Global Perspectives on Health Insurance for the Poor

Susan Matthies, Ph.D.

A Global Visit to India's Future

THE PRESENT

- One billion without insurance
- Out of pocket > 75%
- Public expenditure about 5%
- Primary care and preventive services inadequate/unavailable
- Impoverishment due to hospital expenditures

THE FUTURE

- Nearly all have health insurance
- Out of pocket < 25%
- Public expenditure greater than 30%
- Primary care and preventive services accessible for all
- No impoverishment due to hospital expenditures

Insurance Programs to be considered from:

- China
- Colombia
- United States
- Eastern Europe
- Switzerland
- Netherlands
- Japan
- Taiwan

Results of the Rural Mutual Health Care Scheme in China[1]

- Joint financing - government & household (2005)
- Self-governance by village community
- **Reform of services to include prevention & basic services** (selective contracting with physicians paid a **salary** and bulk purchasing of drugs)
- Insurance covers basic care as well as catastrophic care
- Voluntary enrollment - Project pays 98 rs/person/year, farmers select one of three packages and prepay 57 rs to 86 rs/person/year,depending on the package. Very poor are fully subsidized.

RMHC Results I

- Impact on Utilization by Income Quartile
  - Lowest 25% increased outpatient by 100%
  - Middle 50% increased outpatient by 62%
  - Highest 25% increased outpatient by 90%
- Impact on Utilization by Chronic Condition
  - With chronic condition increased outpatient by 100%
  - Without chronic condition increased outpatient by 70%

RMHC Results II

Impact on Health Status:

- Lowest income had the greatest reported improvement in health measured by mobility, daily activity, pain, or depression
- Those “ill” experienced a greater decrease in reporting “any problem” than those not chronically ill
- Those older than 55 years benefited most in terms of improved mobility and usual activities

RMHC Results III

- 70%+ voluntarily enrolled
- Adverse selection is serious (increased average cost of premium by more than 10%)
- Prevention, basic health services and essential drugs made available at the village level.
- Access and use significantly improved
- Equity--improved
- Risk protection reduced impoverishment by 30% to 50%, depending on measurement used.
- Public Satisfaction greater than 90%.

Universal Healthcare: the Colombia Experience[2]

- In 1993 Subsidized Health Insurance Regime Introduced along with the existing Contributory Regime (CR)
- **Joint financing - general taxes, payroll taxes & household contribution based on ability-to-pay**
- From 1993 to 2008 enrollment increased from 24% to 92% of the population
- Changed the composition of health financing from:
  - 44% out of pocket to 8%
  - 23% general taxes to 40%
  - 26% payroll taxes to 45%

Colombia Experience: Results

- Barriers to access
  - Demand side decreased from 36% to 7%
  - **Supply side increased from 6% to 18%**
- Access and utilization improved in both the subsidized and contributory regimes
  - Compared to similar people without insurance, the insured are 38% more likely to receive care when needed and 40% more likely to have used ambulatory services in the last 12 months.
- Both formal workers affiliated to the CR and informal workers had lower probability of catastrophic health expenditure than non-affiliated workers. (42 and 75% respectively)

Employment-Based Insurance: the U.S. Experience[5]

- Initially quasi-social insurance underwritten by non-profit Blue Cross/Blue Shield and using community rating: considerable cross-subsidization of insurance across industries and firms in the same community and across workers in the same firm.
- Introduction of multiple insurers resulted in premiums based on actuarial information/ utilization experience.
- Community rating could not survive when beneficiaries with lower costs were offered a lower premium and skimmed off the community-rated pool
- 15% of the population is without health insurance

Employment-Based Insurance: the U.S. Experience (continued)

Other Problems

- Comparatively high administrative costs (13%)
- Inequitable sharing of costs - sick pay more
- Inability to cover large segments of the population (students, unemployed, small businesses etc.)
- Contribution to labor-management strife
  - "Job Lock" - inefficient employment decisions
  - Management reduces coverage or reduces wages

Employment-Based Insurance: the U.S. Experience (continued)

More Problems

- Inability of employers to act collectively to make health care more cost-effective
  - Perpetuates the inefficiencies inherent in the fragmented, uncoordinated fee-for-service (FFS) small-scale practice model that still accounts for most of U.S. health care delivery.
  - **FFS contains incentives for overuse, under use of prevention, and misuse; it pays more to providers who cause complications or are slow to make a diagnosis. FFS pays for volume, not quality.**

Social Health Insurance (SHI) in Eastern Europe[3]

Goals

- Expand mandatory coverage
- Contain costs
- Improve quality of care
- Extend voluntary supplementary private insurance

Tools

- Increase provider competition
- **Define minimum benefits package**
- Assess technology to provide evidence for coverage & investments

Some Problems with Social Health Insurance[4]

- Quality of care uneven partly because of poor regulation of/by SHI purchasers.
- Costs of collecting revenues can be substantial, even in the formal sector where non-enrollment and evasion are commonplace
- Difficult to prevent fraud and abuse even with modern information systems
- Does a poor job of covering the non-poor informal sector workers until the economy has reached a high level of economic development

Advantages of Mandated verses Voluntary Health Insurance[6,7]

- Sets affordability standard as contributions toward premiums or cost sharing (co-payments, coinsurance, and deductibles), or both are required.
- Addresses the problem of those who are already eligible for public programs but fail to seek/obtain coverage.
- Levels the playing field by forcing employers or individuals who have been using publicly funded services to pay their fair share of the cost of coverage
- Addresses insurers' concerns that only less healthy people will choose to participate compared to a voluntary program

Recent Mandate: Switzerland[7]

Switzerland faced the 2nd highest health expenditures per capita on the globe

- In 1994 changed from voluntary employment-based system to mandated insurance with no insurance profits on the fixed basic care plan and no “cherry picking” permitted.
- Ten years later the companies are doing fine, administration costs are down to 5.5% and the public is satisfied with the lower premium and slower out of pocket cost increases.

Recent Mandate: Netherlands[7]

- In 2006, Netherlands changed from social sickness funds for 60% of population to a private insurance system using competition and a small dose of regulation to achieve universal coverage and a tighter lid on costs
- All citizens must purchase insurance or pay a hefty fine (130% of premium) and all insurers must offer a policy to anyone who applies
- Income related subsidies are offered to those who cannot afford insurance
- Only 1.1% of citizens failed to enroll in the new program

Cost Control Ideas from the Health Care System in Japan[8]

- All insurers are non-profits, no pre-existing conditions' exclusions permitted
- Rates are negotiated for all procedures/services with all medical personnel. If the volume of services increases, the price per service decreases so that the budget for that service remains the same.
- M.D.s still make house calls

Taiwan's Approach to Health Reform[8]

- Invited experts from 26 countries in mid-90's to consult
- Chose no opt out for the rich (unlike Germany)
- Chose single payer system (like Canada)
- Chose mandated universal coverage (like almost all industrialized countries)
- Chose no gatekeepers BUT if patients have too many visits compared to average patient of same type, they get a visit from the health insurance plan to discuss this.

Some Conclusions

- Sustainability = affordability of (out-of-pocket + subsidies) for any given level of benefits.
- Cost control is the essential counterpart to expanding benefits and beneficiaries
- Increase in coverage can create barriers to access because of insufficient/inadequate supply
- Adapt what you learn to the context of India
- Be prepared for trial, error and change
- Lastly, we will appreciate your advice in the U.S. as we work to improve our own system

End Notes/Sources

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2. *The Impact of Subsidized Health Insurance on Access, Utilization and Health Status in Colombia*, Ursula Giedion, Eduardo Andres, Alfonso Yadira, Beatrice Diaz , Bill Savedoff , May 2007 and Catastrophic and Impoverishing Health Spending and Financial Protection in Latin America: The Case of Colombia, Carmen Elisa Flórez Nieto, Ursula Giedion , Renata Pardo, Eduardo Andres Alfonso, June 2007

3. *Health Insurance Coverage In Central And Eastern Europe: Trends And Challenges*, Hugh R. Waters, Jessica Hobart, Christopher B. Forrest, Karen Kinder Siemens, Patricia M. Pittman, Ananthram Murthy, Glenn Bruce Vanderver, Gerard F. Anderson, and Laura L. Morlock

4. *Social Health Insurance Reconsidered*, World Bank, http://econ.worldbank.org/external/default/main?pagePK=64165259&theSitePK=469372&piPK=64165421&menuPK=641660

End Notes/Sources (continued)

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6. **Setting A Standard Of Affordability For Health Insurance Coverage,** *Health Affairs*, 26, no. 4 (2007): w463-w473 **(Published online 4 June 2007) doi: 10.1377/hlthaff.26.4.w463 © 2007 Project HOPE,** Linda J. Blumberg, John Holahan, Jack Hadley and Katharine Nordahl

7. **Consider It Done? The Likely Efficacy Of Mandates For Health Insurance, Sherry A. Glied, Jacob Hartz and Genessa Giorgi***Health Affairs*, 26, no. 6 (2007): 1612-1621 doi: 10.1377/hlthaff.26.6.1612 © 2007 by Project HOPE

8. *Sick Around the Work: What can the U.S. Learn From Other Countries?*, Frontline, PBS, April 15, 2008

MAKING HEALTH INSURANCE WORK FOR THE POOR

USAID-GTZ Conference, May 5-6, 2008

The Way Forward:
Linking Formal and Informal Systems

OVERVIEW OF SOME EXPERIENCES WORLWIDE

ILO SUBREGIONAL OFFICE, NEW DELHI

STEP (Strategies and Tools against social Exclusion and Poverty) Asia Coordination

ILO STEP 2003/2004 INVENTORIES

	Africa (11 countries)	Asia			
		India	Nepal	Philippines	Bangladesh
Systems	366	43	21	41	20
Beneficiaries	1'928'438	6'120'265	173'447	1'378'669	18'043'743
< 1'000 1'000-9'999 10'000-99'999 >100'000	64% 29% 6% 1%	9% 34% 37% 20%	29% 52% 19% 0%	30% 27,5% 35% 7,5%	11% 31% 26% 32%
Principle risks covered	Health 100% (no information of other risks)	Life 61% Health 56% Disabil 25%	Health 52% Life 38% Accid 24%	Health 71% Life 20%	Life 75% Health 45% Loans 40% Health 39%
Health risks covered	Matern 92% Meds 81% Hospi 72%	Matern 10% Hospi 50% Other 27%	Matern 14% Hospi 33% Other 33%	Hospi 66% Matern 46% Other 49%	Hospi 11% Maternity 6% Other 39%

ILO STEP 2003/2004 Inventories

	Population	MIS beneficiaries	Coverage by MIS	Coverage of health risks
Africa (11 countries)	112'341'000	1'928'438	**1.7%**	**1.7%**
Asia	1'317'361'000	25'716'124	**2.0%**	**0.77%**
India	1'065'462'000	6'120'265	**0.6%**	
Philippines	79'999'000	1'378'669	**1.7%**	
Nepal	25'164'000	173'447	**0.7%**	
Bangladesh	146'736'000	18'043'743	**12.3%**	
Benin	6'736'000	42'330	**0.6%**	
Burkina-Faso	13'002'000	14'690	**0.1%**	
Cameroon	16'018'000	8'736	**0.1%**	
Ivory Coast	16'631'000	858'361	**5.2%**	
Guinea	8'480'000	88'439	**1.0%**	
Mali	13'007'000	499'837	**3.8%**	
Mauritania	2'893'000	13'055	**0.5%**	
Niger	11'972'000	84'372	**0.7%**	
Senegal	10'095'000	294'035	**2.9%**	
Tchad	8'598'000	2'071	**0.0%**	
Togo	4'909'000	22'512	**0.5%**	

Weak in % of the total population

HEALTH MICRO-INSURANCE: THE SITUATION IN ASIA

	N0 OF SCHEMES	N0 OF BENEFIC.
BANGLADESH	14	900,000
CAMBODIA	2	40,000
INDIA	105	13,000,000
LAOS	5	50,000
NEPAL	15	44,000
PAKISTAN	4	450,000
PHILIPPINES	57	615,000
SRI LANKA	3	100,000
TOTAL	**205**	**15,199,000**

Comparative advantages

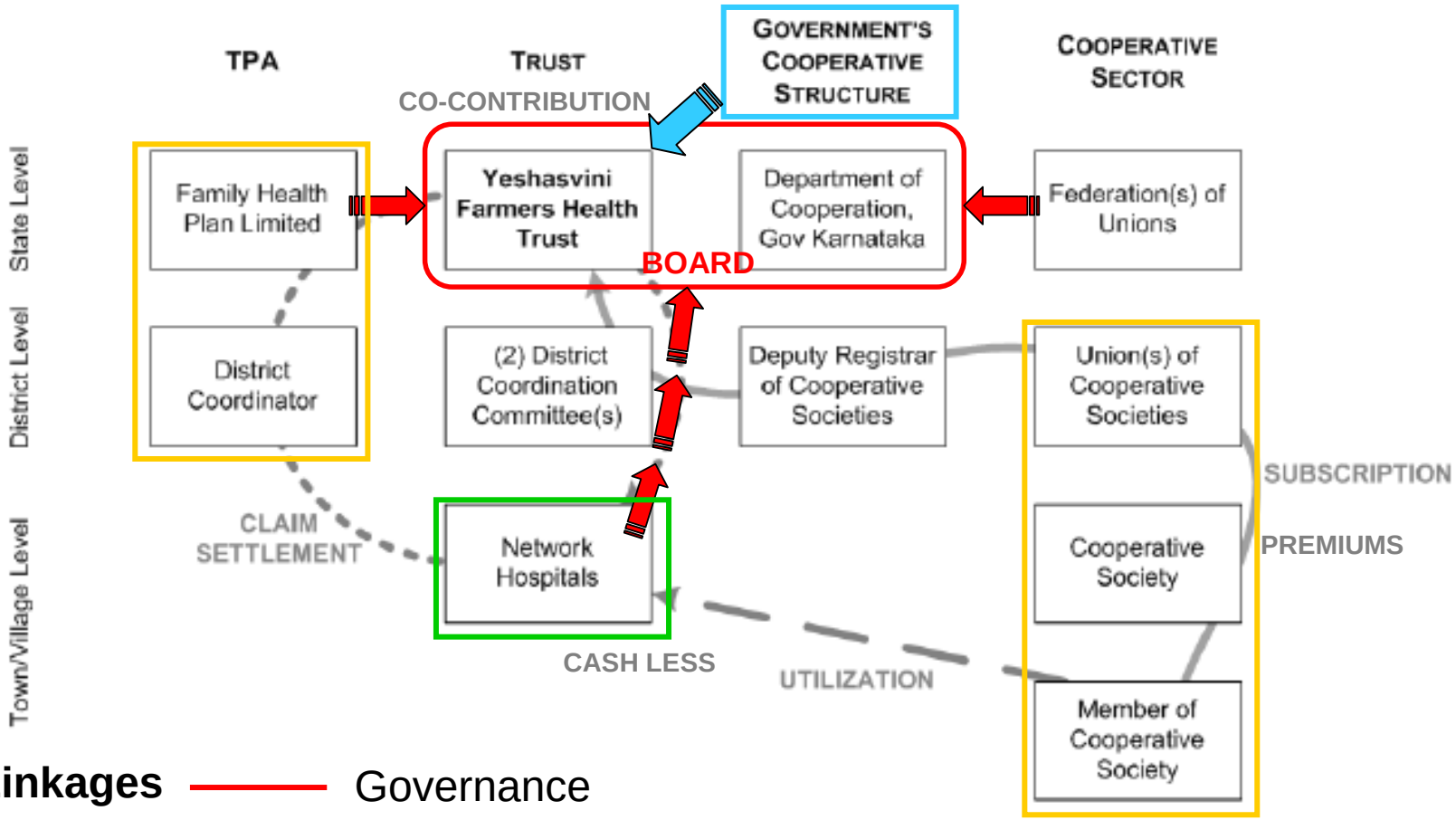
	Statutory SS schemes	& CBHI schemes
Ability to cover IE workers?	**NO.** Civil servants, workers in employment relationship of a certain level of formality	**YES.** IE workers clustering around certain characteristics (occupational, regional)
Affordability?	**NO.** Relatively high and shared by employers and employees	**YES.** Low levels, corresponding to ability to pay
Well suited benefits?	☺ Comprehensive *But* standardized benefit packages	☹ Limited scope and levels *But* well suited to priority needs
Redistribution?	**YES.** Linked with income	**NO.** Flat rate contributions
Risk pool, financial consolidation?	**YES.** Big and geographical diversified risk pools Steady contribution income flows	**NO.** Small and varying size of risk pool Income difficult to predict
Management & administrative procedures?	☺ Computerized MIS, trained staff *But* high standardization, difficult to adapt to non standard groups	☹ Low level of sophistication and training *But* adapted to characteristics of target, low transaction costs, prevention of fraud
Contracting power?	**YES.** Contracting power and agree-ments at a national / regional scope	**LOCAL.** Contracting power and agreements at the local level
Policy planning	Top down policy approach	Bottom up with / without policy support

Country case studies: The Yeshasvini scheme

Where?	Karnataka, India
Why?	Dr Shetty, cardiac surgeon. It is possible to extend access to the most sophisticated health care services to the poor
Benefits?	1600 surgeries, OPD, normal deliveries, pediatric care during the first 5 days after birth, stabilization of defined medical emergencies requiring indoor treatment
Nb insured	2.3 million people insured in 2007-08
Premium	130 Rs / person and year. Discount 15% family of 5.
Decision makers?	Board of 6 trustees (prominent state and private individuals); the chairman is the Principal secretary of the cooperative department
Stake-holders	Government of Karnataka (subsidies: +1/3 of income) Cooperative department (communication) Cooperative societies (enrolment) Cooperative banks (assist in premium collection) FHPL (claims settlement + network of hospital) 320 hospitals (health care provision) ***Low admin costs***

INDIA: YESHASVINI

Figure 2.1 Organisational Structure of Yeshasvini Cooperative Farmers Health Scheme



Linkages

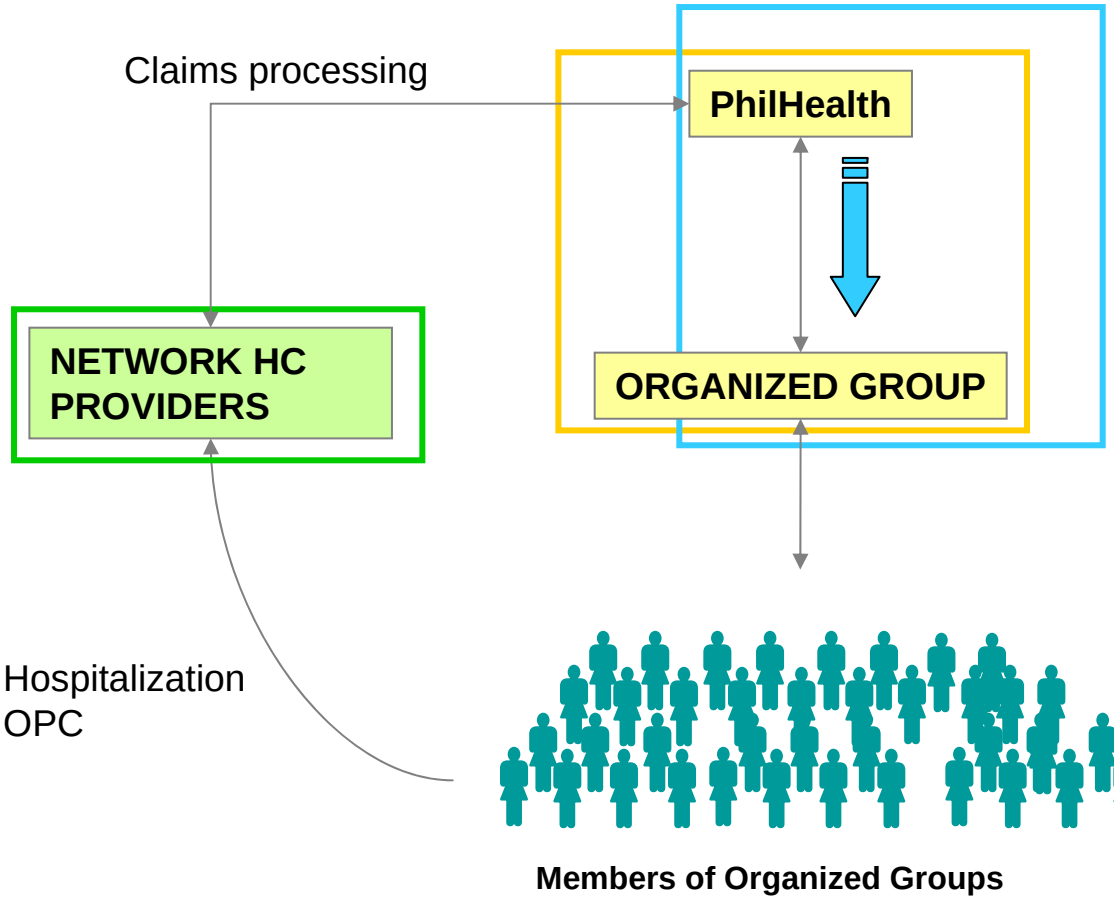
- Governance
- With health care sector
- Administration
- Financial

Country case studies: PhilHealth - KaSAPI

Where?	Philippines, 70% population covered by health insurance ie 62 million
What?	The Individual Paying programme (15% of all PhilHealth insured) targeting IE workers & the POGI / KaSAPI initiatives (2003 & 2005)
Idea behind KaSAPI	Rather than targeting individual households directly, would target groups (*admin efficiency gains, limit adverse selection*).
Funding pattern	The program offers a discounted premium when a group of a minimum level is enrolled under a contract with PhilHealth. An organized group qualifies for the group premium rate if at least 70% of the group size is enrolled in Philhealth and an even more preferential rate applies if at least 85% become members.
Stake-holders	Cooperatives, microfinance groups, NGOs, etc market the Philhealth scheme, register workers and collect contributions on behalf of Philhealth Philhealth is the insurance company

PhilHealth
Your Partner in Health

PHILIPPINES: PHILHEALTH - KASAPI



ID GENERATION
CLAIMS PROCESSING AND PAYMENT OF BENEFITS
GROUP PREMIUM RATE (discount // Nb of members)

