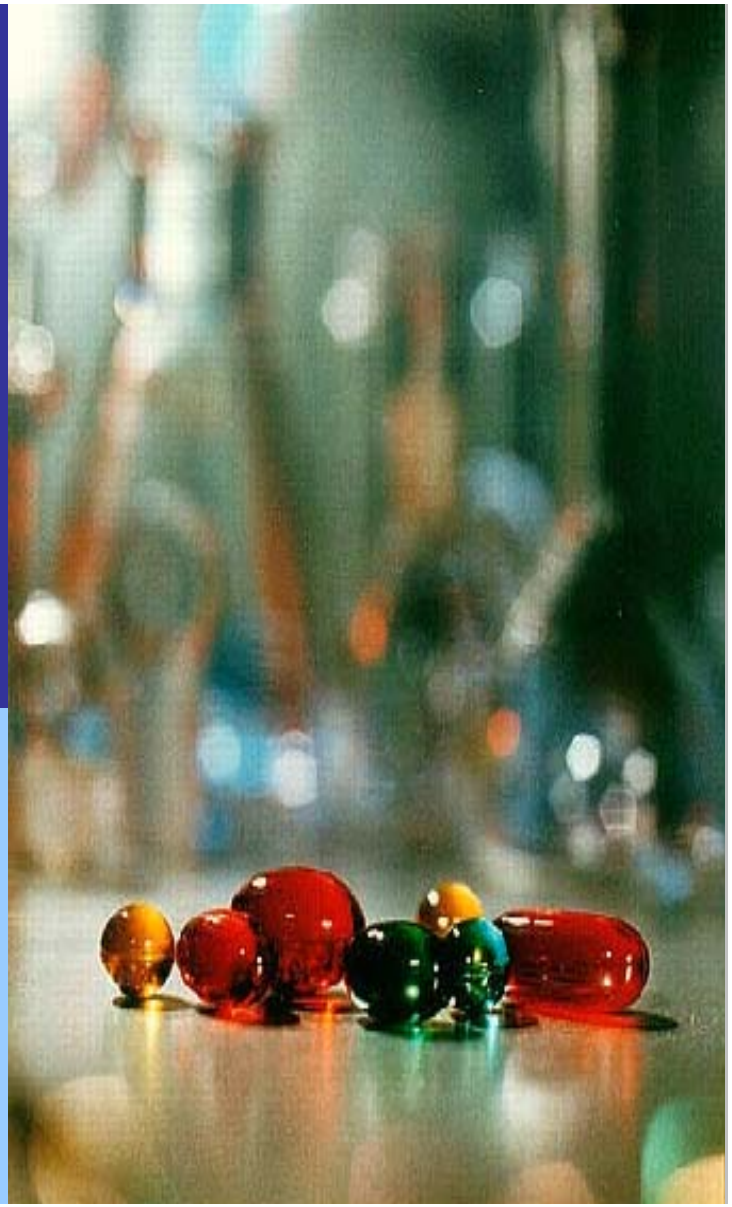
SUSTAINABLE HEALTH INSURANCE

PUBLIC PRIVATE PARTNERSHIP



CONTENTS

- The India Story! - Health Insurance for Financing Care
- Turning the Pyramid – Reaching Out.
- Private Public Partnership
- Myths and Realities
- Sustainable provision of health Insurance

India ……

A country with :

