public health logic, high-risk individuals are people who have a higher requirement of health services. So, through health insurance, these people are protected from high medical costs, because this is cross-subsidised by the healthy. Ways of countering adverse selection are by having a large enrolment unit, e.g. a family instead of

Name and Location of the MHI Target Population ,Year of Initiation As Well As Type of model	Target Population	Premium per year along the unit of enrollment
ACCORD Gudalur, Nilgiris, Tamil Nadu, 1992, Type I	Scheduled tribes of Gudalur taluk who are members Adivasi Munnetra Sangam (AMS) – the tribal union.	Rs.20/ per person
BAIF Uruli Kanchan, Pune, 2001, Type III	Poor women members of the community banking scheme and living in the 22 villages around Uruli kanchan town	Rs 225/per person
DHAN Foundation 2000, Type II	Poor women members of the community banking scheme and living in the villages of Mayiladumparia block.	Rs 100/per person
Karuna Trust T Narsipur Block, Mysore District, Karnataka, 2002, Type III	Total population of T Narsipur block and Bailhongal block, , with a focus on scheduled tribes and scheduled caste populations.	Rs 30/per person
RAHA Raigarh, Jashpur Korba districts of Chhattisgarh, 1986, Type I	Poor people living in the catchment area of the 92 rural and health centres and hostel students.	Rs 20/per person
SEWA 11 districts of Gujarat 1992, Type III	SEWA Union women members (urban and rural), plus their husbands living in 11 districts	Rs 23/ per person
Student's Health Home Kolkata, West Bengal 1952, Type I	Full-time student in West Bengal state, from Class 5 to university level.	Rs 4/per student
Yeshasvini Trust Bangalore, Karnataka 2003, Type II	Members of the cooperative societies in Karnataka	Rs 90/per person
MGIMS Hospital Wardha, Maharashtra 1981, Type I	The small farmers and landless labourers living in the 40 villages around Kasturba Hospital.	Rs30/ per person
Voluntary Health Services Chennai, Tamil Nadu 1972, Type I	Total population of the catchment area of 14 mini-health centres in the suburbs of Chennai.	Rs 250/ per family

Table 1: Micro health insurance schemes in India

Measures to mitigate adverse selection	<ul style="list-style-type: none"> • Definite collection period • Definite waiting period • Family as the unit of enrolment • Exclusions (in some schemes)
Measures to mitigate moral hazard	<ul style="list-style-type: none"> • Referral system • Co-payments • Definite upper limits

Table 2: list of provisions to mitigate adverse selection and moral hazard in Indian MHI scheme

individuals, setting specific collection and waiting periods, and making the insurance scheme compulsory. This means that those with low risk cannot opt out of the scheme and will subsidise the high risk. Moral hazard refers to the way in which insurance changes people’s perspectives. It is defined as “the tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have insured”. For example, knowing that he/she is insured, a person may indulge in more risky behaviour (e.g. smoking, fatty diet) or may use more health services. Consumer moral hazard can be countered by introducing

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co-payments, so that the patient shares some of the medical costs.

Conclusion:

It does become evident that many micro health insurance schemes have not only achieved good enrolment levels amongst their target populations, indicating the existence of demand, but from a policymaker’s perspective, these schemes have also improved access to health services for the poor. In a scenario where ill-health has been a major cause for impoverishment, the value of such financial protection doesn’t need to be reemphasized.

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