EDUCATION/ IEC
ENROLMENT
PREMIUM COLLECTION OF CONTRIBUTIONS
SUBMISSION OF REPORTS

Linkages

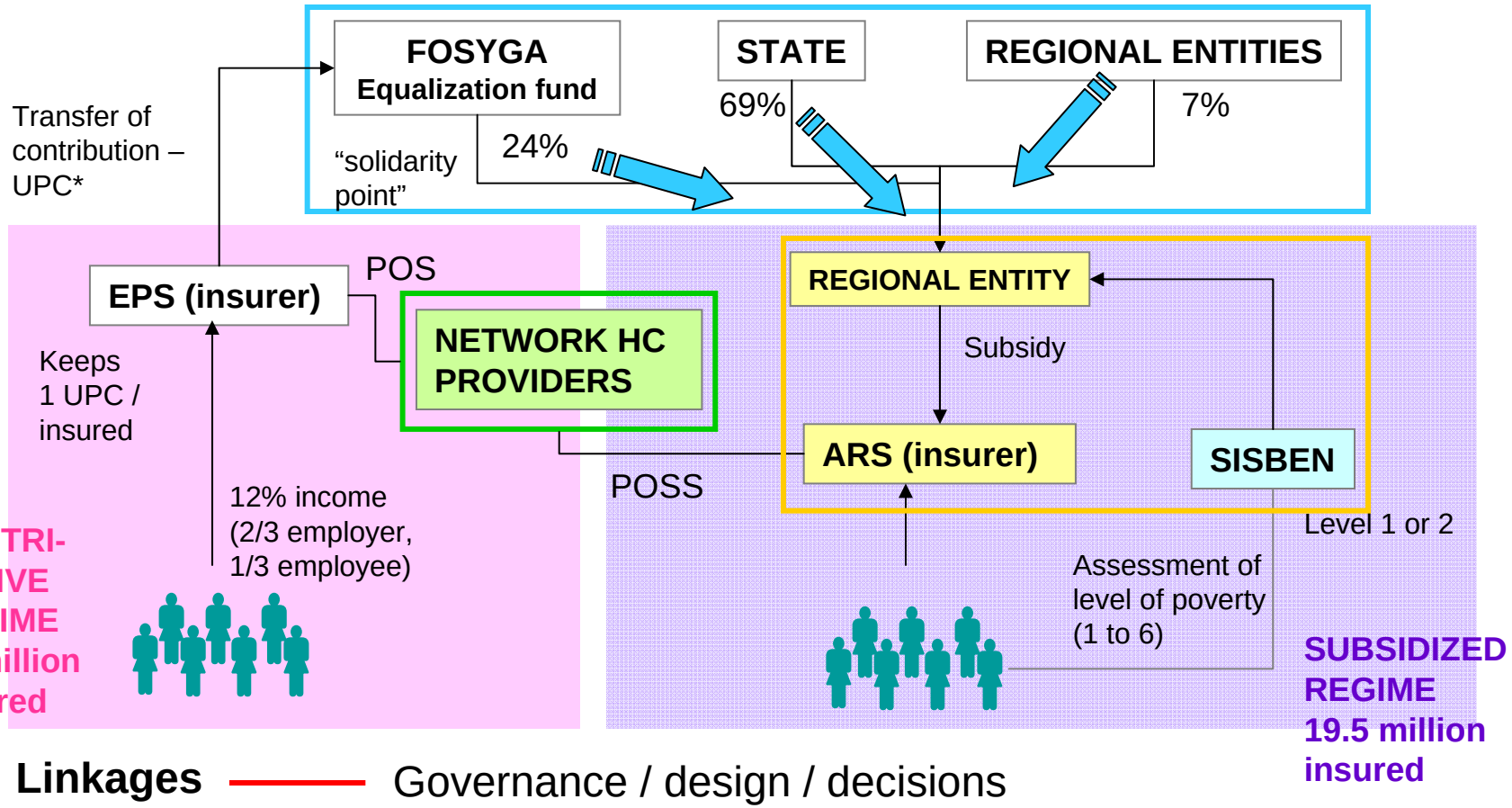
- With health care sector
- Administration
- Financial

PhilHealth
Your Partner in Health

Country case studies: Colombia

Where?	Colombia
What?	In 1993, Bill No100, reform including: •Equity in access to health services •Mandatory health insurance to everyone •Comprehensive coverage (the POS of the mandatory health plan ; the POSS subsidized basket including 50% of the POS) •Free choice of insurer and health care provider Shift from supply side subsidies to demand side subsidies + increase public hospitals efficiency
Population covered	19.5 million through the subsidized scheme 15 millions through the contributive regime Total 80% population in 2007 (28% en 1992)
Funding pattern	•Solidarity contributions (24%) from members of the contributive regime •Transfers from the Nation (69%) •10% was financed through regional sources for health care
Stake-holders	ARS: ESS, Caisse de conpensation, EPS publiques, EPS privées FOSYGA, SISBEN Regional Entities, the State Networks of HC providers

COLOMBIA



Linkages

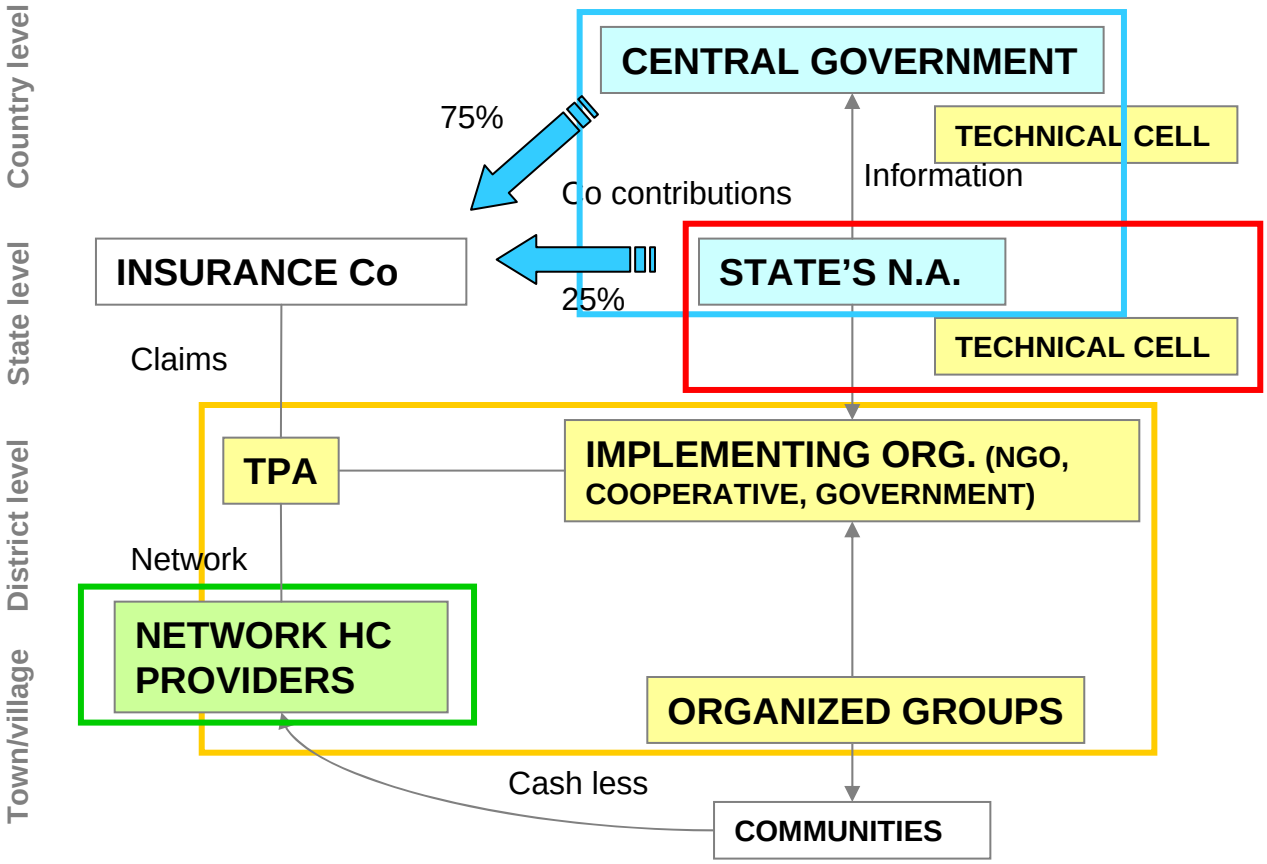
- Governance / design / decisions
- With health care sector
- Administration
- Financial

*UPC: value of the premium stipulated by legislation

Country case studies: Rashtriya Swasthya Bima Yajana

Where?	India, all states
What?	A subsidized national health insurance scheme for the entire BPL population with some flexibility in operational mechanisms at the State level
Why?	Majority of the unorganized sector workers (93% of total workforce) are still without any social security coverage
Benefits?	Total sum insured Rs. 30,000/- per family per year Cashless attendance - All pre-existing diseases to be covered Hospitalization expenses, taking care of most common illnesses with as few exclusions as possible Transportation costs (limit of Rs. 100 per visit, overall limit of Rs.1000)
Nb insured	Target : 300 million BPL – 60 million in Year 1
Funding pattern	Estimated annual premium: About Rs 600 per family per year Government of India: 75% of premium + cost of smart card State Governments: 25% of the annual premium Each beneficiary pays: Rs. 30 / year as registration/renewal fee.
Stake-holders	Central government and States governments, Insurance Companies TPAS, Local Partners including NGOs, MFIs, Co-OP, SHG Federations

INDIA: RASHTRIYA SWASTHYA BIMA YOJANA



GUIDELINES
MONITORING
SUBSIDIES

FORMULATION OF PROJECTS
MONITORING
SUBSIDIES

IMPLEMENTATION
ADMINISTRATION

EDUCATION
ENROLMENT
PREMIUM
COLLECTION

Linkages

- Governance / design / decisions
- With health care sector
- Administration
- Financial

Follow up: role of GIMI / GESS

http://www.ilo.org/gimi/ShowProjectPage.do?pid=211

Go | Bookmarks | 7 blocked | Check | AutoLink | AutoFill | Send to

Yeshasvini
Yeshasvini Co-operative Farmers Health Care Scheme. (YCFHS.)

» HOMEPAGE YESHASVINI- COOPERATIVE FARMER'S HEALTH SCHEME

- Edit Project
- Remove workspace

Yeshasvini Health Scheme is an innovative healthcare scheme for the members of rural co-operative societies of Karnataka and their families to access quality healthcare. It is designed in a public-private partnership model with participation of the Department of Co-operation, Government of Karnataka and Narayana Hrudayalaya Institute of Medical Sciences, a multi- speciality hospital based in Bangalore. Dr Devi Shetty, Chairman of the Hospital is credited to be the brain behind the initiative.

» WELCOME ADMINISTRATEUR

- Home service
- My account
- Add my CV
- Administration
- Logout

How to win points?

» YESHASVINI- COOPERATIVE FARMER'S HEALTH SCHEME

- Workspace Homepage
- Members List
- Resources
- News

HEALTH INSURANCE FOR THE POOR IN INDIA: PROJECTED COVERAGE BY 2008 END

2008

120 million

2004

5 million

Universal Coverage Health Insurance
UC (30 Baht Scheme)
THAILAND

Assoc. Prof. Wongsa Laohasiriwong; Ph. D., M.P.H.
Faculty of Public Health,
Khon Kaen University, Thailand

THAILAND

Population : 64,631,595 (2006 est.)

Ethnic groups:

Thai 75%,
Chinese 14%,
Other 11%

Religions:

Buddhist 94.6%,
Muslim 4.6%,
Christian 0.7%,
Other 0.1% (2000 census)

Literacy:

total population : 92.6%
male : 94.9%
female: 90.5% (2002)

Life expectancy : 2004
Male: **69.4 yrs.**
Female : 74.1 yrs

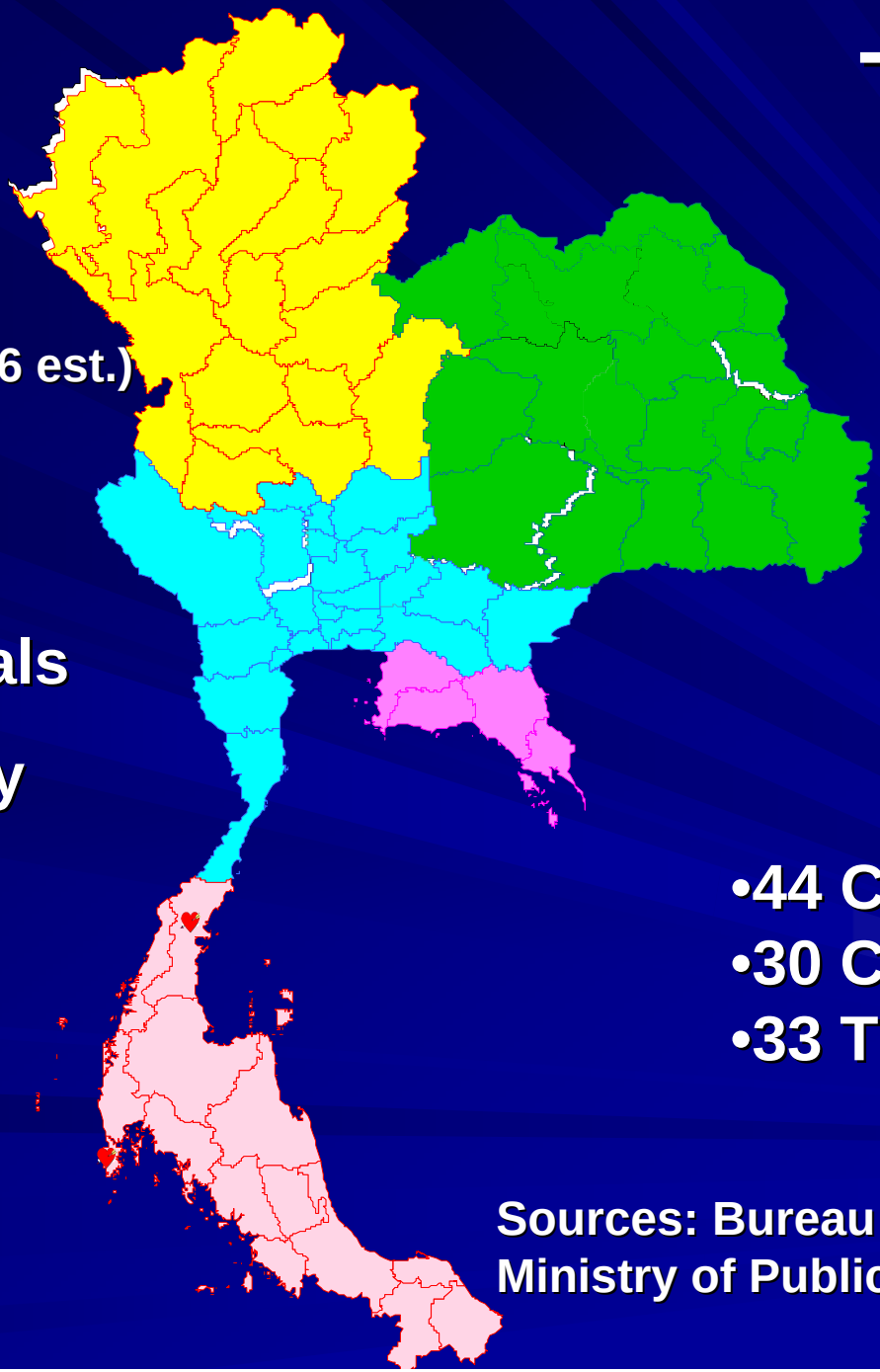
IMR 25.0 /1,000 LBs.
MMR 12.0 / 100,000 LBs.

GDP/cap/yrs.
= $US 2,000 (6,000 - Bpp.)

Health expenditure
$US 120 (360- Bpp) /cap
6% GDP

Sources: Bureau of Policy and Strategy, Ministry of Public Health.2005

THAILAND



- 64,631,595 (2006 est.)
- 76 Provinces
- 95 Regional & General Hospitals
- 725 Community Hospitals
- 9,812 Health Centers

- 44 Cardiac Centres
- 30 Cancer Centres
- 33 Trauma Centres

Sources: Bureau of Policy and Strategy, Ministry of Public Health.2005

Situations Before the UC : Year 2000

- ~30 % of the population(18-20 Million) were uninsured
- **Multi-health insurance systems** covered 70% of population with different benefit packages, government budget subsidies and payment methods;

Health Insurance Scheme	Coverage (%)
Medical Welfare Scheme (MWS) and fee exemption system	~ 37
Voluntary health card (HCS)	~ 12
Civil Servant Medical Benefit Scheme (CSMBS)	~ 11
Social Security Scheme (SSS)	~ 9
Private Health Insurance	~ 10
Uninsured person	~ 30
Total Population (Million)	61.46

Situation Before the UC

- Total health expenditure increased in average of 8.3% per annum which was higher than average increase of GDP;

  Total health expenditure was 250,000 Million Baht.
- Public vs. private source of health care finance

  61 : 39 .... (Year 1998)
- Drug expenditure accounted for 30% of total health expenditure while 23% of population did self prescription when they were sick;
- Increase role of private sector in health care service provision (but was still limited in urban area);
- 25.6% of total hospitals but 21.6% of total number of hospital bed

Situation Before the UC

- Good health care infrastructure
- Mal-distribution of health resources among regions;
  - bed: pop Bangkok = 1:202
    Northeast = 1:766
    Whole kingdom = 1:454
  - physician: pop Bangkok = 1:793
    Northeast = 1:8,311
    Whole kingdom = 1:3,427

  Resulted in different access to care of people and different workloads of health personnel while getting the similar incentive

Situations Before the UC

Problems of multi-health insurance schemes

- Different finance mechanism
- Could not achieve universal health coverage
- Catastrophic health expenditures
- Inequity : government subsidy per capita
  : accessibility to health services
  : quality of care

Situations Before the UC

- The Low Income Scheme unable to
  - effectively cover an amount of poor people.
  - difficulty in effectively target the poor.
- The Voluntary Health Card Scheme:
  -likely to cover more sick than healthy population (adverse selection) leading to
  - poor risk sharing & unstable financing.
- The Civil Servant Medical Benefit Scheme was unable to control rapid rising of expenditure from its application of fee-for-service payment.

Main Features of Health Insurance Schemes Prior to UC

Scheme	CSMBS	SSS	LIC	VHC
Target beneficiaries	Government employees & dependents, retirees	Formal sector employees:	Poor, elderly, children under 12 years,	Non-poor and Marginal poor household in rural areas,
Population Coverage	7.62 millions	6.9 millions	17.7 millions	7.92 millions
Health Benefit	Ambulatory service & Inpatient service (Public)	Ambulatory service & Inpatient service (Public & Private)	Ambulatory service & Inpatient service (Public designated)	Ambulatory service & Inpatient service (MOPH)
Payment to health facilities	Fee-for-service, reimbursement	Capitation	Budgeting	Budgeting

Source: Tangcharoensathien V et al 2006.

Health Insurance Financing

Scheme	CSMBS	SSS	LIC	VHC
Contribution from beneficiaries	None if using public, Co-payment for IP in private hospital	Tripartite 1.5% (1650-15000 B per month); Co-payment for maternity and emergency services if beyond ceiling	Non contributory scheme, full funded by government	-HH 500 B/yr -Gov.500 B/yr, -almost no co pay
Financing Body	Ministry of Finance	SSO	Ministry of Public Health	Ministry of Public Health
Expenditure per capita, 1996 (Baht)	1778	1428	>280 + cross subsidy by public hospital	534 + cross subsidy by public hospital
Budget subsidy per capita	1778	476	280	125

Why Universal Health Insurance Coverage ?

1. **Health : “Security” , “Stabilization”**

- an important component of the quality of life .
- a system of life security that they could be able to
  * develop appropriate health behavior,
  * get access to health promotion and diseases prevention services;
  * received health services without any obstacle when needed.

Why Universal Health Insurance Coverage ?

2. Health : “ Equity”

- Different socio-economic and cultural groups have equal opportunity to get access to health services.
- Responsibility to pay for the expenses should depend on their ability to pay.
- Health resources are distributed to promote the equal access to health service of people of different setting.

Why Universal Health Insurance Coverage ?

3. Health : a human right and dignity

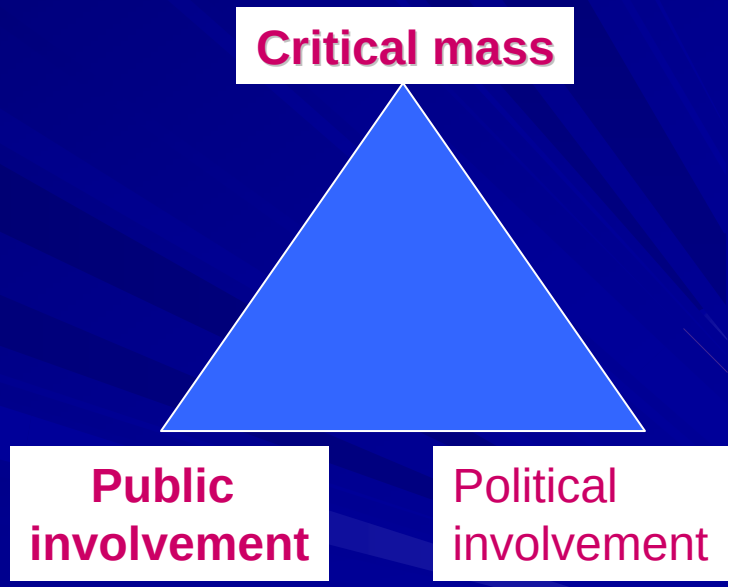
The Constitution of the Kingdom of Thailand 1997

- " health" as a basic right of the public which have to provided by the state.
- "universal" indicates the system all Thai should be entitled to obtain health when they are need, no one is abandoned.
- service delivery should be based on equal respect of human status and dignity.

How we developed the UC ?

- Expanding health insurance coverage based on the Voluntary Health Card Schemes.
- Building the system capacity on HRD to promote critical mass, field model and policy research development.
- Drafting the National Health Security Bill in 1996.
- Organized the national Forum on Health Care Reform and developed the civil network to support the UC policy.

Triangle
that moves the mountain



How we developed the UC ?

- a political party which support the policy got elected and formed the government.
- Launching the pilot project of the UC Policy in 6 provinces (April 2001), then expanding to 15 provinces (June 2001).
- Implementing the UC Policy nationwide in April 2002.
- The National Health Security Act was issued in November 2002.