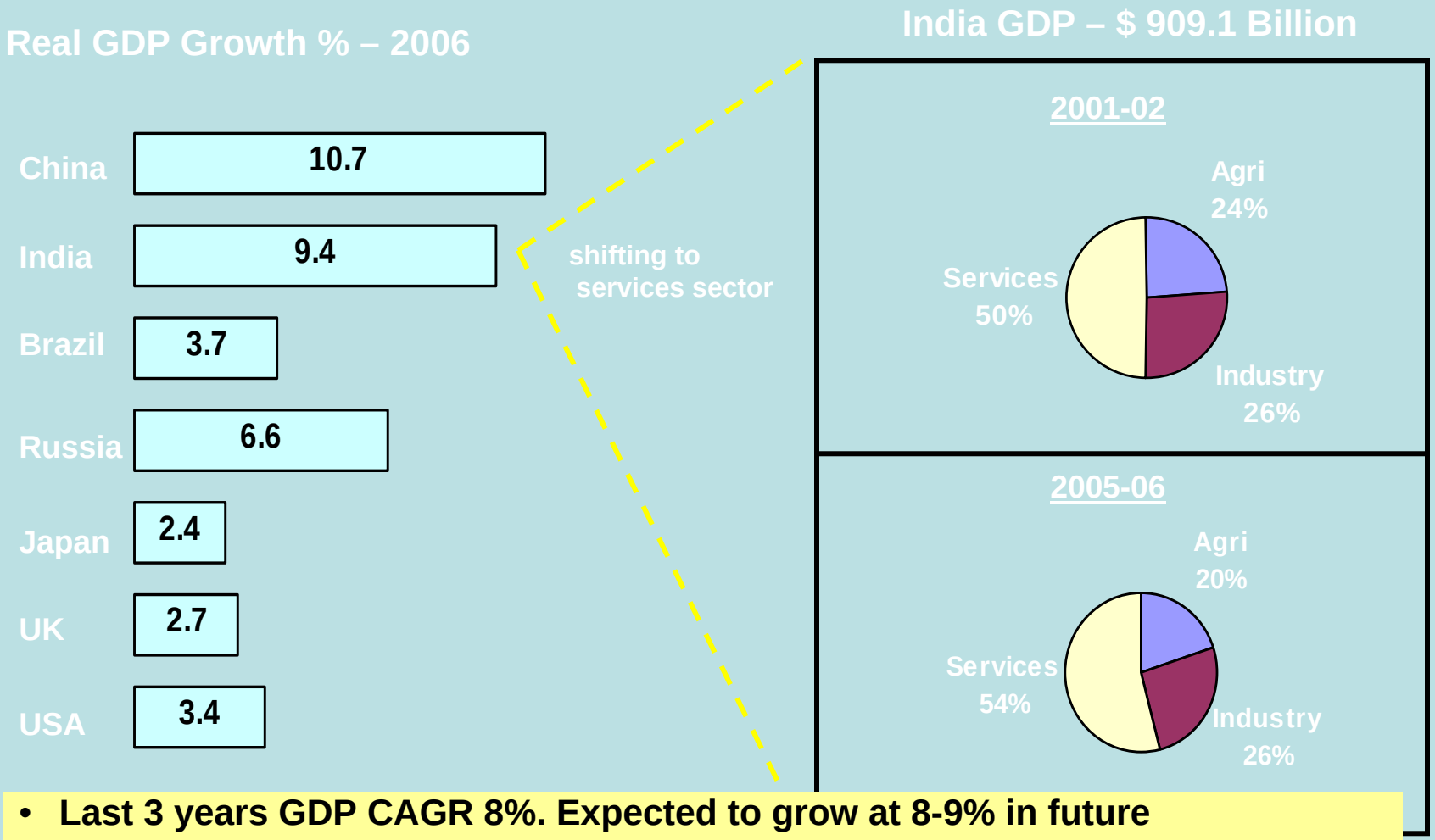
- **Buoyant Economic Growth**
- **Favourable Demographics:- a “young” country**
- **High levels of “Out of Pocket” spend on Health**
- **Promising Demand Dynamics**
- **Conducive Regulatory Environment**

and yet…

An Underdeveloped untapped market – with large volumes…..

…where the latent demand for Health Insurance has not, yet, been effectively addressed.

…the Second Fastest Growing Economy



- **Last 3 years GDP CAGR 8%. Expected to grow at 8-9% in future**
- **A booming Economy attracts US $8.44 billion in the first half of 2007.**

Source:Ministry of Finance website, World Bank data, RBI web site,SEBI

….with an increasing demand for Quality Health Care….

