

A Pragmatic Approach to Universal Health Insurance
A case study of Karimnagar Experiment

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“ The essence of risk management lies in maximizing the areas where we have some control over the outcome while minimizing the areas where we have absolutely no control over the outcome.”

- Peter L. Bernstein
Against the Gods; The Remarkable Story of Risk.

Risk is inherent in all walks of life. Although inevitable, the financial consequences of risks can be minimized if one is aware of risk in the first place. Prudent risk management principles advocate minimization of the impact of uncontrollable losses. Insurance is one of the most scientific, rational, and practical risk management tool for personal property, life, health and liability risk exposures for an individual and as well for the societal loss exposures, based on the fundamental principles of *risk sharing* and *risk pooling*.

Now-a-days, in the process of imitating western lifestyles and food habits, one crucial area, which is often ignored in the run, is the side effects of such so called modern lifestyles. In the whole process, what is visible is that, illness and diseases of varied natures, not known to the earlier generations, are surfacing in children as well as across all age groups. As far as an individual is concerned, health risks can become catastrophic if he is not well prepared for it financially, although for the society as a whole there is very little risk, unless there is an outbreak of catastrophic events such as epidemics etc (*Rao, B.S.R. (2004)*).

Thus, health insurance has become a necessity for a common man, next to food, shelter and clothing. But for the common man, the financing of these expenses either catastrophic or sometimes even for frequently contracted illnesses, is also a major cause of mental agony. The cost of care may sometimes result in complete erosion of the family savings or may even lead to indebtedness as many studies on causes of rural indebtedness bear testimony.

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Health care insurance rightly provides the mechanism for both individuals and families to mitigate the financial burden of medical expenses in the present context. Hence, a well-designed, affordable, health insurance policy is the need of the hour. This again calls for right product, right pricing, and right promotional efforts on the part of insurance companies to meet the growing needs and demands of the consumers. Without access to such insurance, many people are unable to obtain treatment or must incur debts to pay hospital bills. [*Aims Worth, 1998*]

Issues concerning health and healthcare, of late, is gaining importance due to factors such as medical inflation, increasing life expectancies with advancement of preventive healthcare, increasing life style diseases, uncertainties with regard to employment and earnings. With virtual absence of health social security system in India at present, and a high proportion of national health spending being met by households, the need for a widespread health insurance system is urgent and pressing (*Gupta, Alope*)

All this calls for a good public policy on the accessibility and affordability of health care, and intervention of the government at appropriate stages and appropriate times. This calls for designing a public policy to make people aware of what they should do, or to provide them more of what they ought to get or less of what they should not have than what they desire to have (*Rao, B.S.R.2004*). Such a policy driven mass movement for health insurance would not only augment the quality of life for an average citizen but also provide the economies of scale in bringing down the medical costs thus making health insurance affordable in reality.

Further, a health insurance plan can also serve as an income protection plan for the poor (*Krishnan, T.N.*) With inadequate management of public facilities, consumer are forced to visit private facilities and incur large out-of-pocket expenditure for care that could otherwise have been available at no or little cost at Government facilities. In such a scenario health insurance serves as a means of financial protection against the risk of unexpected and expensive health care. [*Razvi, 2000*]

At present, in most of the developing countries including China and India, health insurance as a medium for financing healthcare is growing at a commendable rate. In India in particular, as the business figures for 2003-04 indicate the health insurance segment has shown a healthy 18 per cent growth at Rs. 1370.14 crore from Rs.1160.17 crore in the previous year as per the reports of the IRDA. The latest statistics show that the health care industry was worth Rs.5000 crore in the year ended March 2005, showing a growth of more than 200% over the last year. Presently the total worth of the health care sector comprising the service providers, pharmaceutical and medical devices manufacturers is estimated to be Rs.75000 crore. According to the sources in the ministry of health and

family welfare, by 2010, *lifestyle impact* diseases like cancer, and cardiac diseases will account for nearly 30% of inpatient ailments.