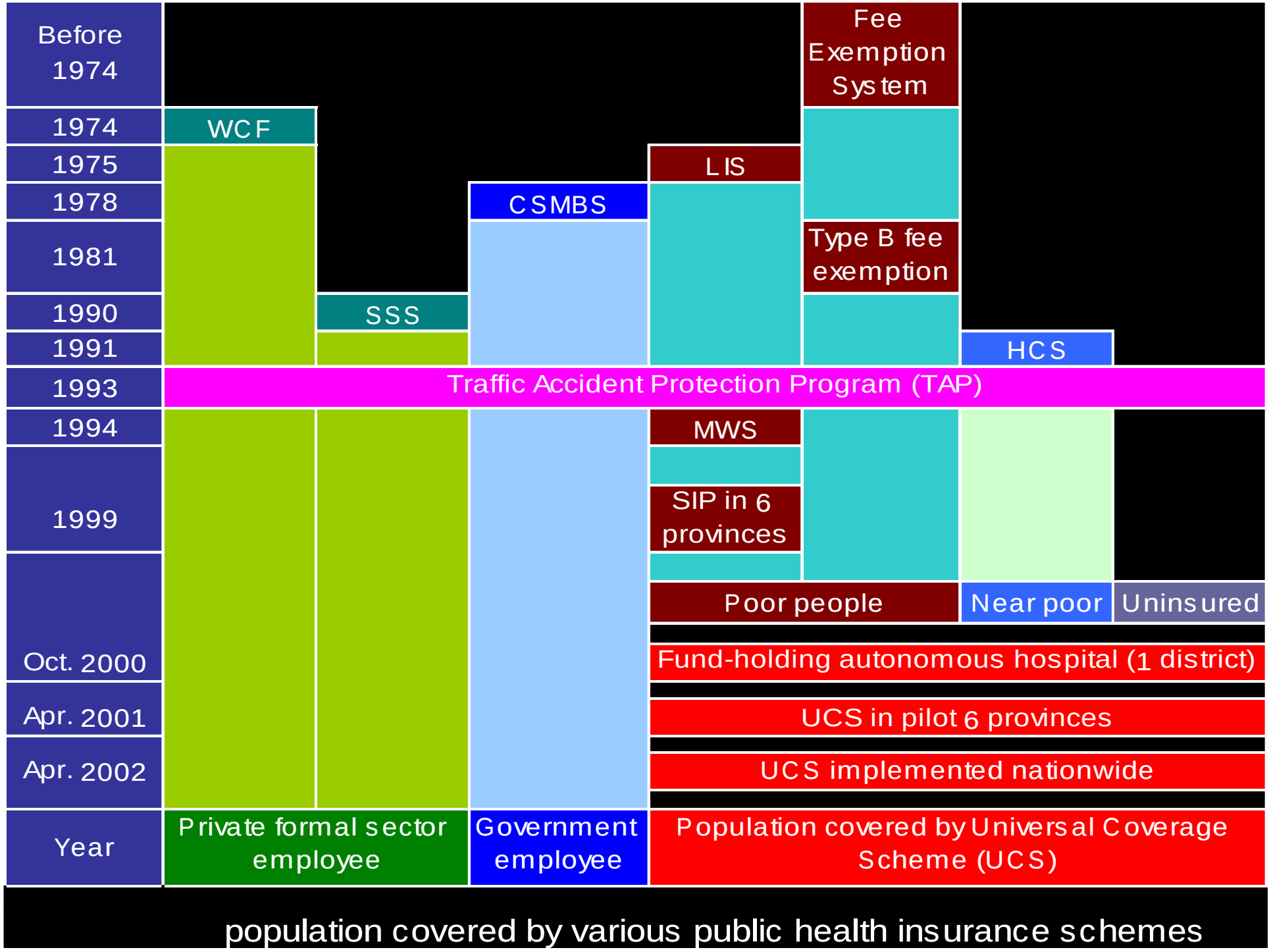

Before 1974
1974
1975
1978
1981
1990
1991
1993
1994
1999
Oct. 2000
Apr. 2001
Apr. 2002
Year
WCF
SSS
CSMBS
LIS
Fee Exemption System
Type B fee exemption
HCS
Traffic Accident Protection Program (TAP)
MWS
SIP in 6 provinces
Poor people
Near poor
Uninsured
Fund-holding autonomous hospital (1 district)
UCS in pilot 6 provinces
UCS implemented nationwide
Private formal sector employee
Government employee
Population covered by Universal Coverage Scheme (UCS)
population covered by various public health insurance schemes

Table 1 Coverage of Health Insurance (%), 1991-2003 in Thailand

Health Insurance Scheme	1991	1996	2001	2003
Universal coverage	-	-	-	74.7
Social Welfare	12.7	12.6	32.4	-
Civil servants (CSMBS)	15.3	10.2	8.5	8.9
Social security	-	5.6	7.2	9.6
Voluntary health card	1.4	15.3	20.8	-
Private health insurance	4.0	1.8	2.1	1.7
Total insured	33.4	45.5	71.0	94.9

Sources: National Statistical Office. *Reports of health and welfare survey, 1991, 1996, 2001, 2003*.

Type	2006	2007	2007
1. OP	585.11		722.18
2. IP	460.35	632.97	
3. Promotion & Prevention	224.89	252.57	
4. Accident & Emergency	52.07	83.69	
5. High Cost	190.00	217.82	
6. EMS	6.00	10.00	
7. Rehabilitation	4.00	4.00	
8. Structural investment	129.25	165.44	
9. Central and regional administration	7.00	NA	
10. Contingency Find	0.53	0.53	0.53
Total (Baht/Population)	1,659.20	2,089.20	1,659.20
Total Population UC (million)	47.75	48.34	48.116

Main Features of UC

- Beneficiaries
  - Thai citizens who are not covered by SSS and CSMBS.
- Benefit package
  - Reference to SSS package (except cash benefit and ARV, ESRD) including OP, IP, AE, HC (comprehensive package)
  - Personal preventive and health promotion services (PP)
  - Copayment 30 Baht is needed for each visit of health service utilization (except for PP services).

Main Features of UC

- Health care provider
  - Public and private health care providers (accreditation and registration are needed to participate the system)
  - Primary care (Contracted Unit for Primary Care: CUP) is a unit for population registration and functions as a gatekeeper (referral is needed to access hospital care)
- Financing
  - Tax based financing (general tax revenue): budget is calculated and obtained on a per capita basis.
  - Budget for system administration is totally separated from the health insurance fund and its amount is based on negotiation year by year.
- Provider payment
  - Mix but capitation and DRG are predominant.

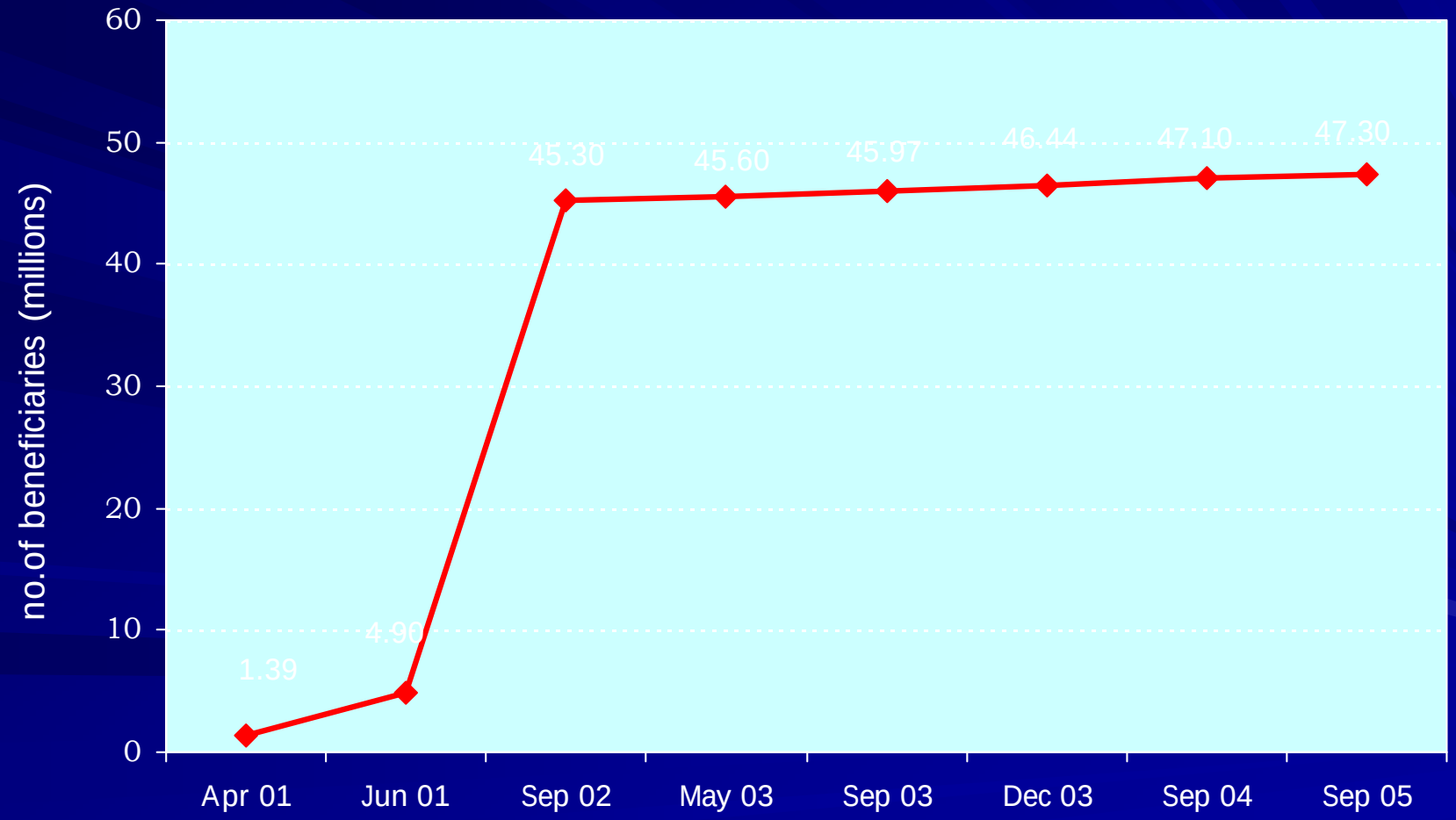
Approved Capitation Rate from 2003-2006

(2007: proposed capitation rate)

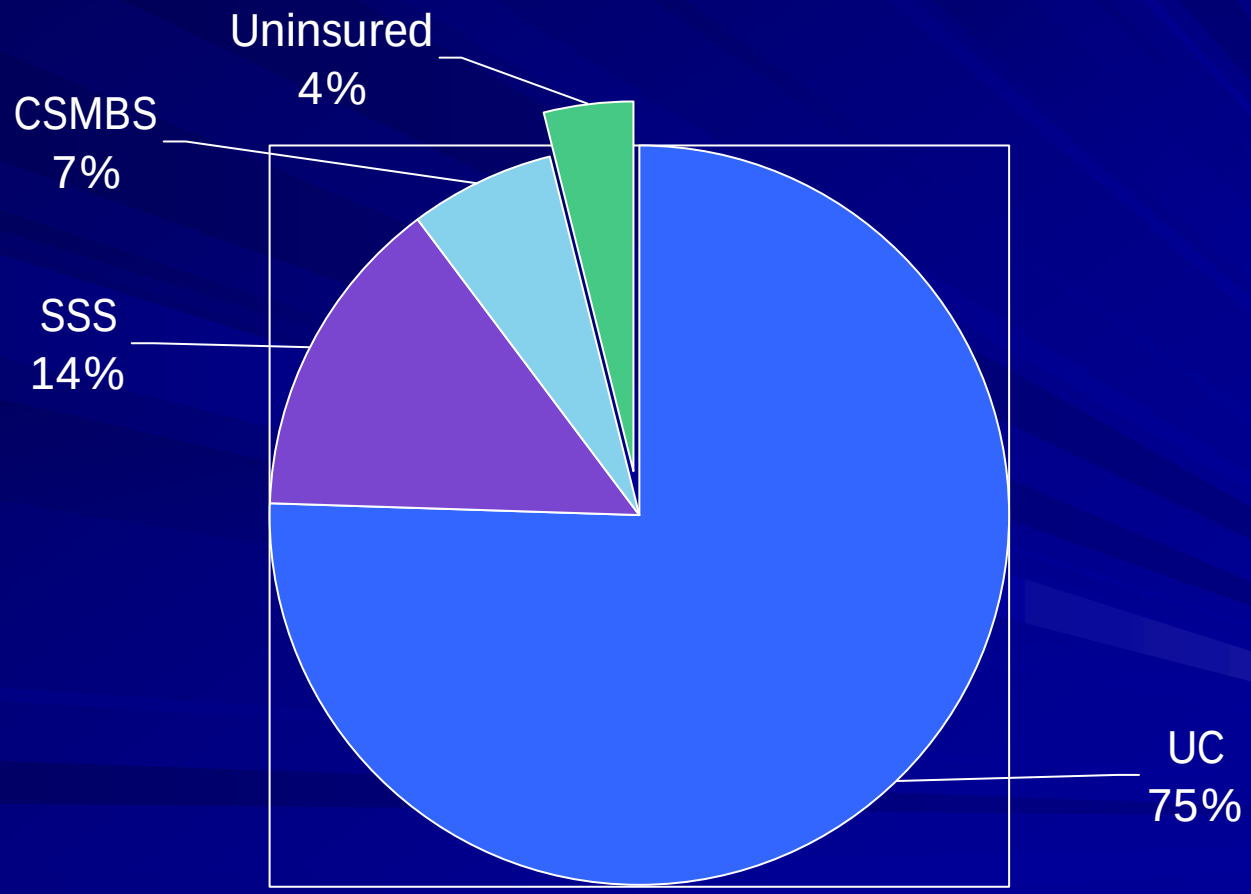
Item	2003	2004	2005	2006	2007
OP	574	488.2	533	585.11	722.18
IP	303	418.3	435	460.35	632.97
PP	175	206	210	224.89	252.57
A&E	25	19.7	24.73	52.07	83.69
High cost	32	66.3	99.48	190.0	217.82
EMS	6	10	6	6	10
Rehabilitation	4	-	4	4	4
Capital replacement	83.4	85	76.8	129.25	165.44
Hardship		10	7.07	7.00	Na
No fault		5	0.20	0.53	0.53
Total	1,202.4	1,308.5	1,396.3	1,659.2	2,089.2
Target pop. (mil)	45.6	46.8	47.0	47.75	48.3

2007 Budget = 2100 Baht/ capitation
Proposed 2007 = 2312.48 Baht/capitation

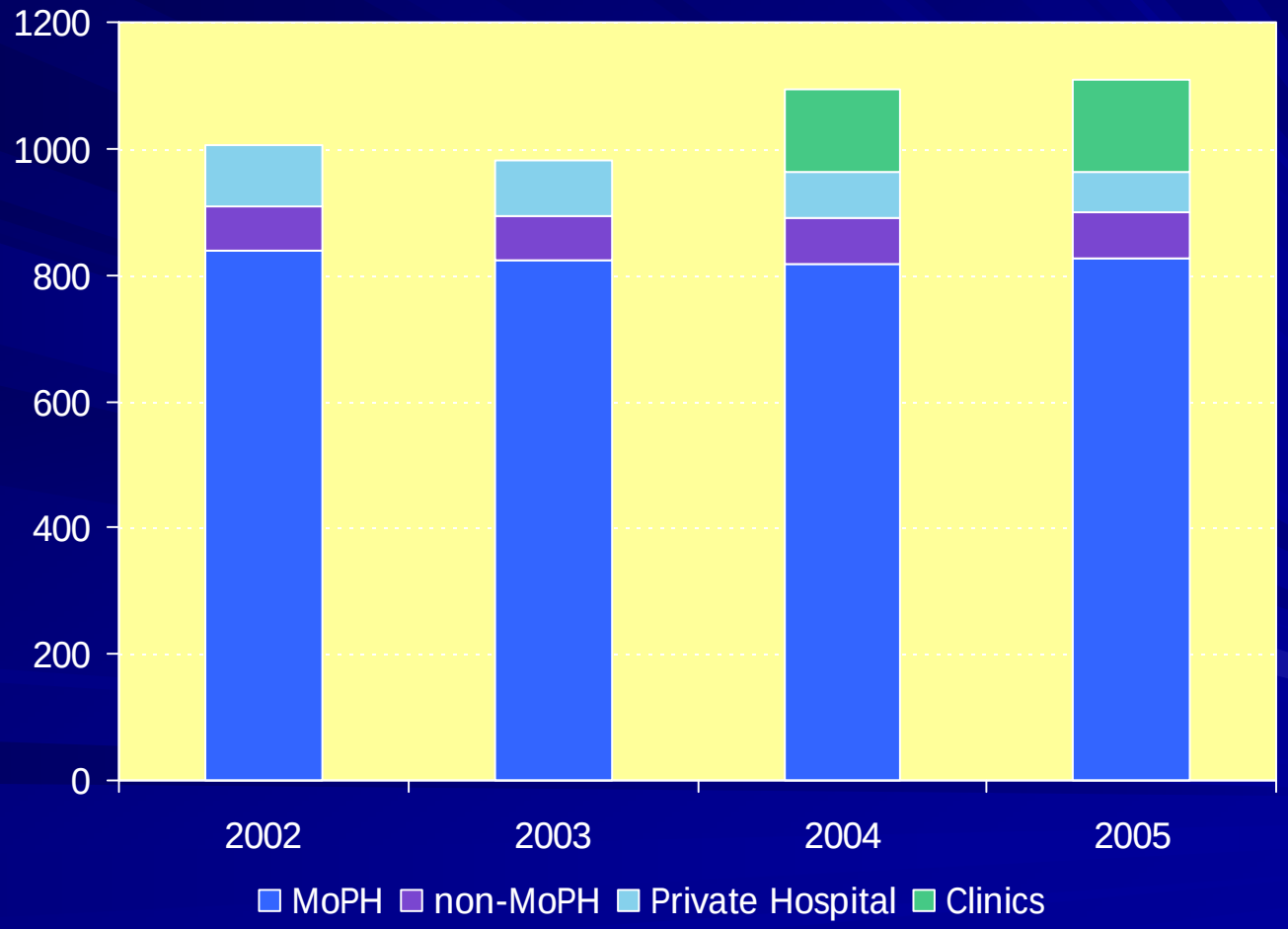
Scheme Coverage



Healthcare Coverage of Thai Citizen 2005



Health Care Providers in UC

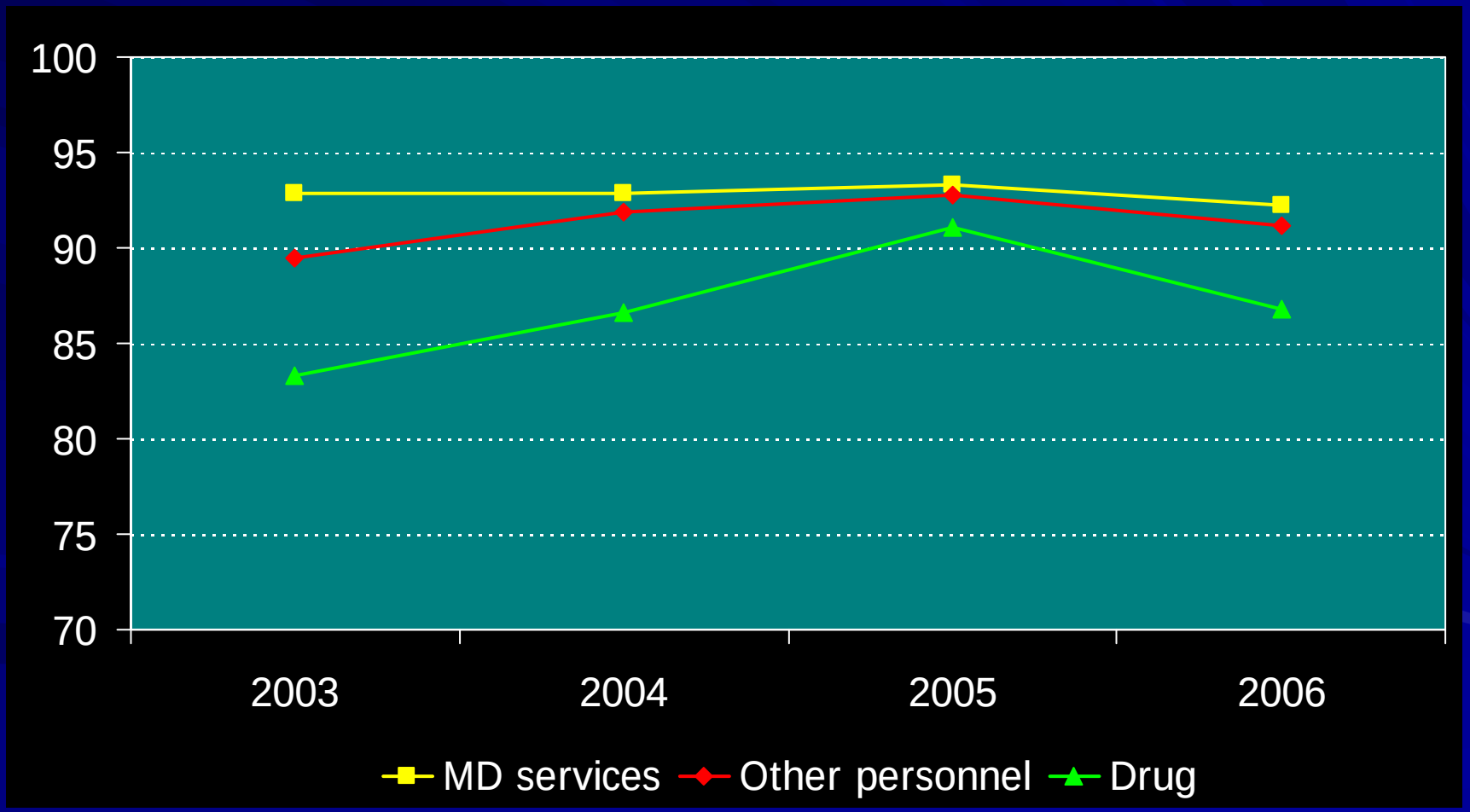


Change of Utilization Pattern

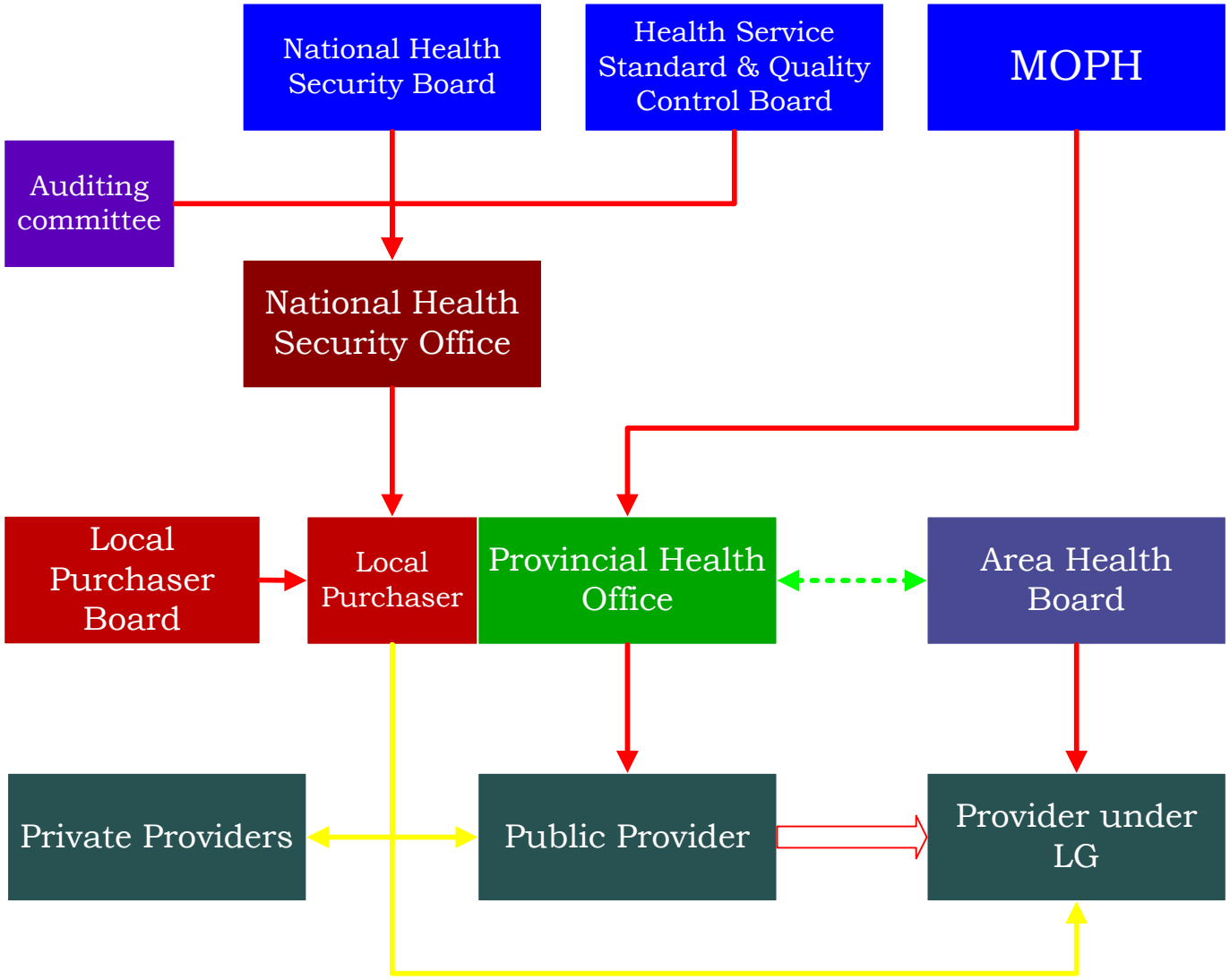
Level of care	OP million visits			IP million admission		
	2001	2003	2004	2001	2003	2004
Primary Care Unit	29.7	43.7	63.8			
District hosp.	19	36.7	46.2	1.1	2.1	2.2
Provincial Hosp.	24.5	14.8	20.1	2.1	1.4	1.8
Annual changes						
Primary Care Unit		47%	46%			
District hosp.		93%	26%		91%	5%
Provincial Hosp.		-40%	36%		-33%	29%