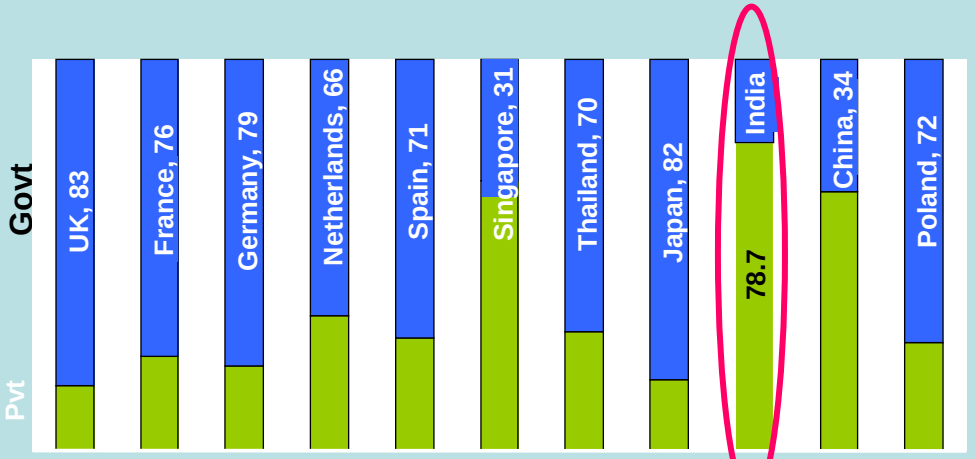
High Spends on Health-Majority Individual Household