Understanding of the working system of health insurance basically requires understanding of *Healthcare as a system*, which is two-dimensional in its perspective, which includes provisioning and financing of the health care services. The *provisioning* of health care, especially in India, includes facilities for administering the health care services, such as clinics, hospitals, doctors, para-medical teams, availability of medical-equipment for diagnostic tests, medicines, etc. On the other hand, the *financing* of health care services refers to the sources from which the individual pays for his/her medical and hospitalization expenses. This source can be either from out-of-pocket, past savings, by raising loans or mandatory health schemes like the ESIS and the CGHS schemes. Further, the different methods of paying the service providers that are the doctors and hospitals also depend upon the health care system adapted in the country.

In a survey conducted in the state of Kerela, it was noticed that the most popular system of treatment preferred by 90 per cent of the Indian elderly is the allopathic treatment, and the remaining 10 per cent prefer either Aryurvedic or Homeopathy. Further the most common source of health services utilized is from Government Sector, followed by private clinics and hospitals [Rajan, 2000]

Healthcare organizations which basically act as financial as well as service intermediaries, can be arranged either on monopolistic, oligopolistic or competitive basis depending upon the cultural, economic and political philosophy of the government of the country. In India, now with the liberalization of the insurance sector, the industry is opened to a level playing field for the public as well as private companies for conducting the operations and to spread the awareness of insurance needs to the grass roots.

The second issue common to any system of health care financing and provisioning system is the rules regarding the rewarding of the providers, especially, the doctors and the hospitals which could be either incentives including *fee-for-service*, or *capitation payment* or *Salary system* and the rewarding of the hospitals could be either retrospective reimbursement or by prospective payment. Hence, for a viable health insurance mechanism to work and to sustain there should be clear-cut roles defined for all the major participants. In India, all combinations of these models can be seen. Healthcare models are required to suit the needs of the country. It can either be arranged for its provisioning and financing under the Private Health Care Insurance, or Direct Taxation or under the Public Health care insurance or purely privately arranged through the Health Maintenance Organizations.

In recent times, there has been a significant transition in India, wherein the concept of managed health care is gaining ground and importance. The *Health Maintenance Organizations*, which are products of private insurance systems, to provide comprehensive health care for a fixed, periodic per-capita payment (or premium) is gaining momentum. Another approach for enabling the lesser fortunate segments of populations to the health care facilities, is soon catching attention is that of micro insurance along with micro financing, at the grass root level which can be implemented by involving the Panchayat system (*Chakravarthi, Srabanthi 2005*). In India some of the reasons for the existing low penetration of the health insurance segment is because of low per capita incomes, high BPL rate, low educational understanding, low priority due to lack of awareness.

However, although India's estimated expenditure on health is amongst the highest among the developing countries, in terms of expenditure relative to GDP, its absolute per capita expenditure compares poorly with that of the other countries as shown in the Table:1 according to the World Health Report, 2002.

Table: 1 Per Capita / Total Expenditure on Health as a Percentage of GDP of select countries

Countries	Per capita expenditure on health at official exchange rate(US\$)	Per capita expenditure on health in international dollars	Total expenditure on health as a % of GDP
United States	4,499	4,499	13 %
Singapore	814	913	3.5
Argentina	658	1091	8.6
Brazil	267	631	8.3
South Africa	255	663	8.8
Thailand	71	237	3.7
China	45	205	5.3
India	23	71	4.9

Source: World Health report 2002, WHO, as cited in Asia Insurance Post Dec.2003

As seen above, India spent 4.9 percent of its Gross Domestic Product (GDP) on health in 2000, of which around 17.8 per cent was accounted for by government expenditure on health. Presently, health spending in India is 6 per cent of the gross domestic product (GDP), and is one of the highest in Asia and in the next five years is estimated to increase to around 7.5 % of the GDP. The health care financing in India has been recognized since independence as an essential social sector investment. It was therefore envisaged that health services in government institutions would be provided free of cost to all. But this scheme could not be continued for long, with increasing awareness and expectations of the people and rising health care costs.