source: NSO HWS2001, 2003 and 2004

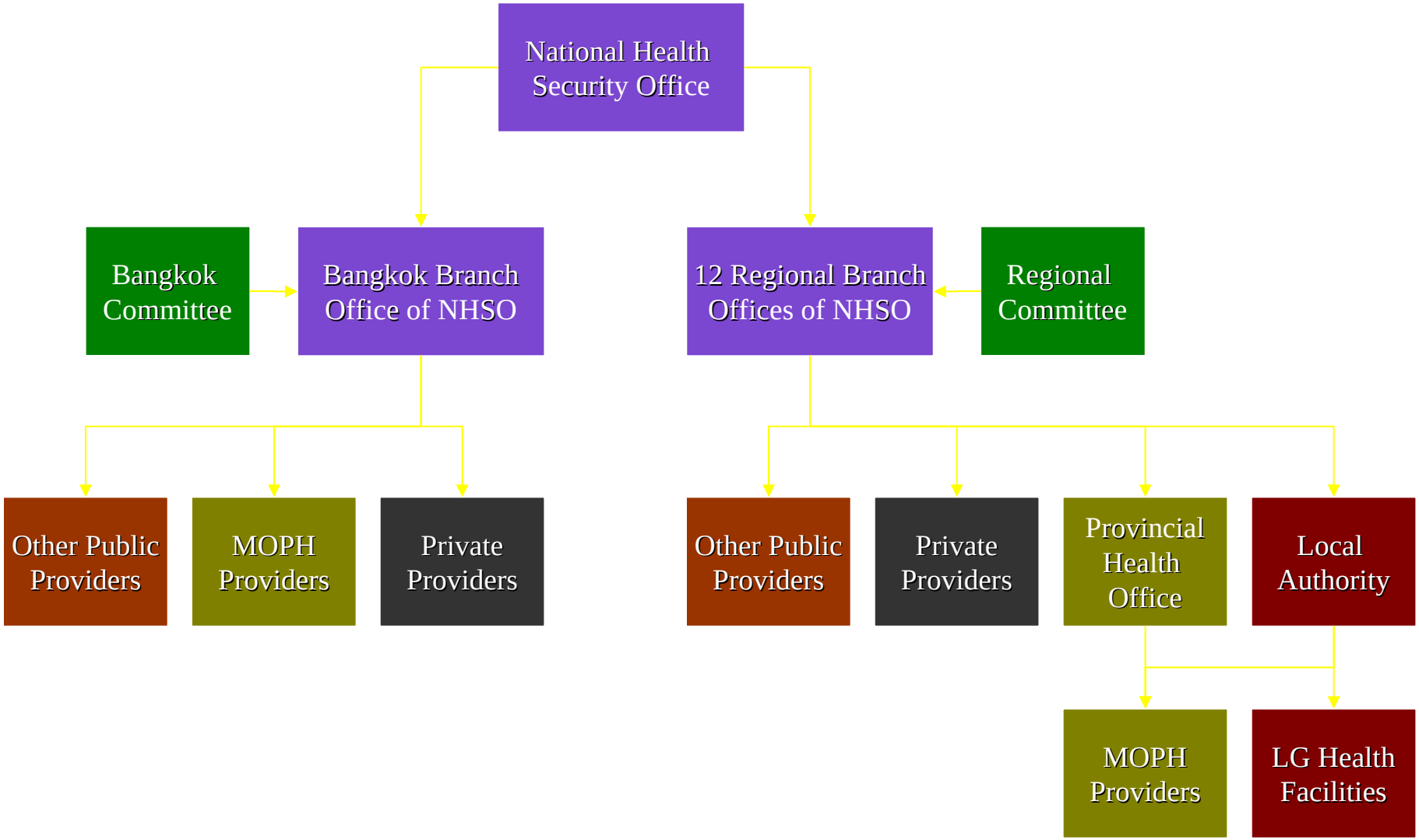
Satisfaction of Beneficiaries



Administrative Structure Before 2005



Administrative Structure After 2005



Problems Encountered

Initial stage

- **Management**
  - Allocation of budget (per capitation)
  - Payment mechanism
  - Purchaser- provider split
  - Information system management
  - Human resource management
  - Quality management.

Problems Encountered

Initial stage

- Staff satisfaction
  - work load, complaints
  - Brain drain
- Client satisfaction
  - Quality)
- Public satisfaction
  -UC vs the Poor
  -Moral hazard

New Challenges

- The use of disease management-DM approach to improve access to specific services.
- The use of vertical approach to improve effective implementation of PP.
- Increase of confidence of consumer on quality of care.
- Insurance coverage of some marginalized groups.
- Harmonization of public health insurance schemes.
- Integration of management of CSMBS with the UC.
- Human resource management.
- Explore new sources of health care financing which are more stable and sustainable.

The Poor

- Since 2004, the poverty line for Thailand has been set at THB 1,242 per capita/per month*.
- population under the poverty line was 15.5% in 2002**.
- the income disparity between the richest and poorest groups was found to be 13.4 fold.**
- 19.7% was rural poor Thai population***.
- 6.7% was urban poor Thai population**.

* Chutimaskul, 2006 .
** Wibulpolprasert, 2004.
*** Thadaniti, 2004,

Urban Poor

- In 2001, 20% of Thailand's ~ 64m population was urban, by the end of 2006, the city-dwelling population is forecast to have reached 42-43% of the total population*.
- In 2003, Thailand had some 5,500 low-income urban communities, containing 8.25 million inhabitants, living in poor quality and often insecure housing.**

* Thadaniti, 2004.

** Boonyabancha,2005 .

Healthcare utilisation under the 30-Baht Scheme among the urban poor in Mitrapap slum, Khon Kaen

86.1 % registered with the 30-Baht Scheme
27.4% were exempted from paying the THB 30 co-payment.

11.2% had other insurances.

2.7 % had no insurance.

84.4 % had monthly incomes under the national poverty line.

35 % of > 60 year-olds still paid 30 Baht co-payments although all of them should be exempted.

- **Healthcare utilisation under the 30-Baht Scheme among the urban poor in Mitrapap slum, Khon Kaen, Thailand – a cross-sectional study (2006) by**
  SOPHIE CORONINI-CRONBERG, WONGSA LAOHASIRIWONG, CHRISTIAN A. GERICKE

Healthcare utilisation under the 30-Baht Scheme among the urban poor.

- 89.5 % had better access to health care.
- 52.5 % Increased utilisation of health services
- 80.3 % always use of registered facility.
- 98.3 % satisfied with the 30 Baht scheme.

Health Insurance Coverage of Urban Poor in the Northeast, 2007

Scheme	Number	Percent
Social Security Scheme	397	75.9
Universal Coverage Scheme	36	6.8
CSMBS	34	6.5
No health insurance	56	10.8

Health Insurance Coverage of the Urban Poor in the Northeast, 2007

Scheme	Number	Percent
Social Security Scheme	397	75.9
Universal Coverage Scheme	36	6.8
CSMBS	34	6.5
No health insurance	56	10.8
Total	523	100

Studied in urban poor community of Khon Kaen ,Nakhon Ratchasima, Ubon Ratchathani, Nong Khai and Surin provinces in 2007 by Surit and Laohasiriwong

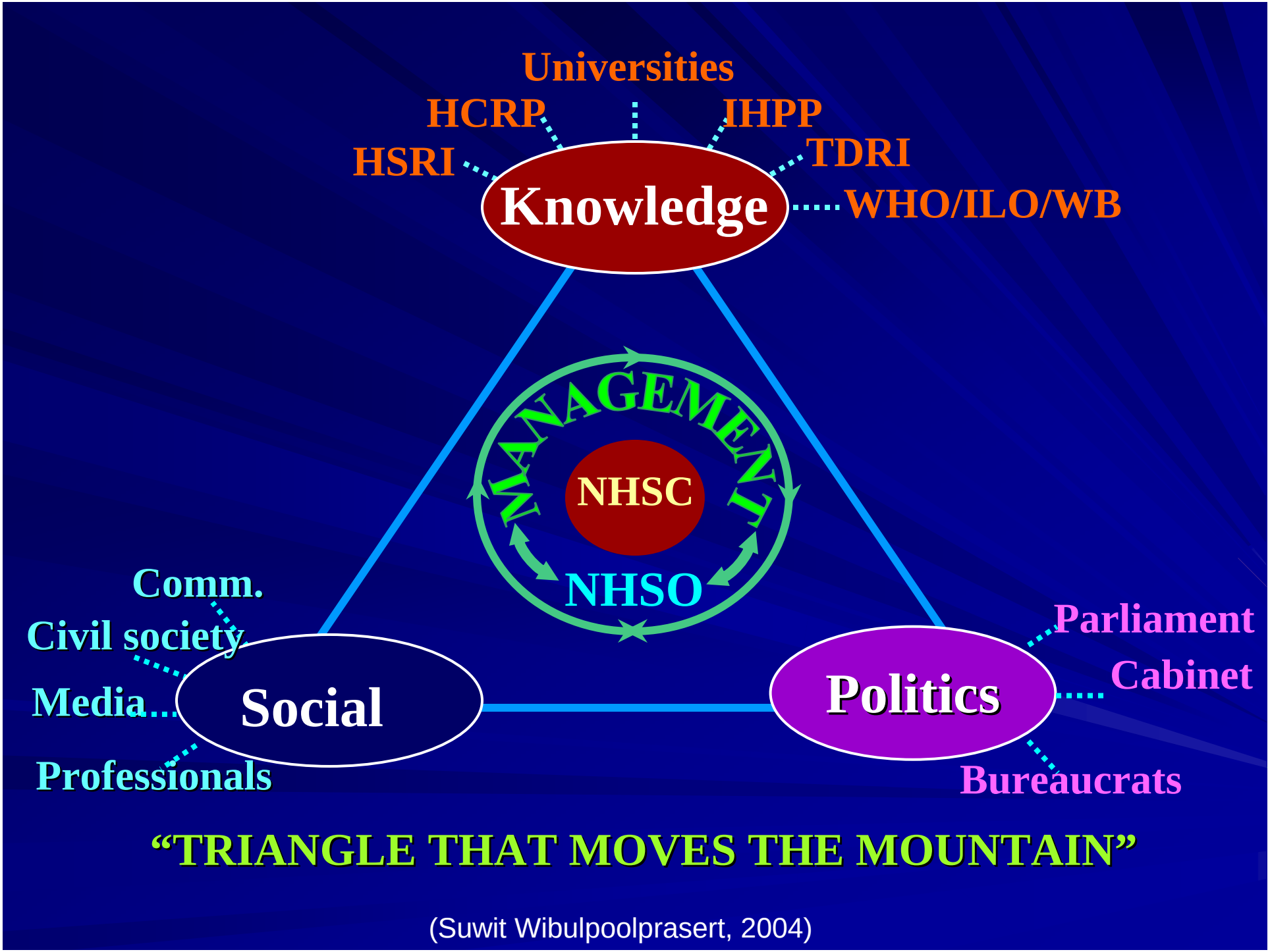
Health Insurance Coverage of the Urban Poor in the Northeast, 2007

- 60.9% had median Income < the poverty line (1,242 baht a month).
- Median monthly income was 3,000 Baht; Min: Max = 0 : 27,000 Baht.
- Median monthly health expenditure was 70 Baht / month (Min: Max = 16 : 3,000 Baht).

The Issues

- How to help them having more coverage of health insurance.
- How to reduce their health expenditure.

Opportunity cost
Opening hours for services
Relationships with health personnel


Universities
HCRP
IHPP
HSRI
TDRI
Knowledge
WHO/ILO/WB
MANAGEMENT
NHSC
NHSO
Comm.
Civil society
Media…
Professionals
Social
Parliament
Cabinet
Politics
Bureaucrats
“TRIANGLE THAT MOVES THE MOUNTAIN”
(Suwit Wibulpoolprasert, 2004)

Thank you:
Kob Khun ka

gtz Partner for the Future. Worldwide.

Landscape of Health Insurance in India – Some Critical Issues

Dr. Nishant Jain

GTZ-Health Sector Support

05.05.2008

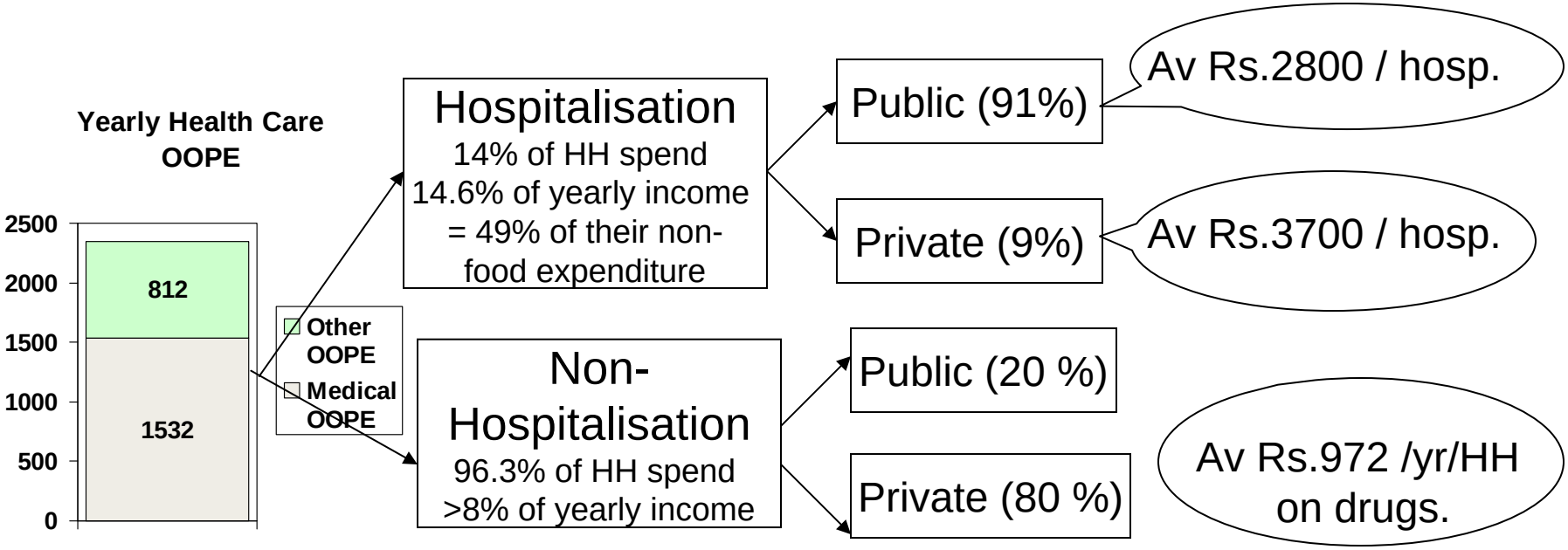
Flow of Presentation

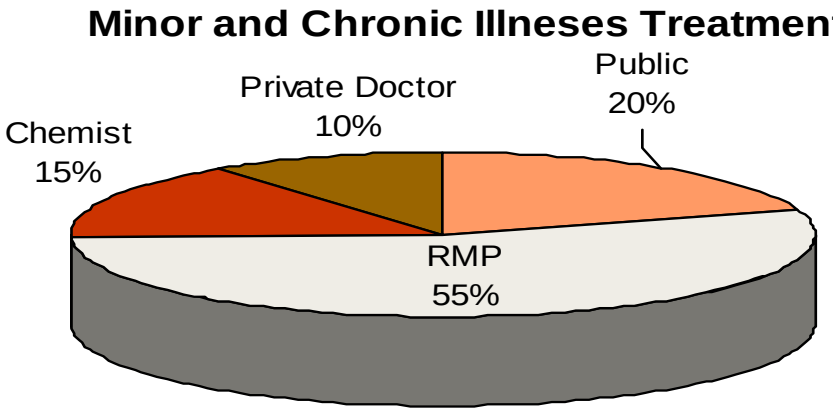
- Introduction
- Some evidence from Studies
- Types of Health Insurance in India
- Landscape of Health Insurance in India
- Community based initiatives
- Government initiated
- Out of Pocket System Vs. Insurance System
- Some Critical Issues

Introduction

- A market boom in Health Insurance in India
- All possible options blooming
- Exponential growth through community based schemes
- Different initiatives from central government ministries, from state governments and NGOs/ MFIs
- Governments acting as a financer and provider at the same time
- People spending a lot even while accessing services from public providers

Some evidence from Studies



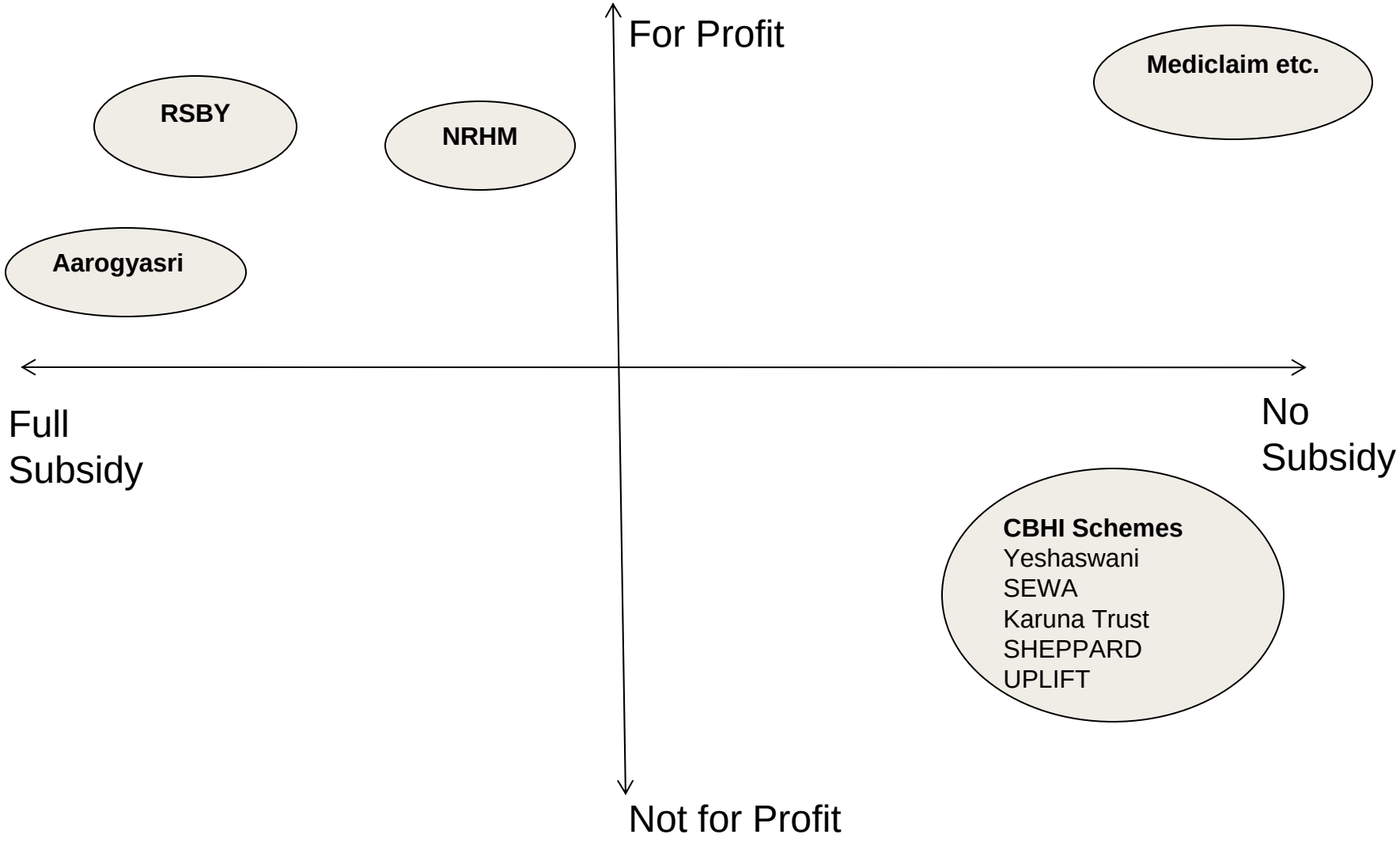


Source: Unpublished report

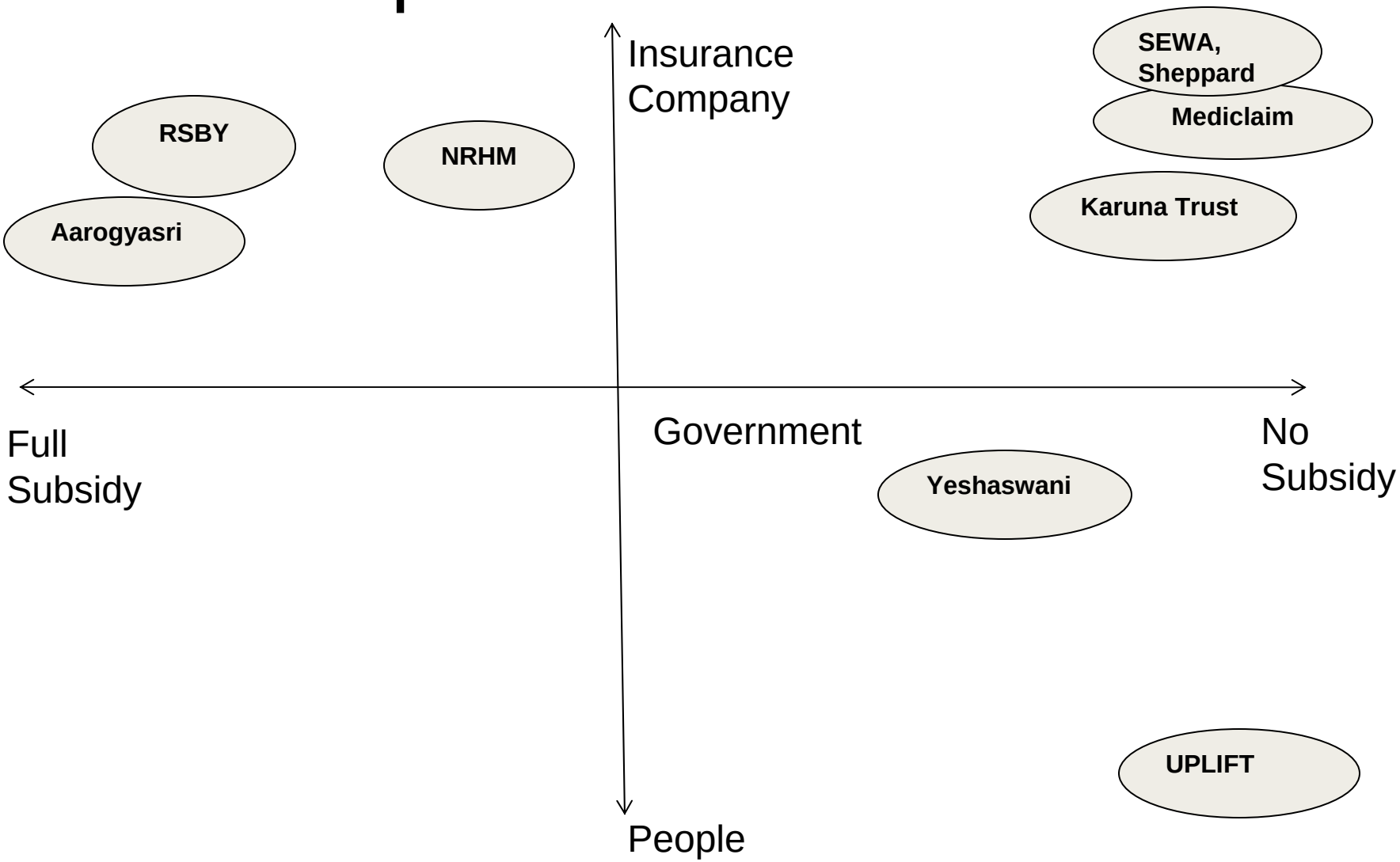
Types of Health Insurance in India

- **Formal Sector**
  - ESIS
  - CGHS*
  - Other Employer sponsored schemes
  - Mediclaim and other similar schemes
- **Informal Sector**
  - Community Based Schemes
  - Government Sponsored/ Subsidised Schemes
  - Other Sponsored/ Subsidised Schemes