Healthcare Expenditures Represent A Significant Portion of GDP

%age GDP spends on health for various countries

Source: WHO; ILO

%age spread between Government and Private spends

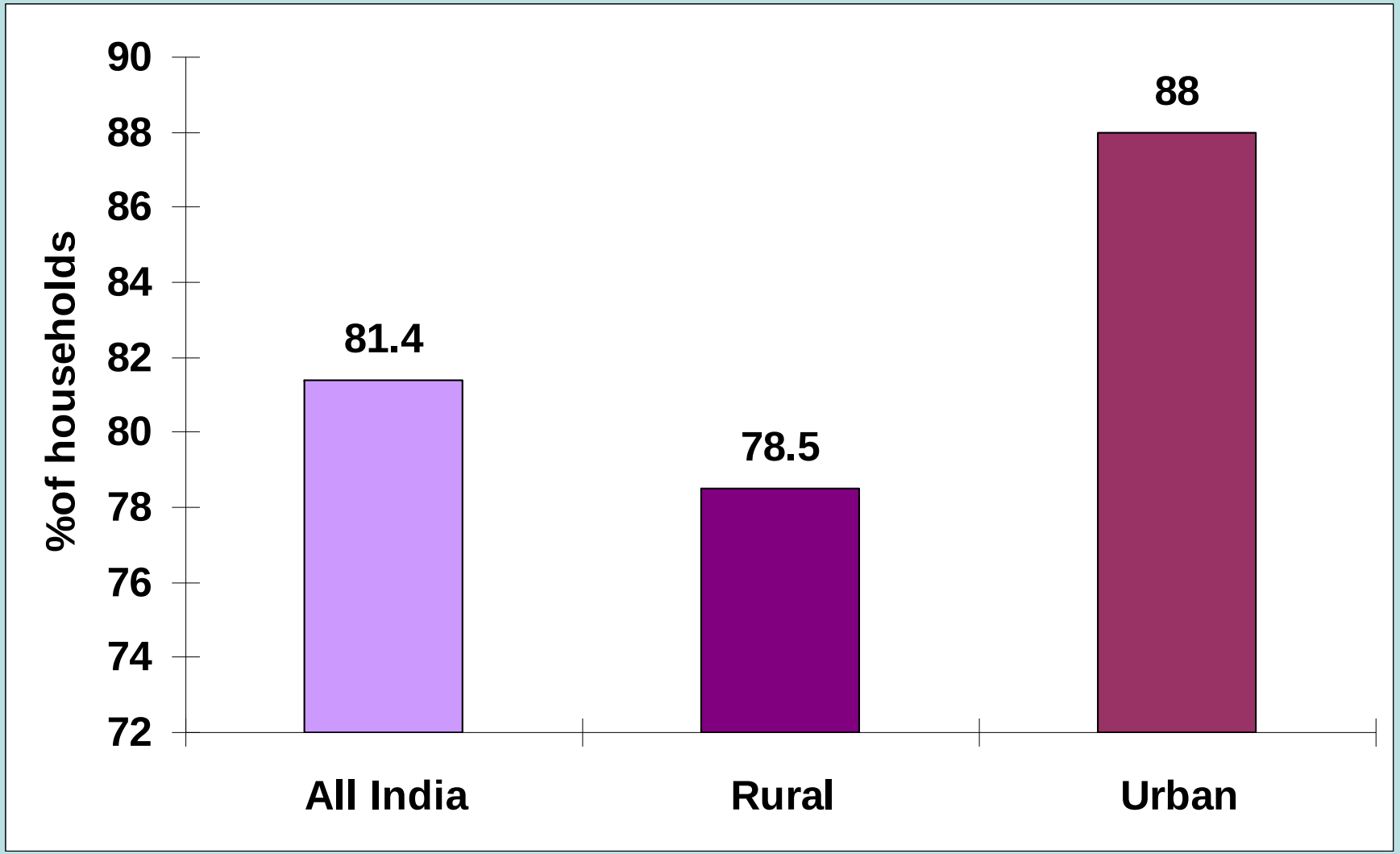


Source: World Health Report 2005

- **Household expenditure on health growing at 14%**
- **Household spends on Health in India (estimated)**