Nevertheless, the government of India has been consistently increasing investment on the health and family welfare sector, showing its concern for the spread of health care services in different plan periods in Public Sector, Center, States, and Union territories as shown below in Table 2.

Table: 2 Pattern of Investment on Health and Family Welfare in Different Plans in India

	Five - Year Plans Period									
	First Plan	Second Plan	Third Plan	Fourth Plan	Fifth Plan	Sixth Plan	Seventh Plan	Eighth Plan	Ninth Plan	Tenth Plan
Health	65.2	140.8	225.9	335.5	760.8	2025.2	3688.6	7494.2	1981.4	31020.3
Family welfare	0.10	5.0	24.9	278.0	491.8	1387.0	3120.8	6500.0	15120.2	27125.0

(Source: Tenth -Five -Year plan Report, Pp.76)

The investment of Indian government in the health sector showed a significant increase over the plan periods, from a meager Rs.65.2 crore, in the first plan to Rs.31020.3 Crore in the tenth plan showing the commitment of the government to the cause.

However, in the Ninth Plan, it was decided that only essential primary health care, emergency life saving services, services under disease control programmes, and family welfare programmes would be provided free of cost. The Central and the State governments initiated, in a phased manner, user charges for people above the poverty line for other services and hospitalization.

Given India's size and the fact that health is a state subject, there are inter-state differences in spending patterns on health. However, the central government provides funds to states under centrally sponsored schemes uniformly, per capita expenditure in states vary depending upon the prevalence of diseases and utilization of funds allocated. The information furnished below in Table 3 shows the existing Health status differentials in the states. At one end of the spectrum are states like Bihar, Madhya Pradesh, Uttar Pradesh and Orissa with low per capita expenditure, poor access to health care and poor health indices. At the other end are Kerala, Punjab, and Tamil Nadu with high expenditure and good health indices. In spite of relatively high expenditure, however Rajasthan and Assam continue to have poor health indices.

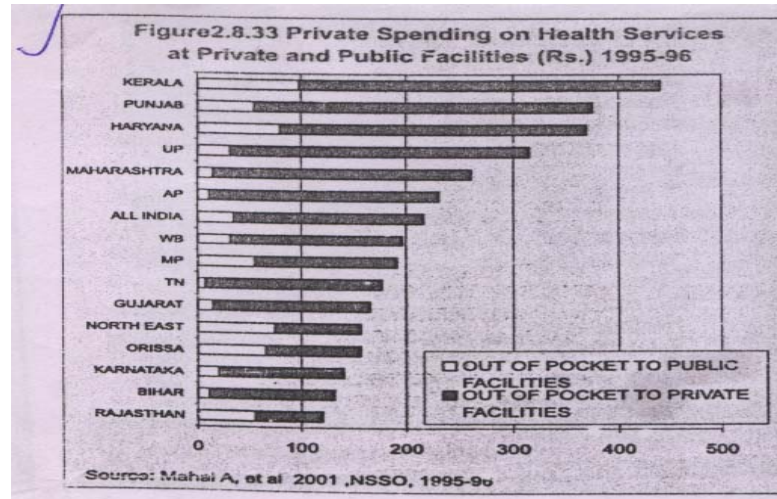
Table : 3 **Differentials in Health Status in India**