Landscape of Health Insurance



Landscape of Health Insurance



Community Based Initiatives

- Initiated by NGOs / CBOs.
- Objectives
  - To increase access to health care
  - To protect families from high medical expenditure
  - For the sake of solidarity
- Target – poor
  - Usually the ‘organised’sections e.g. SHGs, unions, co-operative societies, students,
- Premiums are quite reasonable (<100/person/year)
- Most of the time premium is not subsidised
- Different ways of managing risks

Community Based Initiatives

- Pros
  - Credibility because of the Institutions involved
  - Premiums are quite reasonable >> Sustainable
  - Most of the time premium is not subsidised
  - Testing ground for different types of health insurance models
- Challenges
  - Limited Reach in terms of numbers and geographical spread
  - Difficult to reach poor who are not organised
  - Lack of management capacities

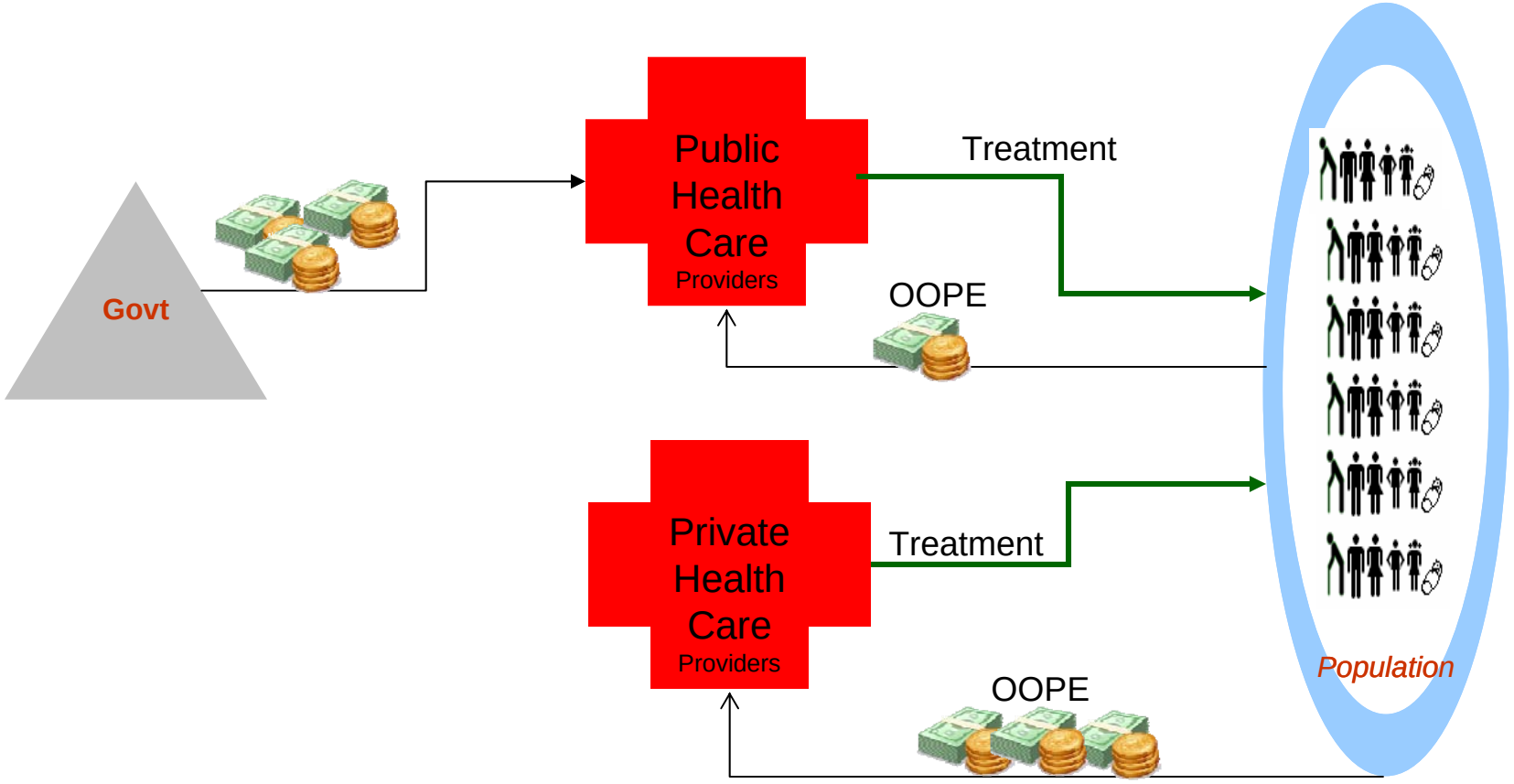
Government Initiated

- Initiated by different State and/ or Central Government
- Objectives:
  - To increase access to health care
  - To protect families from high medical expenditure
  - To provide options in terms of health care providers
  - To improve quality of public health care system
- Target – Poor (Sometimes only BPL)
- Premiums are heavily subsidised (upto 100%)
- Risk managed by Insurance company or Govt.

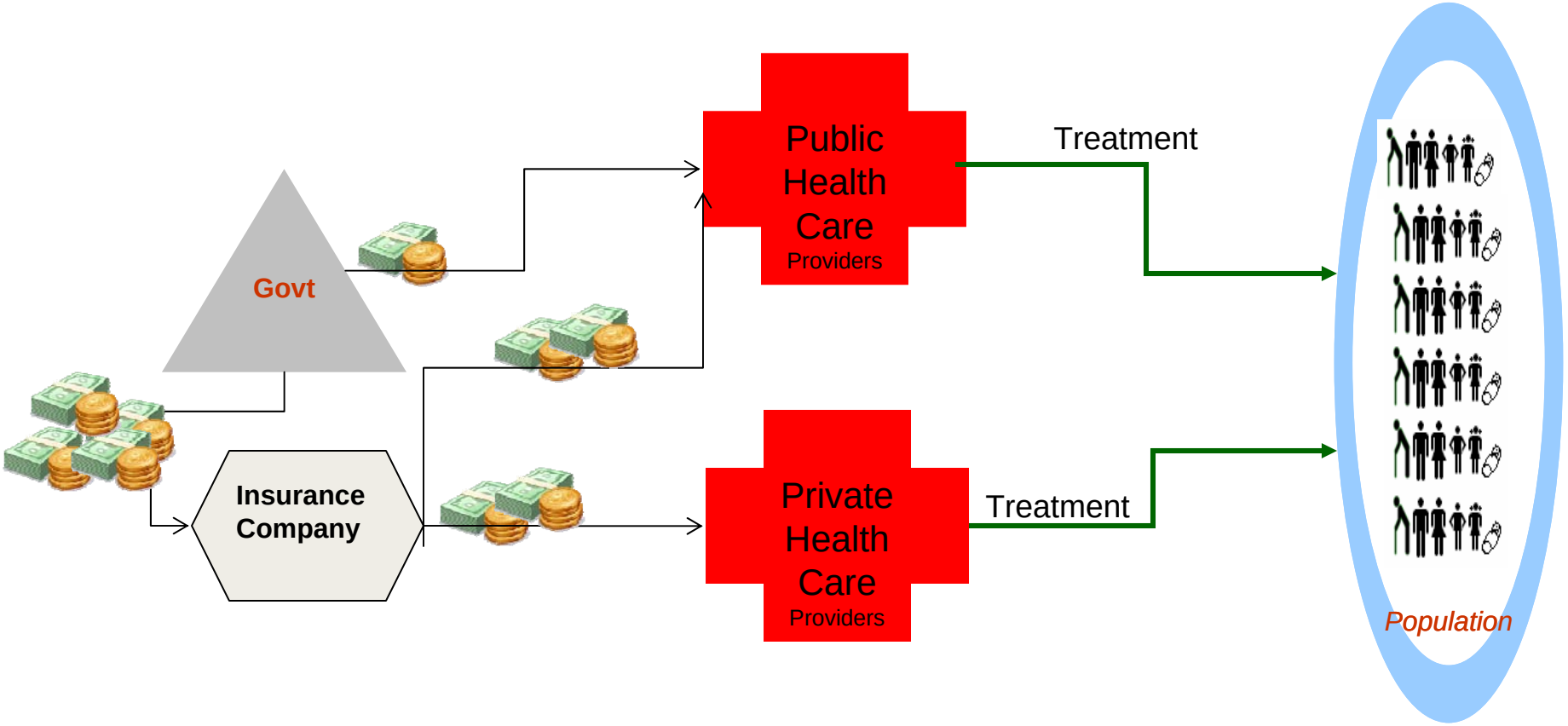
Government Initiated

- Pros
  - Can reach millions of people in one go
  - Government shares a major portion of premium
  - People get options to choose between providers
  - Can improve quality of public health care system
- Challenges
  - Not looking Health Insurance as part of Health System
  - Lack of trained manpower to manage, monitor and evaluate
  - Sustainability
  - Monitoring and Evaluation control

OOPE System


Govt
Public Health Care Providers
Private Health Care Providers
Treatment
Treatment
OOPE
OOPE
Population

Government Initiated Insurance

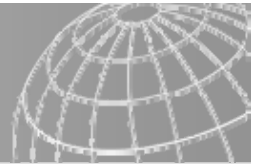


Some Critical Issues

- Health Insurance has to be seen as part of the System and not on top existing health expenditure
- Health budget needs to be redistributed and redesigned
- Ensuring quality of health care
- Standardising cost of delivery of services
- A level playing field should be created between public and private providers which could lead to:
  - Competition
  - Improvement in Quality of public heath care
  - Strengthening of Public health care delivery

Some Critical Issues

- Coordination between different Government Schemes
- Linkages between existing CBHIs and Government initiated mass health insurance schemes
- Developing Institutional capacity within the Government to implement these schemes
- Making people aware about this concept



Thank You

Uplift Health Mutuals

A community owned health protection initiative

Kumar Shailabh

UpLift India Association
Enriching lives of the poor...together

Uplift India Association

Uplift India Association (a SEC 25 Non Profit Company) is a federal organization that associates 9 NGOs in Maharashtra working together on providing development services to urban slum dwellers in Pune, Mumbai and Rural Marathwada

Uplift India Association and its CHAPTERS

Uplift India Association is composed of three *CHAPTERS* based on three thematic areas,

Uplift Health members

- Annapurna Parivar Vikas Samvardhan , Pune-Mumbai
- Parvati Swayamrojgar,Pune
- Swayam Sikhshan Prayog Osmanabad,Solapur

Uplift Health- Mutuals Beginning

- After a dramatic health event of one of Annapurna Mahila Mandal Pune members, other members felt concerned and expressed their needs to setup a solution
- A study including review of the insurers, Health experience and behaviours was done.

Needs and realities post study-2003

Our Needs

- Affordable product for our partners
- Guidance to quality care with discounts
- Impact on health and health behaviour
- Local management with transparent procedures

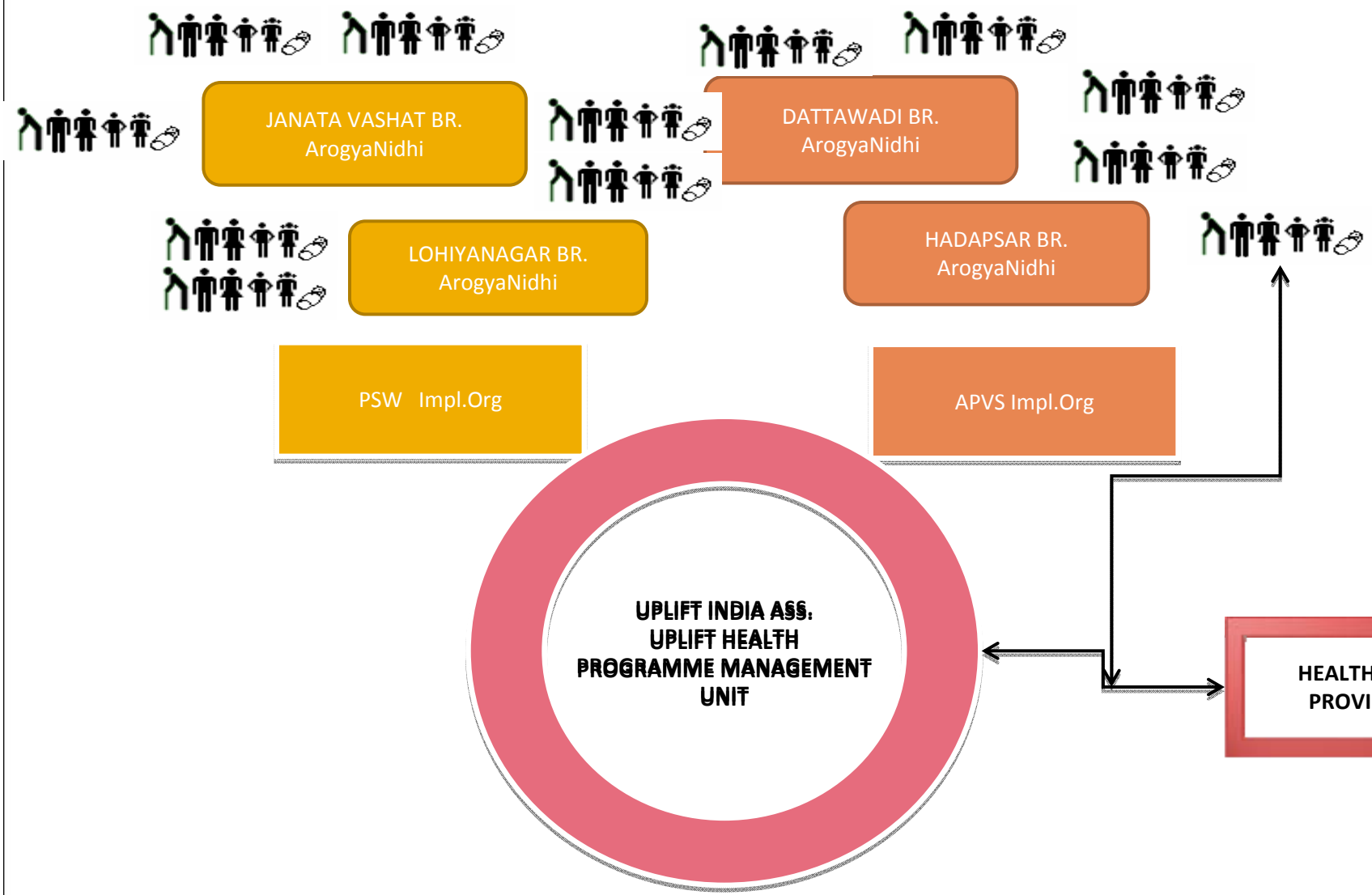
Market realities

- No low cost product (in 2003)
- Non transparent procedures
- No guidance towards quality care
- Health not a concern
- Profit only for Insurance Company

Decision to go in-house/ Risk Pooling Model

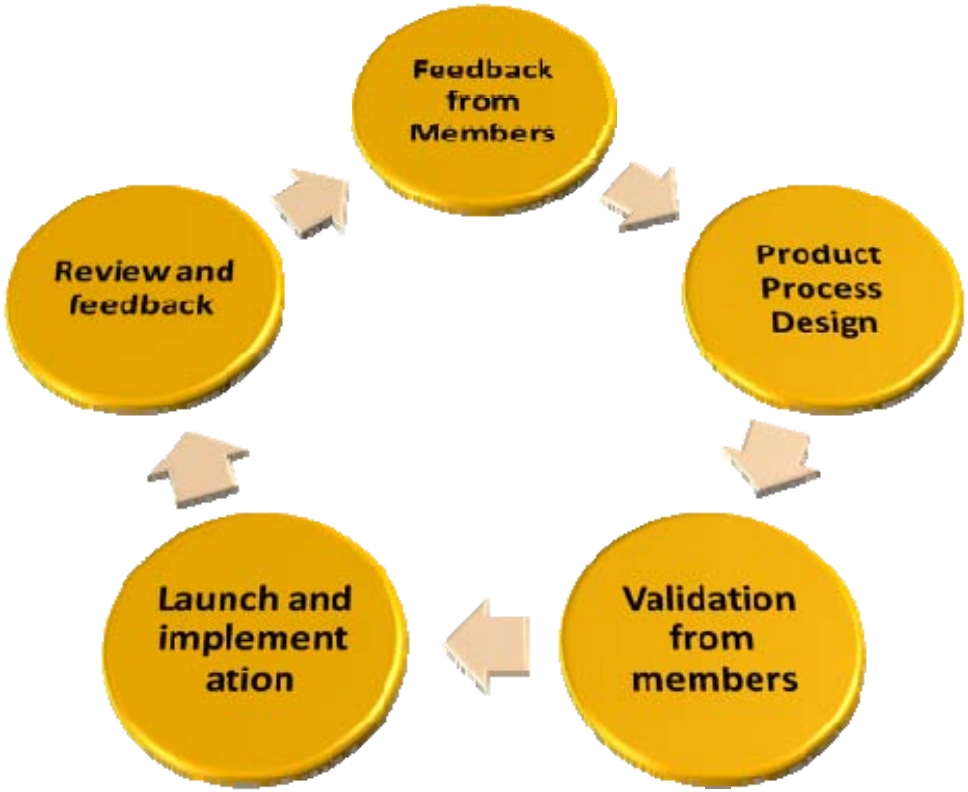
- Women of Annapurna decided to start a health protection fund through mutual contribution when they understood insurance companies would retain the profits in case of no claims
- *It was decided that implementing partners of Uplift would use the infrastructure of their micro credit services to start this mutual fund.*
- Uplift Health was to provide the entire technical knowhow and support to setup and manage such funds

OPERATIONAL STRUCTURE-Uplift Level



Mutuals Design Process

- Capacity to pay
- Access to services



Product Evolution- 2003 to 2008

Contribution at 50 Rs /p/y

- Reimbursement of Rs 5000/person for hospitalization expenses
- Wage loss of 50 Rs for 15 days
- Internal Categories
- Complex maternities covered
- NO AGE LIMIT
- CHRONIC ILLNESS covered if first detection

Contribution at 100 Rs/p/y

- Launched this month, reimbursements up to Rs 15000/person for hospitalization.
- Discount OPD Coupons
- Complex maternities covered
- Internal Categories
- Pre existing covered after three years of membership
- NO AGE LIMIT
- Chronic Illness covered if first detection

Exclusions

Only monetary reimbursement wont happen, all other services can be availed- exceptional cases maybe referred to Solidarity Fund

Contribution at 50 Rs /p/y

- Pre existing not covered
- Self or intentional injury
- Dental and plastic surgery for cosmetic purposes
- Chronic illness if not first detection

Contribution at 100 Rs/p/y

- Pre existing covered if member for three consecutive years
- Self or intentional injury
- Dental and plastic surgery for cosmetic purposes
- Chronic illness if not first detection

Risk Bearer

- Risk Pooling model as against Risk Transfer
- Community itself is the risk bearer in the Mutuals setup
- Risk pooling happens across the various mutual funds in the slums of the city

Delivery Mechanism

- Target population are the slum dwellers who are interested in credit services
- The Micro Credit staff makes the first contact
- Orientation during loan meetings at branch office
- All the services offered by the Organization are explained
- After the member agrees - one time collection of contribution at agreed date or with disbursement of loans

Orientation meeting

Collection/ form filling

Forms and contribution sent to UH BP

First Contact

Promotion Material for effective communication

Administration

- One time collection send to fund account while forms sent to Uplift Centralized Back Office Encoding.