  - **Rs 86,000 crore in 2001-02 (source Mckinsey)**
  - **Rs 1,25,000 Cr in 2006 (source GOI)**
  - **Rs 1,53,330 Cr in 2006 (source E&Y report)**
  - **Rs 3,07,600 Cr in 2015 (source McKinsey)**

A major portion of the expenditure is incurred by Individual Households…

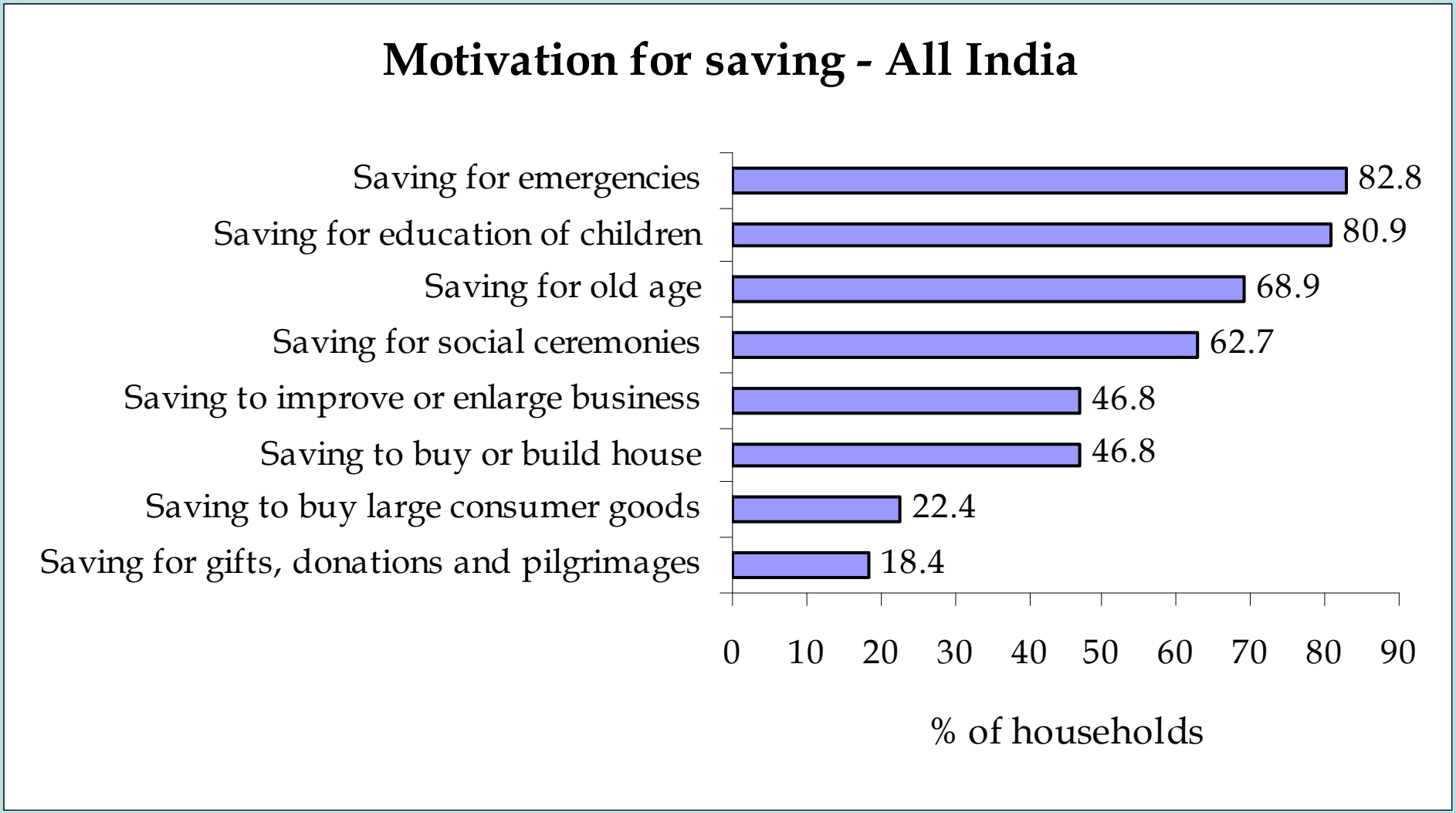
Indians have a High Propensity to Save…
81% Households Save!