Sector	Health Indicators						
	Populations BPL (%)	IMR/1000 Live Births (1999 – SRS)	< 5 Mortality 1000 (NFHS-2)	Wt For age % of children <3yrs (<2SD)	MMR/ lakh (Annual Report,2000)	Leprosy Cases/ 10000 population	Malaria +ve Cases in year 2000 (in '000s)
India	26.10	70	94.9	47.0	408	3.7	2200
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	45	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharashtra	25.02	48	58.1	50	135	3.1	138
Tamil Nadu	21.12	52	63.3	37	79	4.7	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
Uttar Pradesh	31.15	84	122.5	52	707	4.3	99
Madhya Pradesh	37.43	90	137.6	55	498	3.88	528
BPL- Below Poverty Line; IMR- Infant Mortality rate; NFHS-2- 2 nd National Family Health Survey; SD- Standard Deviaton; MMR – Maternal Mortality Rate.							
Source: Health in India: Current Scenario & Future Directions; P Savan (August 2004), as cited in “Health for All Through Panchayat in West Bengal”, Srabanti Chakravarthi, Insurance Chronicle, July 2005 Pp. 63-74							

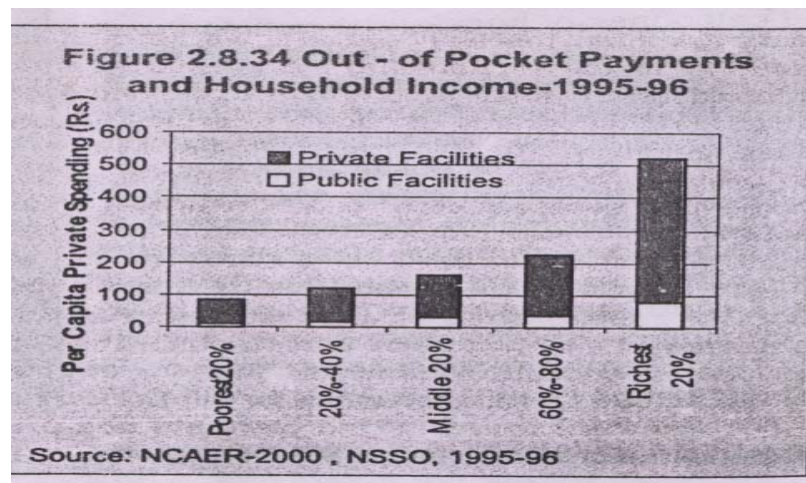
Health care financing in India: some insights

The Tenth five-year plan report has given some deeper insight into the health care financing status in India. The report states that in India financing of health care is mostly from out-of-pocket in both the public and private –funded hospitals as shown in the figure below. Again there are massive differences in private spending on health care services in public and private facilities. Patients in the states of Kerela and Punjab spend about four

times more on health as compared to patients in Bihar, while in Rajasthan, the expenditure in private and government hospitals is almost equal, because the state has implemented the user cost and the cost for drugs as seen below in Figure 1.

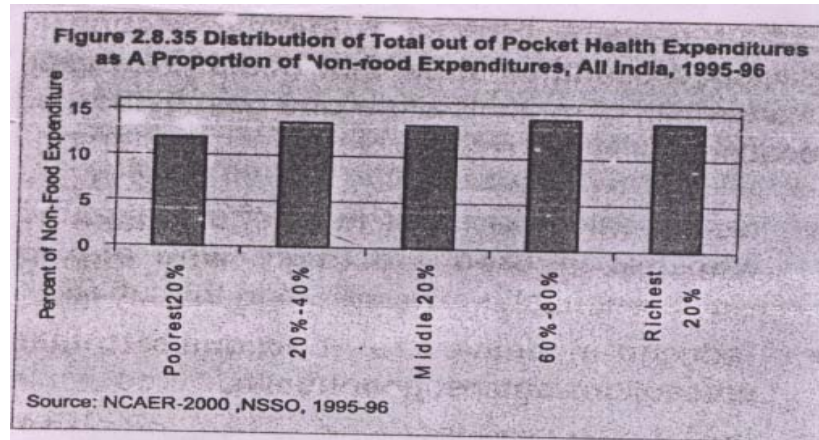


Further, in India the poorer segments of population have less access to both public and private sector curative services than the better off sections. The out-of-pocket expense on both public and private facilities for the lowest quintile is about one-fifth that of the highest quintile population as shown in Figure 2. The private health care expenditure is four times that of public health care and there is little preference for Government health delivery system vis-à-vis the private. This is because of the poor quality services in the Government managed facilities. [Gumber, Kulkarni, Chaterjee, 2001]