- Data is encoded in the In-house Software (SYSLIFT) and Health Cards are printed from the software

Administration

- Health Cards are then distributed to members during the first installment collection drive by Service Executives at the branches
- The software generates branch wise financial statements which are then displayed in the branches and put for community validation

VIRTUAL ACCOUNT CHARTS

शीर्षक/महिना Title/month	एप्रिल April	मे May	जून June	जुलै July	ऑगस्ट Aug	सप्टे Sept	ऑक्टो Oct	नोव्हे Nov	डिसे Dec	जाने Jan	फेब्रु Feb	मार्च March	एप्रिल April	मे May	जून June
या महिन्यापासून सोसले नवीन जमाजन New Member	221	149	47	87	177	107	198	170	220	211	220	218			
पूर्वीपासूनचे चालू सभासद On going Member	1892	1978	1969	1995	2106	2149	2312	2342	2328	2320	2353	2277			
आरोग्य निधी एकूण Fund Balance	31451	44344					55311	57946	63440	66808	69488	68133			
या महिन्यात कलेक्ट झाले कनव्हाल उपलब्ध रक्कम Earned Premium	4663	4893	4858	4910	5205	5336	5530	5370	5524	5588	4421	5489			
दाखल केलेले एकूण क्लेम्स Claim Opened	0	0	1	5	2	3	1	3	2	4	2	-			
क्लेम पोटी दिलेली रक्कम Claim Amount Disbursed	0	0	1975	6172	2295	3322	1500	2735	1410	4021	0	-			
क्लेम रेशो Claim Ratio	0%	0%	41%	126%	44%	0%	27	51%	27%	71%	-	0%			
रेफ्रल दिले (Referral letters)	15	14	18	9	27	17	5	26	12	24	18	22			
रक्कम वाचली Amount Saved	-	-	-	-	-	410	745	865	290	1740	1495	25265			

Branch Operational Structure

1 Branch Manager

4 Micro Credit Staff/Family Development staff

1 Service Executive

1 Services Coordinator

Health Services Support Setup

- Realizing that people need health and access to health services Uplift has planned an elaborate system of Referrals and Guidance

- Service Executives posted in each Branch located in the slums provide referrals to members on need and demand with compulsory follow-ups

- A network of 100 Health Care Providers including multi specialty hospitals, clinics, medicines shop, diagnostic centers, pathology labs and access points in Govt Hospitals

Uplift Health Care Providers Network

- Network built by Uplift health for two purposes
- Access to Services and rationalization of medical care costs
- Uplift manages to get 10-50% discounts through negotiation on the hospital's schedule of rates
- Criteria for Empanelment- Members demand, Qualified doctors, Proper infrastructure- space equipment, qualified para medical staff

- Grading based on medical facilities available-specialty, multi-specialty, super-specialty
- Costing of Services- Average of schedule of rates of trust hospitals
- Uplift Schedule of rates given to HCPs
- Upon agreement of discount percentages and quality assurance- MOU with HCPs

Health Services Support in the Mutuals model

- Network of localized 24 OPD doctors act as gatekeepers and provide more frequent services to members
- 24X7 helpline created to provide members round the clock referrals
- Discounts on medicines, surgical items
- Referrals to rehabilitative services
- Administrative Support

Health Services Support

- Organization of Monthly demand based health check up camps

- Conducting health talks based on seasonal mapping of diseases-with emphasis on early diagnosis and treatment compliment the range of services members avail together.

Claim Services

- Uplift Organizations follow the reimbursement model
- Cashless Facility was intensively studied but it was concluded that it will result in cost rise of the health care providers schedule of rates and also remove the element of ownership of the members
- An advance payment facility is being studied and will be piloted from this month in one of the partner organizations for planned surgeries

- Claim is first medically validated by the network doctor and all claims (including the ones medically rejected) are then settled by the communities on the following criteria

✓ Use of Network Hospital

✓ Emergency or Non emergency

✓ Earned Premium of the Branch

✓ Exclusions

✓ Health Behaviour

Claims Process

- Declaration to SE/Co/ND/BPI or through phone (Any time)
- Guidance toward Most appropriated and fairly priced quality health care provider
- Cure-submission of Docs at BO
- Claim file preparation and validation by UH BPI
- Validation in Monthly Claim Committee (education /instruction of the claim)
- Claim decision by the Members Claim Committee
- Claim reimbursement
- 30 days Claim settlement period as claims are settled monthly

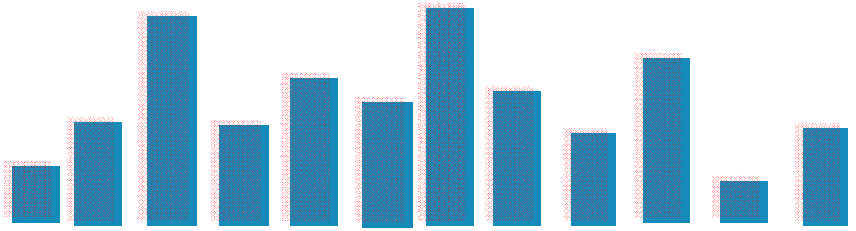
In Case the Branch does not have sufficient funds they can either use the reserves according to a tool available (Reserves Utilisation Tool) or can request funds from other branch funds

Funds Management

Fund Allocation for Claim Indemnisation

J | F | M | A | M | J | J | A | S | O | N | D

Claims:



Administration

(24 Rs / person)

IPD Indemnisation Fund

(36 Rs)

Contributions Collected

(60Rs/ Person)

Monitoring in the Mutuals

- Monitoring is divided into two sections
  - Front Office- Promotion, Education,Referrals,Guidance,Claims
  - Back Office- Operational ratios coming from Syslift, Business Plan Target Achievements, Accounts and Admin
  - Operational Manual and Job Descriptions help in monitoring the quality standards across processes and personnel
  - Weekly Audit of Branches by Uplift
  - Meticulous Collection and recording of Services Data
  - Operational ratios coming from the Software helpful for the management to take policy decisions
  - Sharing of fund information with members
  - Uplift health reviews operational processes and performance on a monthly basis with each partner organization.
  - Monthly Meeting of Uplift Health Chapter to review progress, take policy decision

Governance in Mutuals

- Community Representatives (CR) elected/selected to lead the community in the mutuals operations
- CR play a crucial role in mutuals operations as well as in grievance redressal
- Monthly Committee Meetings- main platform for sharing by members
- Uplift Health Governance to now have(this month)
  - An Executive Committee comprising IO chief functionaries
  - A Representatives committee composed of the community representatives
  - Uplift health technical team to report to both these committees.

Community Members have been receiving training on mutuals management now for a year.

Mutuals Performance 2007

Performance Indicators	Micro Health Insurance units
Ongoing Members	33,545
Contribution Collected	Rs 20,65,620
Amount disbursed	Rs 8,10,104
Reimbursement Ratio	77%
Reimbursement Rejection Ratio	15%
Reimbursement Frequency	1.5%
Renewal Ratio	55%
Reserves	Rs 7,08,458

Services Report for Mutuals 2007

Services Indicators	Performance Data
No of IPD referrals given	1,952
% of positive referrals	73%
Health Camps	79
Attendance	4,147
Health Talks	94
Attendance	1,263
No. of OPD referrals	2,112
Amount saved of members (fund)thanks to referral services	Rs 14,63,124

SHEPHERD HEALTH INSURANCE

PARTNER – AGENT MODEL EXPERIENCES

DATE : 05.05.08

NEW DELHI

Shephed is a Professional development organization working with 42,000 low income families in 6 districts of Central Tamilnadu, South India.

- Promoted 2481 Surabhi's (SHG)
- Providing services like
  - Savings,
  - Credit,
  - Micro Insurance (Package)
  - Micro Pension and
  - Livelihood promotion.

VISION:

To empower the low income families.

Genesis of Social Protection:

- Micro insurance was started in 1998 because
  - Six women from Surabhi died in one year
  - 700 Huts were burnt in communal riots
  - 40% of internal loans from surabhi has been spent for “curative” purpose

- Federations took a decision to link with formal insurance companies.
- We handled schemes like GSS, OGI, and JBY for life.
- Developed a Health package namely **Uni Micro Health Insurance** with the support of United India insurance company in the year 2003.

PRODUCT AND SERVICES:

Food Security: Fistful rice Collection & Distribution

i.e) Pooling the resources and sharing the risks.

Life Security: Compensation of financial loss to Insured families.

Fistful rice

Health Security: Three attributes.

- Prevention-Medical Camp
- Protection-Health insurance
- Promotion-Health education

Sugam Fund: Financial assistance for emergency operations and exclusions.

Asset Security: Financial support for the asset loss.

Old age Security: Micro Pension-contributory system.

Micro Pension Launching

Present Partners in Micro Insurance:

- Life: LIC & Bajaj Alliance
- Non-Life: UIIC & VimoSewa(ICICI Lombard)
- Micro Pension: UTI-MF
- Promotional Support: Ford foundation.

OPERATIONS:

- Providing package of service (Life and non life) to our surabhi members.
- Voluntary in nature.

- At present the benefits are;

Category	Sum Insured (Rs.)
• Life	10,000
• Accident	25,000
• Hospitalization	10,000
• Asset	10,000

Premium: Rs.200/- (Including admin cost)

Admin Cost 20% of the Premium.

(A) Prevention :- (Medical Camp)

Under this aspect SHEPHERD is collaborating with the local committed hospitals to conduct medical camps to women, children & adults. These camps help in identifying diseases and facilitating them to take treatment at the earliest.

Protection :- (Insurance)

We found that, poor need to keep good health, inorder to go for wage employment and improving their livelihood. So, we educated the women in the surabi meeting and enrolled 16500 (current year) women in the health insurance.

Promotion :-(Health Education)

Prevention is better than cure. We initiated health education to women, children, adolescent girls and men. So, that fall in sickness will come down, financial loss can be minimized, ultimately income to the family will be increased. We are giving training inputs to surabi, federations and community.

Premium Collection : Surabhi will pay the premium amount to SHEPHERD by way of A/C payee cheque (or) cash deposit.

Claim Processing : MI worker will visit the family / Hospital immediately inorder to give solidarity to the member / family.

Field visit report with surabhi leaders views.

Claim Committee : Consists of women leaders and director. One women leader is the chair person of the committee.

Frequency : Once in a month (or) need based meeting

Claim Settlement : A/C payee cheque (or) DD infavour of surabhi. The leaders will draw money from bank and settle the claim in the meeting with community witness.

Claim Rejection : If the claim was rejected due to exclusion clause (or) insufficient documents MI worker will visit the village, organise surabhi meeting and explaining the reasons behind claim rejections.

Cashless Agreement : Working with 5 committed, ethical based hospitals, who are not commercial in nature.

(Walk in/ Walk out)

Emergency Health Fund : (Financial Assistance Refundable)

1. Major operations

2. Transportation services to hospital (Emergency Van)

3. After Discharge, Medicine Expenses

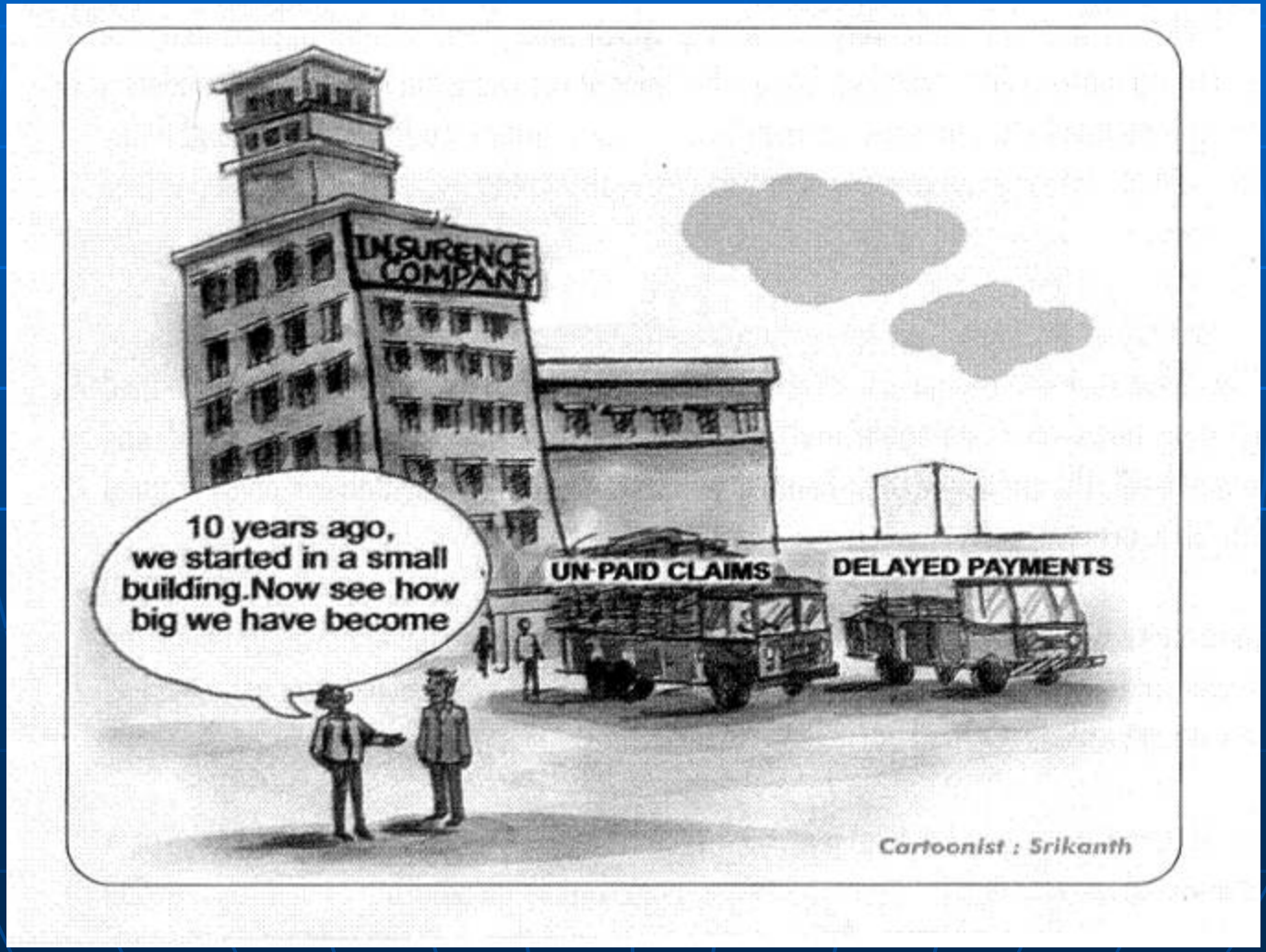
4. Excluded cases under MI

Lesson's Learnt:

- Poor women are asking refund of premium, when there was no claim
- Insurance companies are interested in premium collection than claim settlement.
- Insurance education to members are done by us (No financial support from insurer)
- Some doctor's are giving bills in just letter head papers
- Some hospitals escalating treatment cost, If they know that she will get insurance claim.

- Mission/service hospitals are not keen to sign MOU with insurance company for cashless treatment. However they did it with us.
- Claim settlement delay more than 50 days average gives negative feeling on health insurance in villages.
- Women are asking quick claim settlement.

PARTNER-AGENT STUDY FINDINGS



Operational highlights till Dec'07

Insurance company	LIC	UIIC	VIMOSEWA	TOTAL
No of policies	42558	12312	31247	86117
Premium paid (Rs.)	1570954	1265790	1916542	4753286
Co payment (Rs.)	1570954	Nil	Nil	1570954
Total Premium (Rs.)	3141908	1265790	1916542	6324240
Claim paid (Rs.)	1430362	132891	1507439	3070692
Claim ratio	45%	11%	79%	45
Partner-profit margin	55%	89%	21%	55
Profit to insurance company (Rs.)	1711546	1132899	409103	3253548
Claim settlement duration (package)	59 days	126 days	66 Days	
Claim rejected By insurer	2.8%	12.5%	40.%	
Rejected Claim paid by shepherd	2.2%	6.2%	0%	

Challenges:

1. Insurance (health) policy is in English and complicated.
2. Same terms and conditions for Micro insurance and General mediclaim policies (cost vs. commercial)
3. No separate staff for MI in insurance companies (work load)
4. Unknown to member also termed as pre-existing
5. Claim settlement duration too long ranging form 55 days to 135 days.
6. All insurance claims are handled by same staff (marine, motor, health and miscellaneous)

7. We are building the corpus of insurance companies than assisting the poor.
8. No referral fee or incentives to NGO who do all the work
9. Ins.companies are not keen to give claim advance
10. Government hospital bills are not considered by insurance companies

Shepherd's Initiatives:

- Sugam fund Rs.4 lakhs has been established for operations and exclusion
- One lakh rupees has been established for quick claim settlement.
- Panel doctor's committee was established
- Net working with committed hospitals
- Separate staff are handling social protection

Insurance Annual Meet

Suggestions:

1. Simpler definition of a claim rules for rejection and reduced documentation.
2. Keeping a share of the premium with a qualified agent (NGO) in order to pay claims faster
3. Insurer margin (profit) should be shared to members by the way of
   - Increasing the sum insured (benefits)
   - Reducing the premium cost.
4. Providing 10-15% of premium cost to NGO's will have greater impact in outreach and claim servicing

5. Removing service tax will benefit the poor
6. Encouraging community mutual will be a better solution to enroll more women (self help basis)
7. Active participation in claim committee and insurance education to insured
8. Ensuring timely services to insured
9. Treat NGO's as real partner in Risk mitigation

THANK YOU

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(or)

ssafe.india@gmail.com

Karuna Trust and Vivekananda Girijana Kalyana Kendra

A brief overview

Karuna Trust

"Our vision is for a society in which we strive to provide an equitable and integrated model of Health care, Education and Livelihoods by empowering marginalized people to be self reliant"

"Our Mission is to develop a dedicated service minded team that enables holistic development of marginalized people, through innovative, replicable models, with a passion for excellence"

Karuna Trust

- Founded in 1986 in response to high prevalence of Leprosy in Yelandur taluk-
- Community based, people oriented, need based, culturally acceptable models using appropriate technology with minimum cost to the community

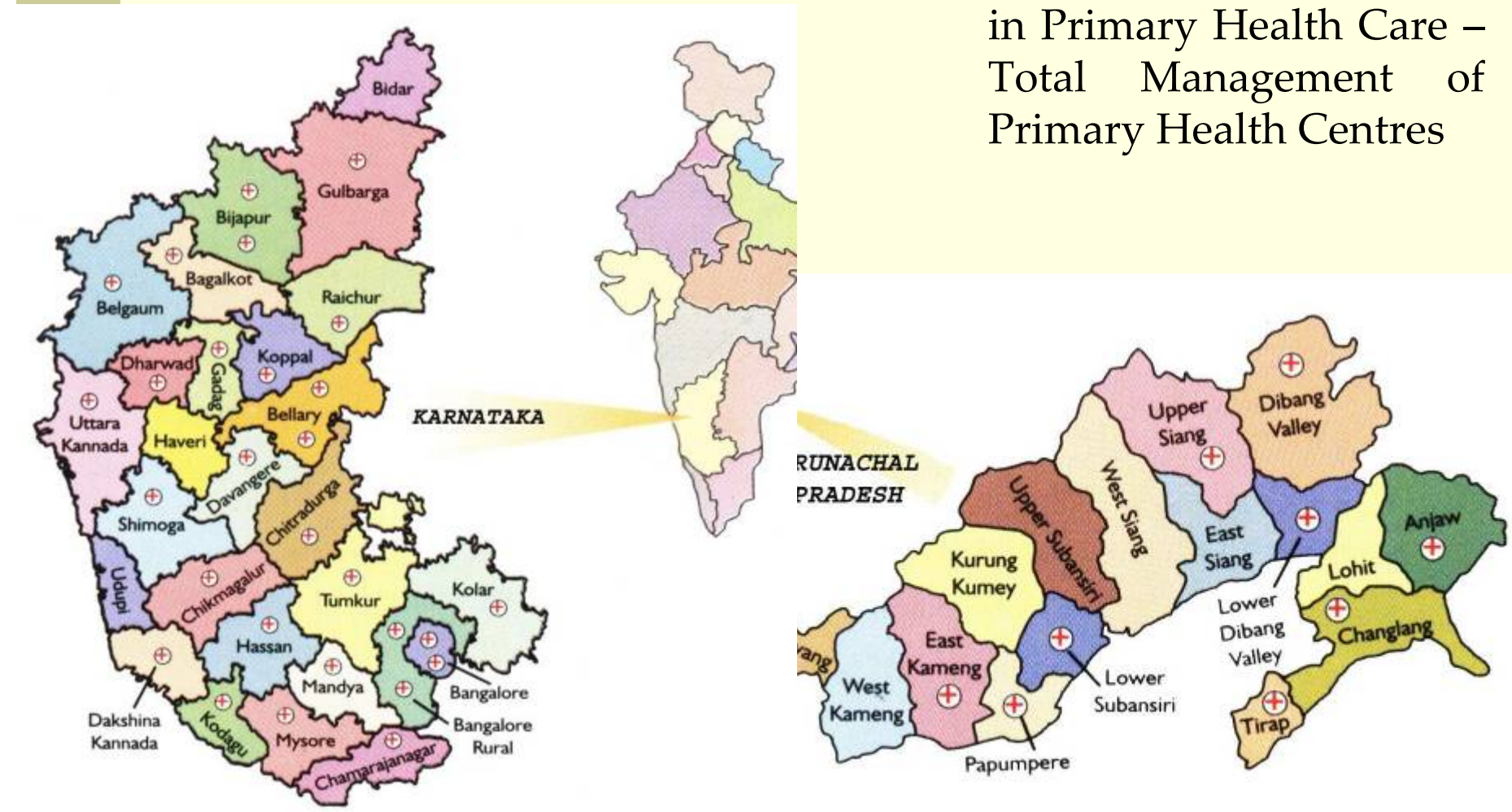
Public Private Partnership

Partnership with Voluntary Organizations:

- Entrusting Management of PHCs to VOs and Private Medical Colleges. Karuna Trust is managing 25 PHCs in Karnataka and 9 PHCs in Arunachal Pradesh
- Tele Medicine project – Asia Heart Foundation and Karuna Trust & Village Resource Centres
- Tribal ANMs Project
- District Health management
- Community Health Insurance
- Task Force on Health & Family Welfare
- Good Governance in Health – Karnataka Lokayukta
- ASHA training
- Community Monitoring under NRHM (possible role as 'mini IRDA')

Health

Public-private Partnerships in Primary Health Care – Total Management of Primary Health Centres



Innovations in Primary Health Care

- 24-hour PHC with HQ availabilty of all staff
- Gender sensitive PHC
- Integration of Community Mental Health in PHC
- Mainstreaming of HIV/AIDS in PHC
- Essential Obstetric Care
- Rational Drug Use, essential drugs
- PHC Waste Management
- Community-based Rehabilitation of people with disability

Community Health Insurance – 2002

Partner Organizations

- Ministry of Health & Family Welfare, GOI
- UNDP
- Department of Health & FW, GOK
- Karuna Trust
- CPD
- National Insurance Company

Objectives

- Developing & Testing a model of Community Health Financing for Rural Poor
- Increasing access to Public Health Care by Rural poor
- Ensuring Equitable distribution of Health Care through Social Insurance
- Empowering Rural Poor for better Health

Implementation stages

- Baseline survey
- Design of Scheme
- Awareness generation
- Enrolment and claim facilitation
- Extension of operational area
- Advocacy

Baseline survey findings

- 60% went to Private allopathic hospitals
- Out of pocket expenses – drugs, travel, escorting wage loss, speed money
- Only around 20% were aware of health insurance
- Reasons for not availing insurance – too expensive, high premium, why pay before falling sick, no trust, hassles of claiming

Two models of Community health Insurance

- T Narsipura model – Strong NGO presence
- Bailihongal model – Government led, NGO monitored/supported

Empowerment of Rural Poor - PRA, Micro-plan, Village, Sub Center & PHC Committees

Gram Sabha, GP, TP & ZP Health Plans

Right to Health approach

Salient Features of Karuna Trust Insurance scheme

- **Low Premium**: Rs.22 per person per year
- Premium costs shared by community, Milk Co-operatives, SHGs, UNDP and GPs
- **No exclusions** - all age groups, pre-existing illness including HIV/AIDS - Hospitalization due to any illness
- Rs. 50/- paid to patient for daily wages lost and Rs. 50/- to the hospital for extra drugs per day of hospitalization

Features of Insurance

- Rs.1000/- for surgery : 500 for patient and 500 for buying drugs etc
- Ambulance Services and Referrals - Diagnosis & Treatment are also covered
- Maximum of 25 days of Hospitalization
- Amount paid to patients every day through the revolving fund at each Hospital
- NIC settles the claims once a week

Raising awareness

T Narsipura – Street theatre, video shows, public announcements, one to one, posters, hoardings, community meetings (SHG, VDC)

Bailihongal – use of existing Government IEC systems – ANMs AWW during RCH/Immunisation sessions, posters on PHC/hospital walls, community spaces

Enrolment

- BPL/SC/ST identified from official lists (subsidised premiums)
- Non BPL SC/ST motivated by SHG
- Beneficiary contribution sent to Karuna trust or taluk health office
- Subsidy element added and sent to NIC
- Speed ensured by special software/identification cards with all details/simple processes

Changes

- Enrolment increased from Rs 12,500 to 74,200 (TNarsipura) and 5,600 – 1,49,200 (Bailihongal) from Sept 2002 – Aug 2003
- Increased use of Government PHC from 66,000 in 2001 to 1,01,640 in 2004
- Indirect spinoff – Increased staff commitment

Challenges

- Changing existing patterns and perceptions '*We feel that it is superstitious to plan for an illness that has not happened – inviting the 'evil eye'*
- Reducing dependence on private healthcare facilities
- Motivating Government functionaries

Progress

- Access to public health care by Rural Poor & Women has improved. Essential Drugs made available for BPL.
- Extended to 25 PHCs – 25 Districts of Karnatka.
- Working with Government of Karnataka (World Bank Project) to extend it to rest of Karnataka in phases.
- Include HIV/AIDS patients – VCTCs & ART
- Sustainability of the project through SHGs

Requirements for Rural Sector Health Insurance

- Low premium or subsidized premium
- No Exclusions – All age groups, Pre-existing illness including HIV/AIDS
- Utilize both Public & Private Health providers
- Compensation for daily wages lost for BPL – cover out of pocket expenditure.
- Take responsibility to provide Health care in backward and remote areas.

Future focus

- Motivate women to pay more attention to their health '*Women need to be convinced that they are an important part of society and therefore their health is as important as their husbands or families'*
- Sustainability
- Strengthen partnerships with Government health care facilities

THANK YOU

Healing Fields Foundation

(DRG Model)

Donna Swiderek

d.swiderek@sasktel.net

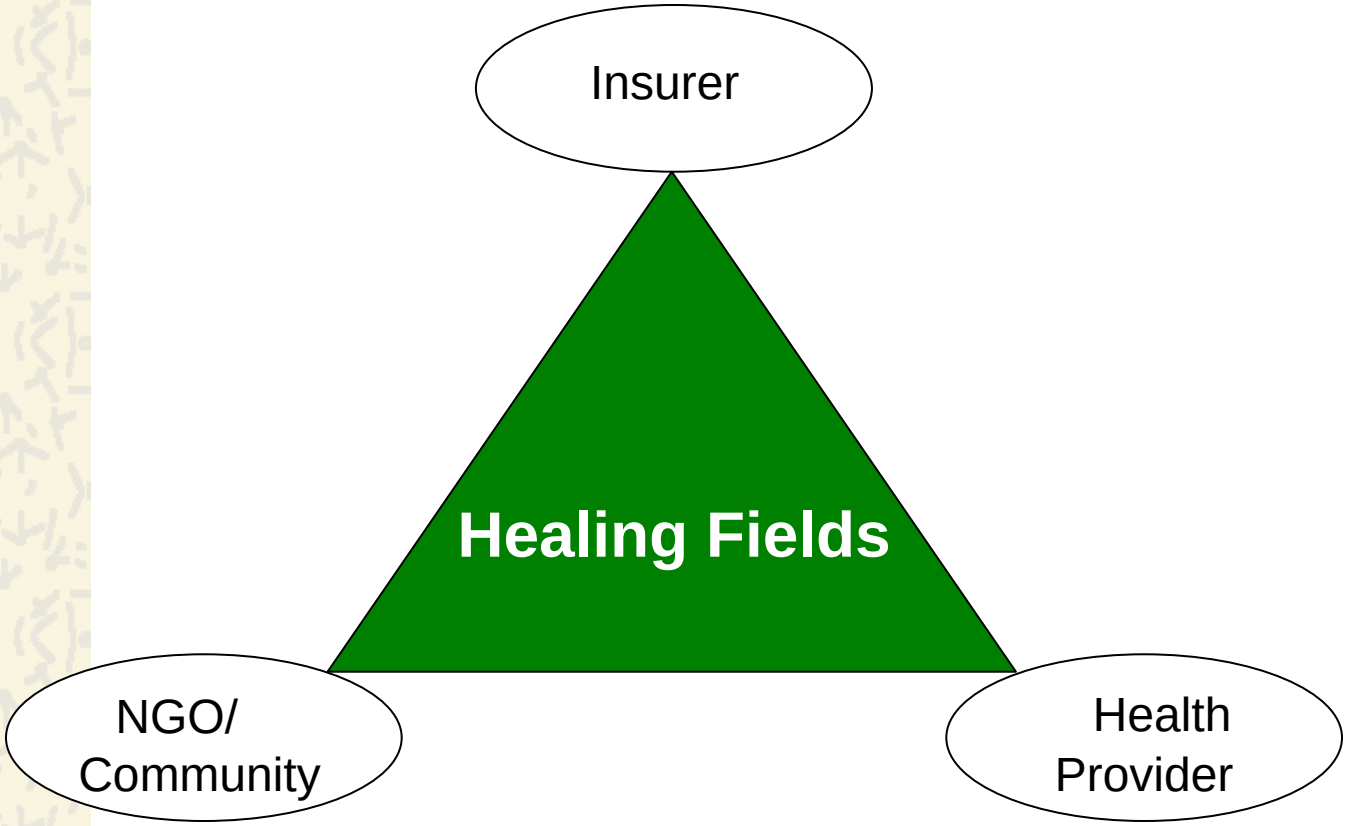
Introduction

- Aims at making quality healthcare accessible and affordable to all people in India, particularly the poor, underprivileged, marginalized population.
- The project seeks to create a healthcare financing and administration “ecosystem” for the poor.

Introduction (cont'd)

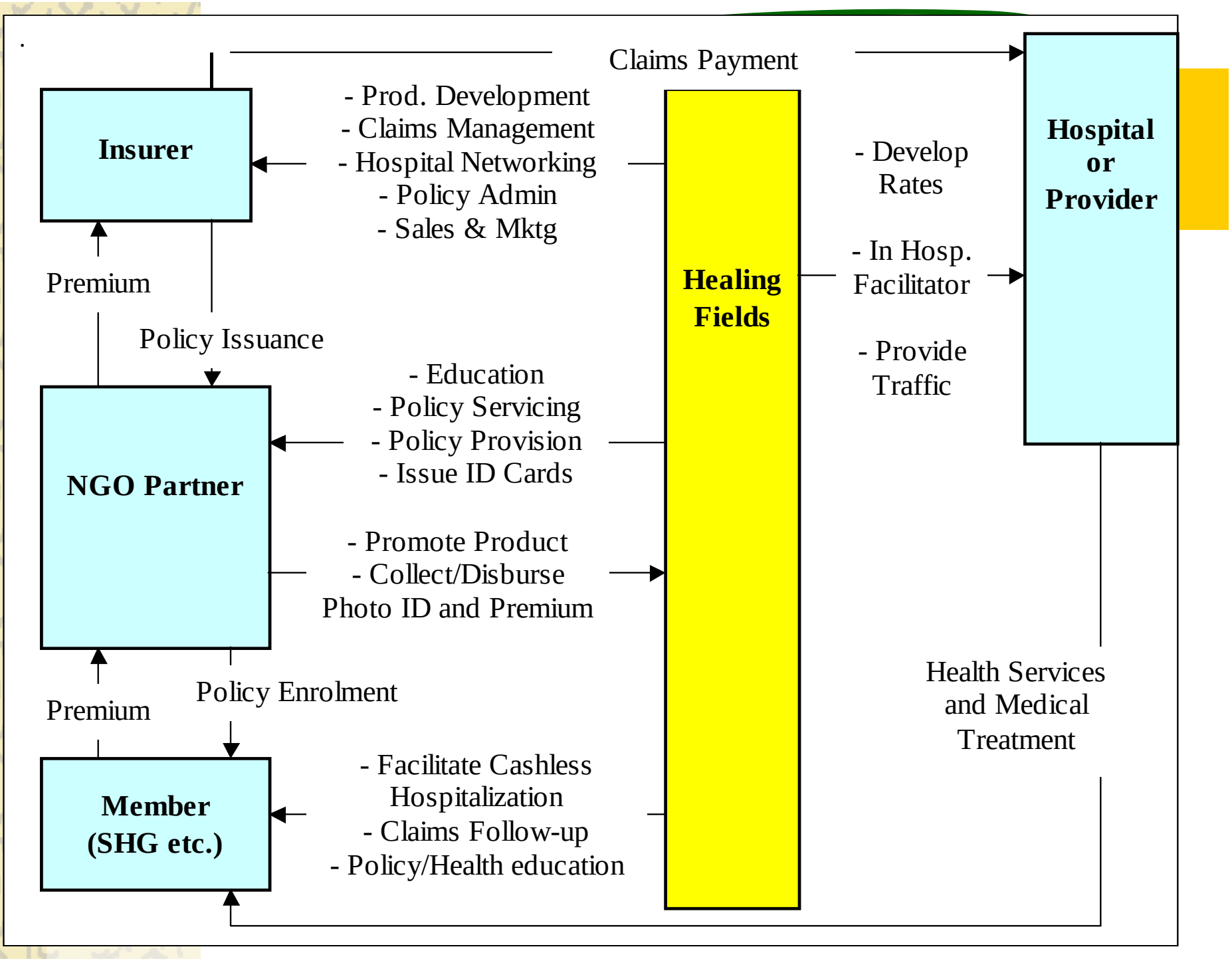
- Brings together NGO's, insurance companies and healthcare providers under one umbrella.
- Organizes and supports NGO's through insurance process.
- A strong board with a vast knowledge base and a variety of professional skills.

Service Integrator Model



HFF Model – Service Integrator

- NGO/Partner Networking
- Central Administration
- Client Education and Awareness
- Enrolment and Renewal Processing
- Hospital Networking
- Client Service Delivery (HFF Facilitator)
- Transaction Processing
- Innovative Solutions


Insurer
NGO Partner
Member (SHG etc.)
Healing Fields
Hospital or Provider
Claims Payment
- Prod. Development
- Claims Management
- Hospital Networking
- Policy Admin
- Sales & Mktg
Premium
Policy Issuance
- Education
- Policy Servicing
- Policy Provision
- Issue ID Cards
- Promote Product
- Collect/Disburse Photo ID and Premium
Premium
Policy Enrolment
- Facilitate Cashless Hospitalization
- Claims Follow-up
- Policy/Health education
- Develop Rates
- In Hosp. Facilitator
- Provide Traffic
Health Services and Medical Treatment

Package Details

- Rs 336 per year plus one time registration fee.
- Health (hospitalization)
- Personal Accident Benefits (Death/Disability)
- DRG covering 43 illnesses
- Risk Bearer: HDFC-GICL
- Wage compensation, Post hospitalization drug coverage, Pre hospitalization coverage and transportation benefit in remote tribal areas

Enrolment

- Requires commitment, time and organization of the NGO
- Providing training and support to the NGO is essential
- Health education and insurance awareness creation are key to motivating people to buy.
- Fixed registration fee declines with larger participation rates

Enrolment (cont'd)

- Willingness to pay:

  Rural areas: 60% willing to pay Rs120-240

  Urban Areas: 35% Rs 361-600

  30% Rs 601-1200

Administration

- Annual premium is collected by NGO
- Variety of skills, experience and knowledge in different disciplines required.
- All business processes are shared with and maintained by the MIS department.

Empanelment of Providers

- The Providers are rated before empanelling them into the network.
- Qualified providers sign a MoU
- Must follow the Healing Fields Foundation Medical Management processes
- A Healing Fields Facilitator is appointed
- Must honour the pre-negotiated rates of the DRG

Claim Settlement

- Cashless Payment system
- 25% Co-payment of the bill by member at time of discharge
- Average time for payment to providers: 15 days

Risk Management

- *Network standards* and *efficiencies* force transparency and a high level of medical competency
- Hospital treatment and costs must have *pre-authorized approval.*
- All claims are *scrutinized.*
- Utilization of hospital services are closely *monitored*

Monitoring

- Full detailed monthly reports are given to the NGO's, insurer, hospitals and internal departments
- Used for Benchmarking, planning and minimizing of potential outbreaks (I.e.) typhoid.

Types of Reports:

- Claims ratio (overall and by NGO)
- Claims frequency (by geography and disease)
- Incidence Rate
- Claims Settlement time
- Rejection Rate
- Renewal Rates

Lessons Learned

- The Model creates reduced healthcare expenses and improved health outcomes
- In our experience this is one of the few models that reduces the claims cost. This component is very important to develop viable micro health insurance programmes.

2004 Household Health Expenditure Study

	Karnataka	Healing Fields
Hospital Claims covered by DRG and pd by Ins. Co.		Rs 121
Co-payment (paid by member)		Rs 40
Gaps in Coverage		Rs 150
Total Hospitalization	Rs 652	Rs 311

Lessons Learned

Causes of Reduced Claims Cost and Improved Quality of Care:

- Treatment protocol, monitoring of health provider and continuous dialogue regarding care
- Pre-negotiation of price with providers
- Post hospitalization Drug coverage
- Health education
- In the future, including OPD could further reduce hospitalization cost as treatment can occur before disease escalation.

Lessons Learned

Enrolment and Retention

- Lack of primary healthcare structures in more remote rural areas is a major obstacle.
- Innovative solutions are needed to encourage those most in need
- The commitment and fit of the NGO to the Healing Fields objective was essential.

Lessons Learned

- The model was expensive and time consuming at this small scale because of start up costs, a learning curve and constant process improvements.
- Making the admin operation more cost effective and efficient is vital to the long-term success of the Model.
- It takes time to reach viability: 7-10 years.

Accreditation Empanelment Criteria for Insurance

Girdhar J. Gyani
Secretary General, QCI

Accreditation

Public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external assessment of that organisation's level of performance in relation to the standard.

(ISQua)

Accreditation

Accreditation relies on establishing technical competence of healthcare organisation in terms of accreditation standards in delivering services with respect to its scope. It focuses on learning, self development, improved performance and reducing risk. Accreditation is based on optimum standards, professional accountability and encourages healthcare organisation to pursue continual excellence.

Regulation

An instrument mandated by the Government to impose set of conditions, which a healthcare organisation must comply with, before and after it is permitted to operate in the country. It is based on the minimum standards, inspection, enforcement and public accountability

Regulation Vs Accreditation

- Regulation is mandatory
- Accreditation is voluntary
- Accreditation is promoted by way of incentives and market forces
- In order to achieve best of both worlds, regulation in time to come can simply rely on accreditation

Quality Council of India (QCI)

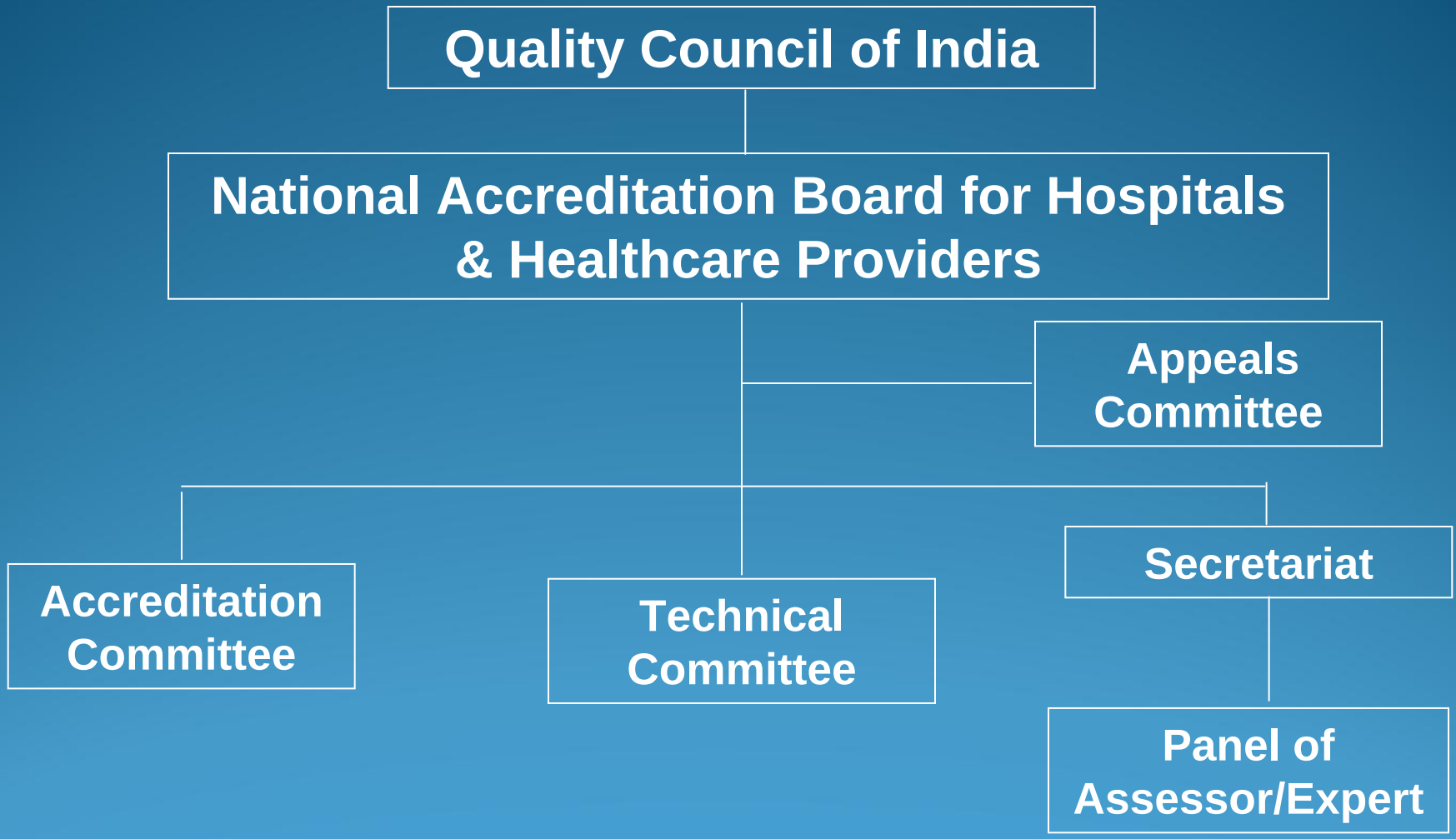
- QCI is an autonomous body set up by Govt. of India to establish and operate accreditation structure in the country.

Structure of QCI

NABH

- Set up in association with Govt. of India and the Indian Health Industry.
- Catering to the needs of the consumers and setting standards for progress of the health industry.
- Supported by all stakeholders and having full functional autonomy in its operations

Structure of NABH



Composition of Board

1. Chairman (Dr. P.K. Dave)
2. Indian Medical Association
3. Consumer Co-ordination Council
4. Insurance Regulatory & Development Authority (IRDA)
5. Indian Nursing Council
6. Sree Chitra Tirunal Institute for Medical Science & Technology
7. Director General, Armed Forces Medical Services
8. Department of Bio-Technology
9. Postgraduate Education Institute (on rotation basis)
    1. PGI Chandigarh
10. CEO NABH (member secretary)
11. Chair, Health Committee - CII
12. Chair, Health Committee - ASSOCHAM
13. Chair, Health Committee - FICCI
14. Academy of Hospital Administration (AHA)
15. Ex Officio Members
    1. Secretary General - QCI
    2. Chair – Accreditation Committee – NABH
    3. Chair Technical Committee – NABH
    4. Chair – Appeal Committee – NABH

International Linkages

- NABH is an institutional member of the International Society for Quality in Health Care (ISQua)
- NABH is also a member of ISQua Accreditation Council
- NABH also represented ISQua Accreditation Council on WHO International Patient Safety Committee.

International Linkages

NABH is the founder member of newly emerging Asian Society for Quality in Healthcare (ASQua) being registered in Malaysia

NABH Standards

1. Access, Assessment and continuity of Care (AAC)
2. Patient Rights and Education (PRE)
3. Care of Patient (COP)
4. Management of Medication (MOM)
5. Hospital Infection control (HIC)
6. Continuous Quality Improvement (CQI)
7. Responsibility of Management (ROM)
8. Facility Management and Safety (FMS)
9. Human Resource Management (HRM)
10. Information Management System (IMS)

NABH Standards for Hospitals

- 10 chapters
- 100 standards
- 503 objective elements

NABH Standards for Small Health Care Organisations (SHCO)

- 90% of hospitals are with beds less than 100, there was demand to have specific guidelines on how to apply hospital accreditation standards for small healthcare organisations.
- Present standard is a compilation of all applicable standards from hospital accreditation programme, which are relevant for small healthcare organizations.
- This will facilitate small healthcare organizations in easy understanding and implementation within their facilities.

NABH Standards for Small Health Care Organisations (SHCO)

- 10 chapters
- 63 standards
- 294 objective elements

NABH Standards for Blood Banks/Blood Centres & Blood Transfusion Services

- Blood bank accreditation programme strives to the quality and safety of collecting, processing, testing and transfusion of blood products.
- Ensures safety as well quality culture within the facility.
- Accreditation is granted for collection, processing, testing, distribution and administration of blood and blood components.

Quality Begets

- Corporate Environment.
- Competitive Advantage And Better Market Positioning.
- Customer Focus And Customer Satisfactory Fulfillment.
- Confidence Of Regulatory Authorities.
- Minimisations Of Litigational Losses.

Problem of Health Care Facilities

- The large existing and expected growth in infrastructure represent divergent unregulated pattern.
- The diverse nature of healthcare practices range from globally compatible tertiary care centres to small nursing homes to unqualified professionals and quacks.
- Poor regulatory mechanism either from government or within the medical professions leads to mushrooming of sub standard facilities , malpractices and create unhealthy imbalance between the excellent and dismal, creating lack of credibility for health care infrastructure as a whole.

Driving Factors

- Healthcare Scenario in India is going through a revolutionary phase of transition and evolution.
- Growth in next decade anticipated comparable to IT boom in the decade.
- Private expenditure on healthcare likely to reach more than double the present figures by 2012.
- Additional 7.5 Lakh beds likely to be added to present 15 lac in next decade.
- Marketing strategy.

➢ INSURANCE AS A KEY DRIVING PLAYER IN THE COMING DECADES

Driving Factors

- Consumer Protection Act
- Clinical Establishment Bill
- **Insurance Companies regulation**
- Empanelment of health facility like CGHS,ECHS etc.
- Community Awareness & Response .
- Health Tourism.

The key Question

How could the healthcare customer be assured of credibility and trust that the services being offered are as per the stated standards while conforming to minimum basic professional standards required to deliver the stated and implied quality.