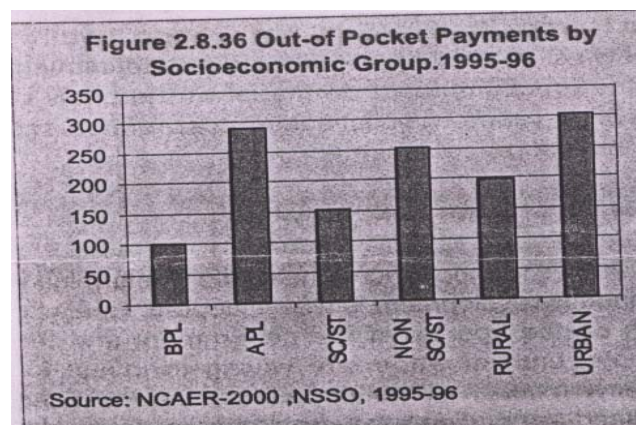


It means that the richest quintile utilize both the private and public facilities more than the poorest quintile.

On further analysis of the sources of finances for health care, the tenth plan report reiterated that, *out-of-pocket* is the most common method of payment for the private health care services. The poorest 20 per cent of the population spend 12 per cent of the *non-food* expenditure on health care, while the richest about 14 per cent as shown below in Figure 3.

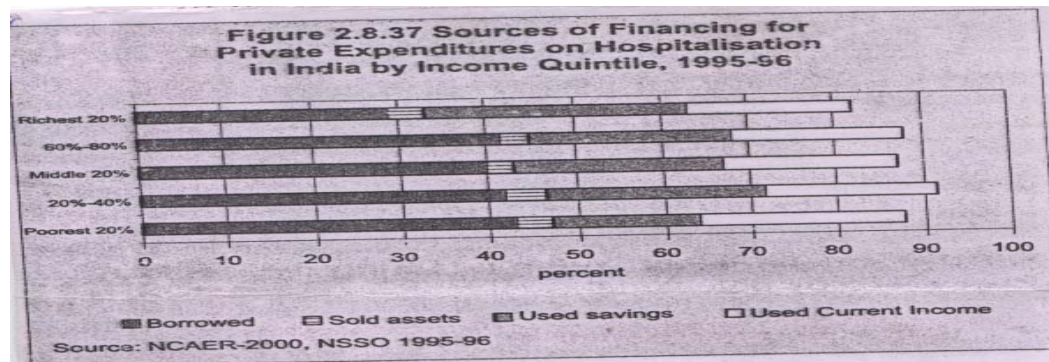


The out-of-pocket spending for private health care is also dependent upon the availability and accessibility to quality health care. Hence, it is seen that the out-of-pocket expenditure of the SC/ST population in India is higher than the BPL families because they have greater problem in the access of health care services. At the same time the urban population spend more than their rural counterparts because they have ready accessibility to quality and hi-tech health care as seen below in the Figure 4.



The above figure shows the out-of-pocket payments by different socioeconomic groups in India.

Mechanisms by which different income groups meet the out-of-pocket expenses for hospitalization are shown below in Figure 5



As seen in the above figures, hospitalization for major illnesses is a cause of indebtedness in all income groups. The various include, borrowings, sale of assets, savings, and current incomes also. Thus it is clear that financing health costs may ultimately ruin an individual financially. Hence it is also imperative on the part of the government to come to the rescue of some segments of the population which cannot on its own look after its health care needs.