Benefits to paying and Regulatory Bodies

Accreditation provides an objective system of empanelment by insurance and other third party. Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care

Contact Details

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AAROGYASRI COMMUNITY HEALTH INSURANCE SCHEME

Scenario in the State

- Govt. hospitals unable to serve state wide demand of poor suffering from serious ailments
  - Lack of specialist pool of doctors
  - Lack of equipment and infrastructure
- Network of Private Hospitals available for quality medical care in such cases
  - Treatment is, however, expensive
  - In many cases, patients unable to access medical treatment

Aarogyasri

A PUBLIC – PRIVATE – PARTNERSHIP

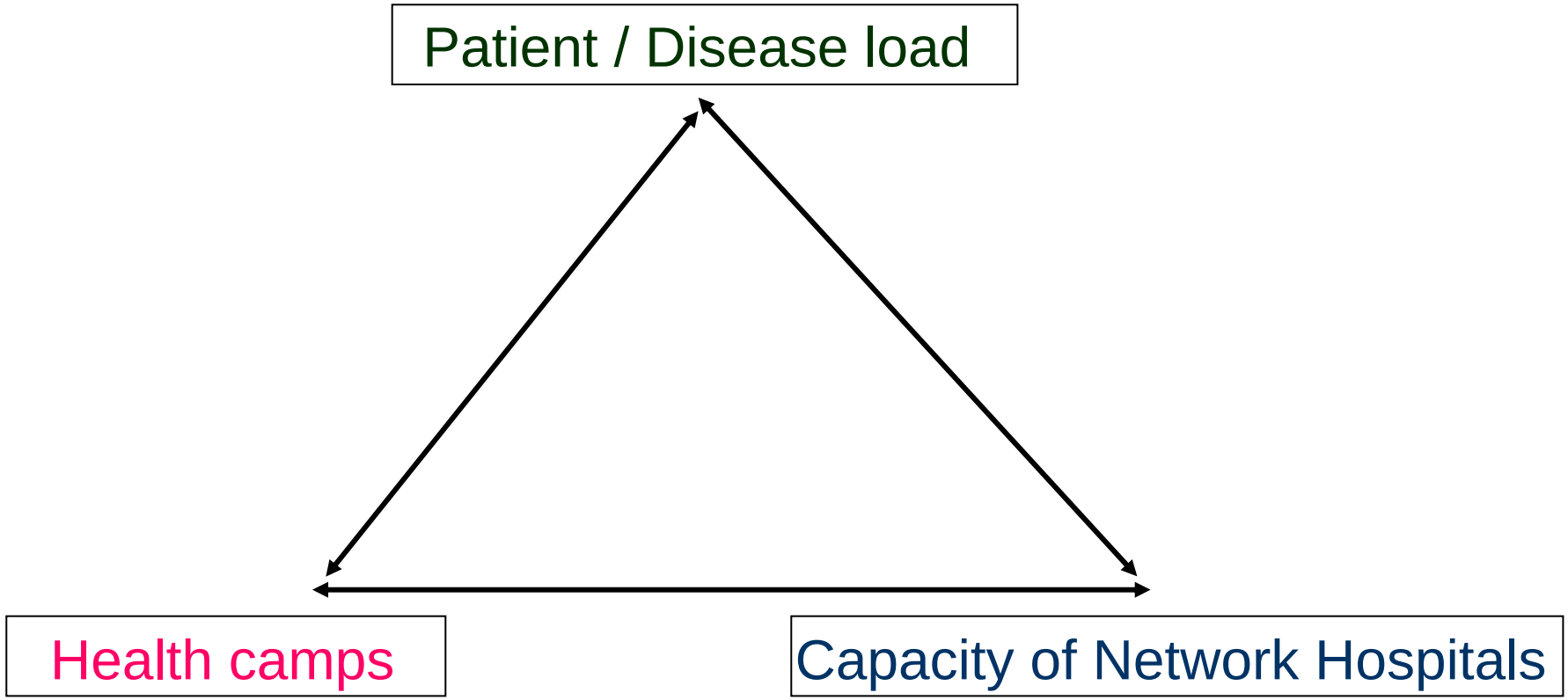
(NOT A CONVENTIONAL INSURANCE SCHEME)

➢ AAROGYASRI TRUST	REGULATOR
➢ INSURANCE COMPANY	RISK COVERAGE
➢ NETWORK HOSPITALS	SERVICE PROVIDER
➢ DISTRICT ADMINISTRATION	MOBILISATION
➢ FED. OF SELF HELP GROUPS	HEALTH WORKERS (AAROGYA MITHRAS)

Striking Features

- Universal Coverage
- Cashless treatment
- Health Workers (Arogya MITRAs)
- Simple Procedure: White Family Photo card as Health card
- 100% Premium borne by the Government
- Identified diseases involving hospitalization and surgery
- Packages for end-to-end treatment of patients
- Choice of Hospital – Left to patients
- 24 hour toll free help line – 1800-425-7788

Fine Balance



Beneficiaries

- All families living Below Poverty Line (24 lakhs in Anantapur, Srikakulam and Mahboobnagar & 48 lakhs in 5 districts w.e.f 1st Dec 070.
- Family as enumerated in BPL card
- Average family size is 3.6

HOUSEHOLD CARD

Card No	:	WAP140700400298
F.P Shop No	:	4
పేరు	:	తేలుగు.కొండయ్య
Name of Head of Household	:	Telugu.Kondaiah
తండ్రి/భర్త పేరు	:	చెన్నయ్య
Father/ Husband name	:	Chennaiah
పుట్టినతేది /Date of Birth	:	
వయస్సు/ Age	:	35
వృత్తి /Occupation	:	Daily wage earner
ఇంటి.నెం. /House No.	:	1-23/A
వీధి /Street	:	ACHARYAPUR
Colony	:	ACHARYAPUR
Hamlet Village/Thanda	:	ఆచార్యపుర/Acharyapur
Rev. Village	:	ఆచార్యపూర్ / Acharyapur
Mandal Name :	:	కోయిల్‌కొండ / Koilkonda
జిల్లా /District	:	మహబూబ్‌నగర్ / Mahabubnagar
Annual Income (Rs.)	:	11,000
LPG Consumer No.	:	No Cylinder

Family Members Details

S.No	Name	Relation	Date of Birth	Age
2	Manemma	Wife		30
3	Krishnaiah	Son		12
4	Chandrakala	Daughter		10
5	Raghavender	Son		7

కార్డుదారుని సంతకం/వేలిముద్ర

31/03/2007
జారీచేసిన తేది

ఎమ్.ఆర్.ఓ / ఏ.ఎస్.ఓ

Coverage

- Surgeries in the following systems

i. Heart ii. Cancer iii. Neurosurgery iv. Renal
v. Burns vi. Poly trauma, *not covered by the M V Act*

Total surgical procedures : 1st phase 163 Procedures - April 2007
2nd phase 213 Procedures –Dec 2007

Additional:

i. Lung ii. Liver iii. Pancreas iv. Congenital malformation
v. Post burn contractures

3rd phase & 1st phase Procedures 272 – April 2008

Sum Insured

- Sum insured per family Rs.1,50,000/-
- Benefit on floater basis.
- Additional Rs 50,000 buffer for excess expense on an individual case basis

Financial Implications

- Premium -
- Rs 330/- per family; Policy taken for 20 lakh families – 1st Phase
- Rs.220/- per family; Policy taken for 48 lakh families - 2nd Phase
- Rs 249/- per family, Policy taken for 34 lakh families - 3rd phase
  & Rs 119 for 1st phase renewal

- Coverage:
- 24 lakh families; 85 lakh population – 1st phase 3 Districts April 07
- 48 lakh families; 160 lakh population – 2nd Phase 5 Districts Dec 07
- 34 lakh families; 123 lakh population- 3rd phase 5 Districts April 08

- Profit sharing – Insurance co. to pay back 90% of profit, if any, after deducting 20% as administrative cost.

Network Hospital – Responsibilities

- Organize Health Camps
- Dedicated Reception, Registration and Special Ward
- Free Transport to and from Mandal HQ
- Free food for in- patient
- Free consultation, diagnostics and treatment, irrespective of surgery
- Cashless services

Health Camps (1st April 2007 to 31st March 2008)

District	No. of camps	Patients screened	No. referred for admission
Mahboobnagar	346	76228	6697
Anantapur	421	62093	5545
Srikakulam	286	52302	4764
	1053	**175566**	**15702**
East	**197**	**37425**	**4666**
West	**194**	**51678**	**5942**
Chittor	**227**	**76505**	**6114**
Ranga Reddy	**145**	**25015**	**2583**
Nalgonda	**204**	**30160**	**3822**
Total	**967**	**220783**	**23127**

Health Camps (1st April 2007 to 31st March 2008)

	District	No. Surgeries	Amount
PH 1	Mahboobnagar	3363	15.63 Cr
	Anantapur	4096	21.33Cr
	Srikakulam	4178	15.46Cr
		11637	**52.42**
PH 2	East	**2415**	**11.29 Cr**
	West	**2820**	**13.17 Cr**
	Chittor	**1350**	**5.88 Cr**
	Ranga Reddy	**1587**	**7.01Cr**
	Nalgonda	**1964**	**7.69 Cr**
	Total	**10136**	**45.04 Cr**

Health Camps

PALAKONDA - SRIKAKULAM

Health Camps

SHADNAGAR - MAHBOOBNAGAR

Health Camps

AGENCY AREA - SEETHAMPET - SRIKAKULAM

Issues

- Lack of reliable data on morbidity
- Constraint of infrastructure and medical professionals for expansion
- Funding of the scheme
- Exemption from Service tax on Premium

Thanks

RASHTRIYA SWASTHYA BIMA YOJANA

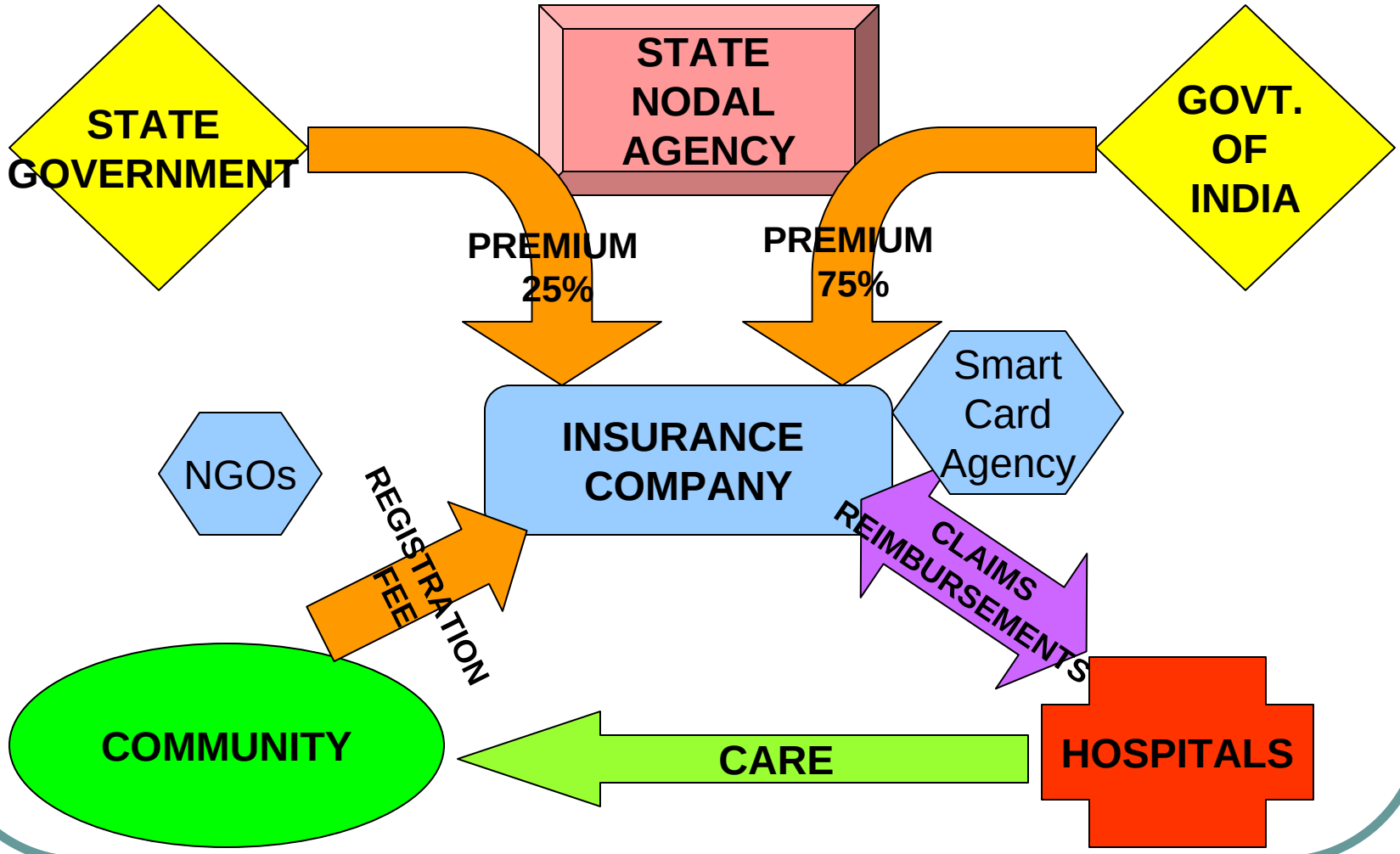
05/05/2008

The Rashtriya Swasthya Bima Yojana

1/10/2007	PREPARATORY PHASE	1/04/2008
Announced		To become operational

- Nodal department is the **Ministry of Labour** and Employment, but in close collaboration with other Ministries especially the Ministry of Health & Family Welfare

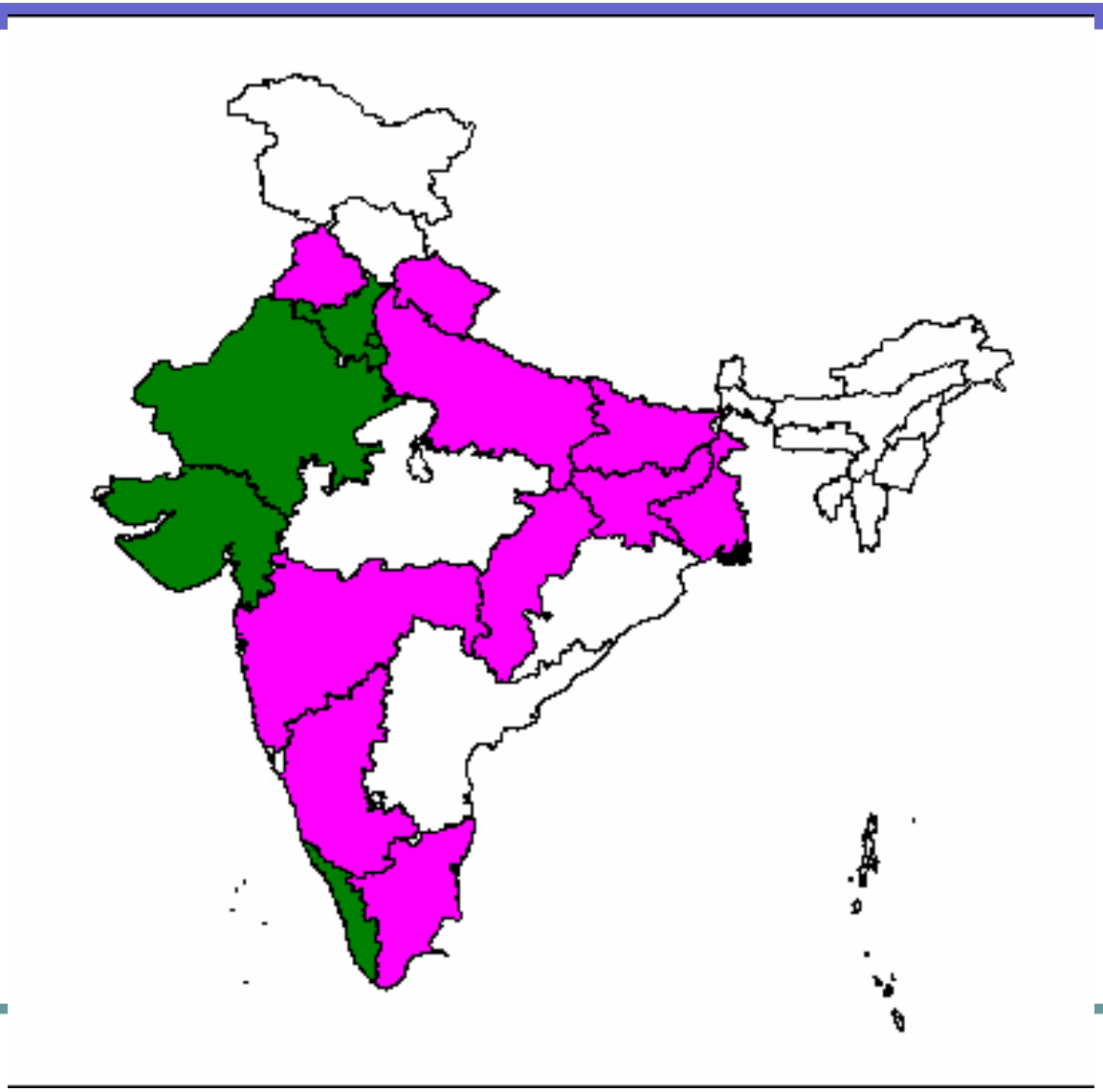
The Rashtriya Swasthya Bima Yojana



SMART CARD


सत्यमेव जयते
राष्ट्रीय स्वास्थ्य बीमा योजना
Rashtriya Swasthya Bima Yojana
Issued:Jan.2008
XXXX(Vernacular)
XXXX (English)
AGE: 42 yrs.
GENDER: MALE
0000 1651 0700 0012 6

Progress so far

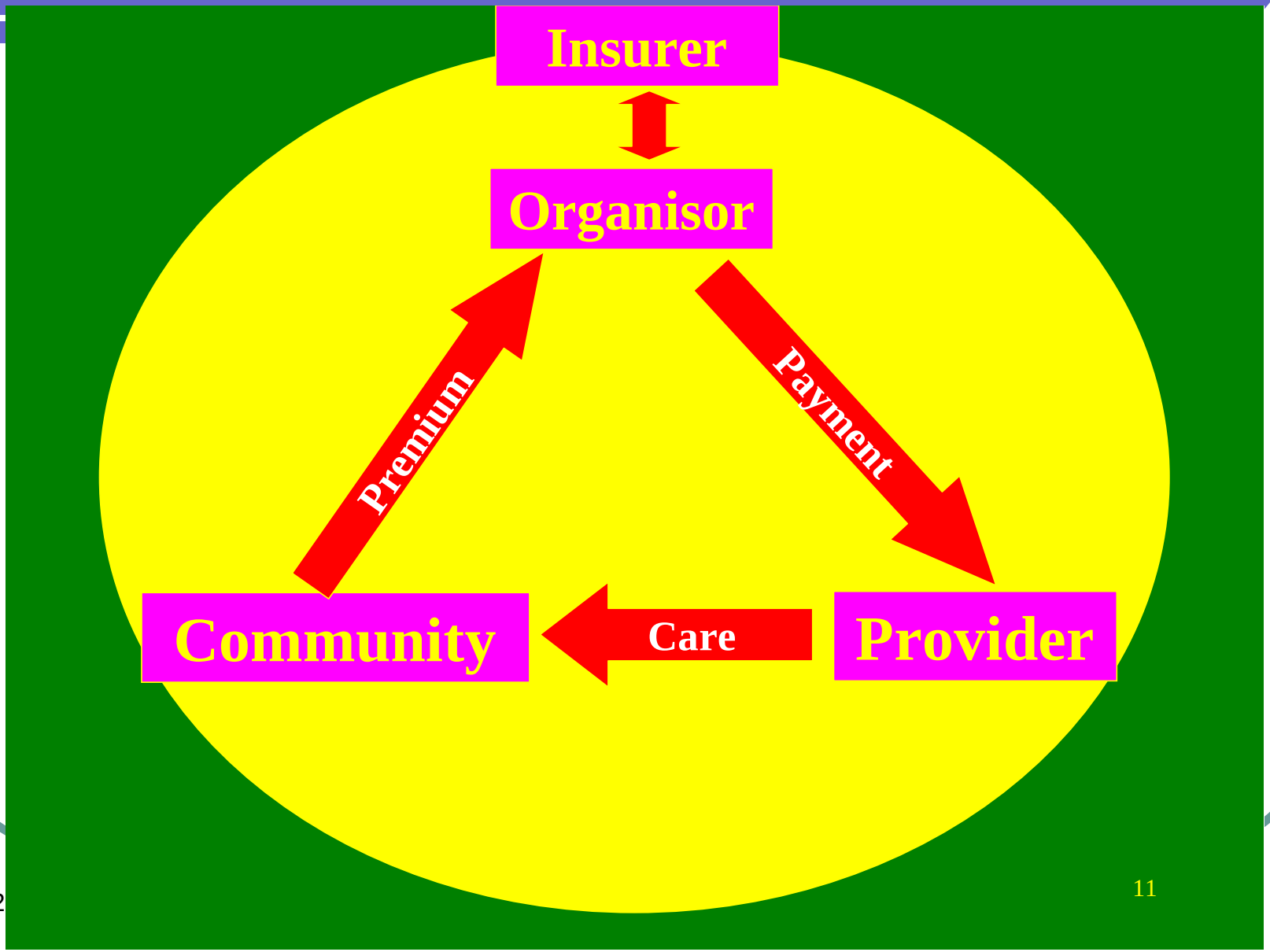


Strengthening the implementing agency

Dr. N. Devadasan, ***MBBS, MPH***

Institute of Public Health

Implementing agencies



Organiser

- In India, can be an NGO / CBO or the Government
- **In the case of NGOs / CBOs**
  - They have considerable social skills in mobilising the community
  - They know what the community wants
  - However, they lack technical and managerial skills e.g.
    - In negotiating
    - In actuarial calculations,
    - In designing the product
    - In monitoring the programme

Organiser ….

- **In the case of the governments**
  - They have the money and want to introduce health insurance
  - However, we find that most of them have very little understanding
    - Of health insurance per se
    - Of the community that they want to insure
    - How to mobilise communities
    - Of techno-managerial requirements

Organiser ….

- So what needs to be done?
  - **Capacity building, capacity building and capacity building.**
  - Experimenting with various models
  - Documentation and dissemination of best practices
  - Health insurance is a long term proposition
  - Self regulation of the CHI schemes
  - A multi-sectoral cell at the GoI level to set policies and strategies

Insurer

- Insurance companies are more used to insuring individuals.
- Most insurance companies are in the business for making profits
- So for them insurance for the poor is a contradiction
- They have
  - Very little understanding of the community
  - Products that are not tailored to meet the needs of the community
  - Very little presence in the rural areas
  - Problems in servicing their products
  - Little credibility among the community

Insurer ….

- So what needs to be done?
  - Have to do their homework
  - Have to look at HI in India on a long term basis
  - Build credibility
  - Experiment – even if it is loss making
  - Look at large volumes rather than large margins
  - Remember that even the poor in India are insurable

Community

- Are not only the purchasers of health insurance, but also very useful in implementation
- Useful to disseminate the message of health insurance
- Can be used for social audits to regulate fraud
- But currently have very little understanding of health insurance

Community ….

- So what needs to be done?
  - Community education in a concerted manner
  - Involve them at all stages of the plan
  - Trust them

Conclusions

- We have seen many products and schemes being delivered
- But most of them die in the infancy itself
- One of the main reasons is the poor implementation
- Without this being strengthened, other schemes will also meet a similar fate

THANK YOU

Dr. N Devadasan

Institute of Public Health