The government of India in its effort to bring in health care reforms implemented some programs in the Tenth Five-Year Plan [2002-07] which include addressing the issues of need and equity in access to health care and at the same time devising a targeting mechanism by which people below the poverty line have ready access to health services to meet essential health care needs, while those above the poverty line pay for services both in government and private care facilities. The government of India has emphasized in the current plan that there is an urgent need to evolve, implement and evaluate an appropriate scheme for health financing for different income groups which include *health insurance* for individuals, institutions, industries and *social insurance* for BPL families.

In its effort to make available health care facilities, the experiment of the health care provider “Pratima” in Karimnagar is note worthy. In tune with the “Corporate Social Responsibility” of the health insurance providers, precisely the health care providers, in Karimnagar, the Pratima Institute of Medical Sciences (PMIS) have taken upon themselves to make available the benefits of all hi-tech health care services and to

reach a wider segments of population including that of the lowest of the lowest i.e. the BPL segment, the micro insurance clients. This mission and vision of the corporate provider “Pratima Hospital” is achieved with the introduction of the novel schemes.

Thalli Bidda Samrakshana Pathakam Scheme { exclusively for pregnant women }

This scheme is a typical scheme exclusively for women, to take care of her pregnancy related costs and expenses. On the payment of Rs.2000/ from the time of inception of pregnancy, till delivery including caesarian, all the risks, and hazards are covered. The cover includes, the monthly check-up costs, investigations, medicines, and any other complication at the time of delivery. The scheme does not discriminate women on the basis of economic status. The success of the scheme is clear from the data given below in Table 4.

Table :4 Thalli Bidda Samrakshana Pathakam Scheme

Registrations of members from August 2003 – June 2005			
	2003	2004	2005
Total registrations	460	1047	700
Average monthly registrations	92	87	116
Total registrations till date	2207		
Total Deliveries Done till date	1851		
Percentage of deliveries	83.6 %		

(Source: PIMS hospital records)

Hospital sources place on record that out of the total deliveries performed, the cases of normal and caesarian deliveries constitute 50 percent each. Further, the beneficiaries are mostly from the low socio economic strata.

Mee Athmeeyulam (for all)

This second scheme is also a unique scheme where in the hospitalization expenses and surgical expenses are not charged to the patient at all. The patient is required to buy medicines and all consumables at his own cost. On the diagnostic tests also they are given a discount of up to 25 percent of the costs. The figures of this scheme reveal the success of the scheme as seen in Table5.

Table: 5 Mee Athmeeyulam Scheme

Admissions from August 2003 – June 2005			
	2003	2004	2005
Total	328	994	539
Average monthly admissions	65	82	89
Total admissions till date	1861		

(Source: PIMS hospital records)

The male beneficiaries of the scheme, according to the hospital records comprise 70 per cent and the female 30 per cent of the total. Further, out of the males 70 per cent of the beneficiaries are from the age group 40-70 years. 80 per cent of the treatment given under the schemes is for surgical operations including for Hernias, Lumps, Tumors, Hydrocele and other complicated issues and the remaining 20 per cent is medical services. Majority of the beneficiaries are from the lower socio economic strata of the society.

Karimnagar Arogya Raksha Pathakam (Proposed Plan)

The Objective of the proposed Scheme is “to provide good hospital services to the rural poor population residing in Karimnagar and falling under the category of eligible beneficiaries as defined under the scheme covering the revenue district of Karimnagar

This is a proposed health care insurance scheme, which involves the active participation of the

- Zilla Samakhya (District Federation) of Self Help Groups, Karimnagar District, a society established with the support of the Indira Kranthi Patham (IKP) program being implemented by the Society for Elimination of Rural Poverty, Government of Andhra Pradesh, having its District Administrative office at Karimnagar, Andhra Pradesh.
- Prathima Hospital - the health care provider
- District Project Management Unit, IKP, Karimnagar, Government of Andhra Pradesh.

The hospital is actively engaged in the public service in Karimnagar District and is recognized as referral a hospital for employees’ insured under the ESI Act and also as recognized hospital for the treatment for the government employees. The Society for Elimination of Rural Poverty is an independent registered society formed in Karimnagar under the Government initiative and is engaged in rural poverty reduction activities including improved access to essential health and education services for the poorest households. The Arogya Raksha Patakam is a scheme proposed for the provision of essential health services to Self Help group members of Karimnagar District with the joint initiative and collaboration and support of government machinery of the IKP program, who will act as facilitator at all levels.

The health care scheme is for the beneficiaries who include the family of the SHG members consisting of the member, and dependent members not exceeding four in number, of whom at least one of the family member shall be a member of the SHG recognised and recommended by the Zilla Samakhya. All persons in such families irrespective of their age are eligible to enroll in the scheme. The monetary benefit is set at Rs.60,000 for the family of 5 or less and not for individuals. Un-availed portion of the benefit shall expire on the completion of the benefit period. The benefit period shall be a period of 3 years or 36 calendar months from and including the calendar month of commencement. The health

services under the scheme include medical services of Investigations, out –patient and In-patient charges, and other Surgical treatment in listed departments. The consideration of the health services undertaken by the hospital, the sponsor undertakes the responsibility to pay 448/- per beneficiary, or to pay the premium amount in three installments under 1st installment of 25 % of the premium on the commencement of the policy, 2nd installment of 50% at the end of 3rd month of commencement of the policy, and 3rd or last installment of 25% by the end of 12 months, after commencement of the policy.

The unique achievement of these schemes is that, there was no formal marketing efforts of any nature undertaken by the organization, and on the other hand, although the local RMP and PMP doctors, tried to scuttle the schemes; still, the scheme could reach the needy through the *word of mouth*. Moreover a survey conducted by students of MBA program on the satisfactory levels of the beneficiaries of these scheme revealed their utmost satisfaction and trust in the organization.

The survey results provide proof of the satisfaction of the beneficiaries of the schemes. Almost all the beneficiaries became aware of the hospital only through word –of- mouth publicity. 73 per cent of them believe that the services of the hospital are reachable. 87 per cent of the total are highly satisfied with the doctor’s services, and 76 per cent with the pharmacy services. 50 per cent of the beneficiaries also emphasize that the service of this hospital is better compared to other hospitals. Further, an analysis on opinion on the cost of service shows that 17 per cent of the users consider the cost to be high, while 57 per cent regard it as inexpensive and the remaining 36 per cent of them believe that they are getting *value for money*. Lastly, 85 per cent of the beneficiaries opine that such schemes are advantageous to the poor and needy. On the whole, the hospital services are rated as excellent by 24 per cent , while 69 per cent rate them as good, 14 per cent as average and only 3 per cent as poor.

Conclusion

Thus, with the active involvement of the IRDA, the insurance companies, and the hospitals as service providers and other organizations such as the NGO's as facilitators, micro health insurance in India indeed would become a reality. Moreover the recent initiatives of IRDA in the constitution of the committees for bringing in reforms into the health sector is noteworthy.

The recommendations of the committees, including introduction of long-term savings linked health products that would serve as an incentive for the younger people to buy health insurance. Stand alone health insurance companies with lower capital and hospitals to be made as stakeholders to curtail costs can be effective when monitoring of the whole system is good. Although the introduction of the savings – linked scheme is a novel idea, the stand-alone company with a narrow capital base is a matter of doubt, and will have to be examined carefully in the context of solvency norms as required by IRDA. The idea of the hospital being made a stakeholder is seen as a check against the problem of moral hazard to some extent and will help in the speedy settlement of claims.

The paper suggests the replication of the schemes such as these successfully experimented in Karimnagar, Andhra Pradesh, in other parts of India, with the government machinery monitoring the implementation of the schemes, and the insurance companies as the sole facilitator in the role of the promoter of the schemes

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