Source: Max-NCAER Indian Financial Protection Survey 2007-08

..The potential source for channelizing Disposable Income into Premiums ..

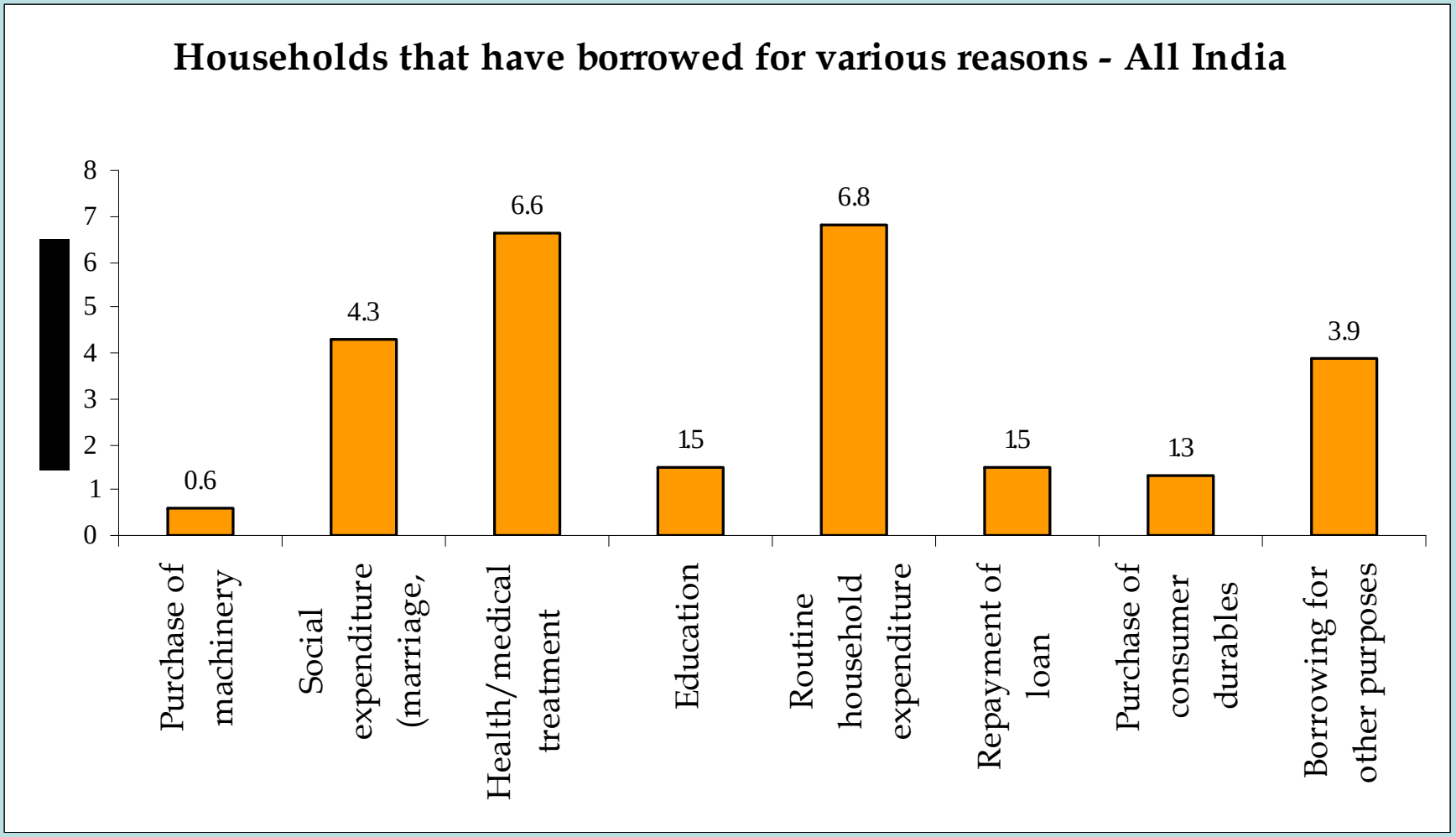
What motivates India to save ?–



SOURCE:: MAX NEW YORK LIFE-NCAER REPORT 2008

.. most Indians save for emergencies…health being a major concern.

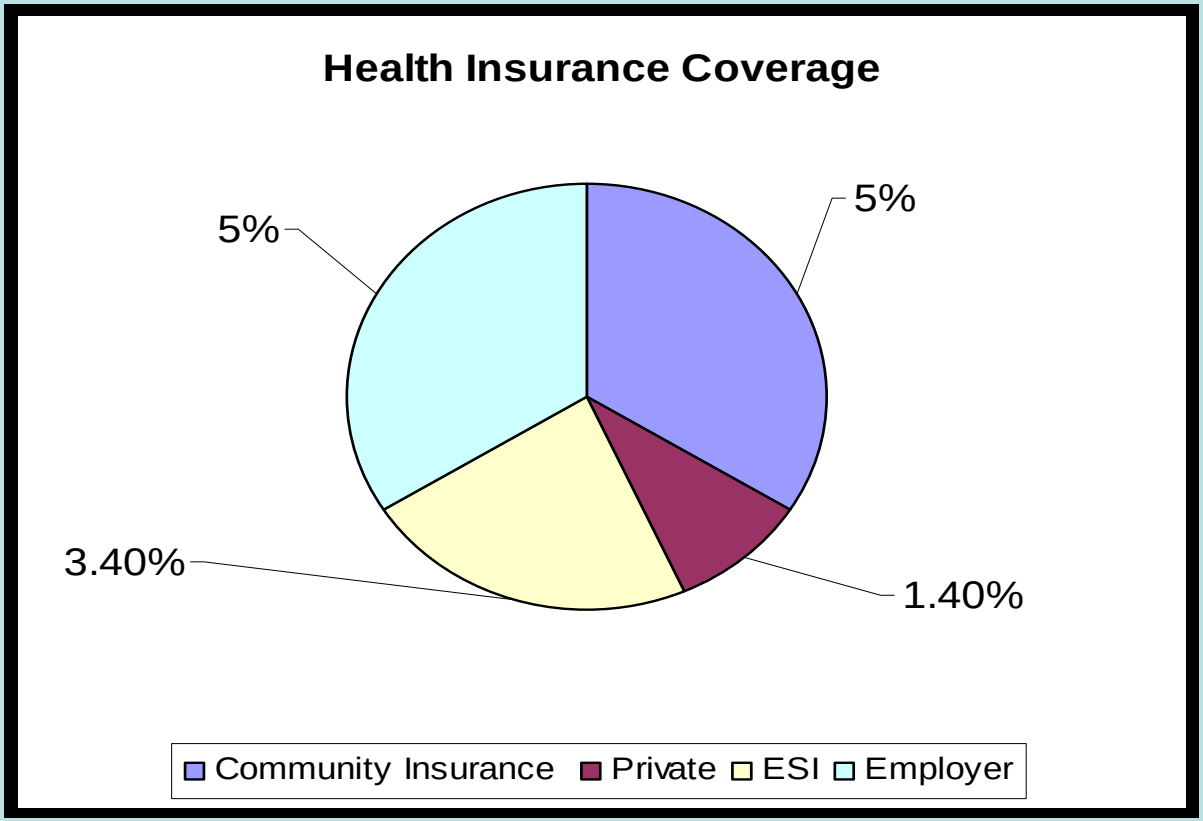
Reflected in the Borrowing Pattern…..



SOURCE:: MAX NEW YORK LIFE-NCAER REPORT 2008

….with high levels of health- related borrowings

Only ~15% Indians have Health Insurance Coverage

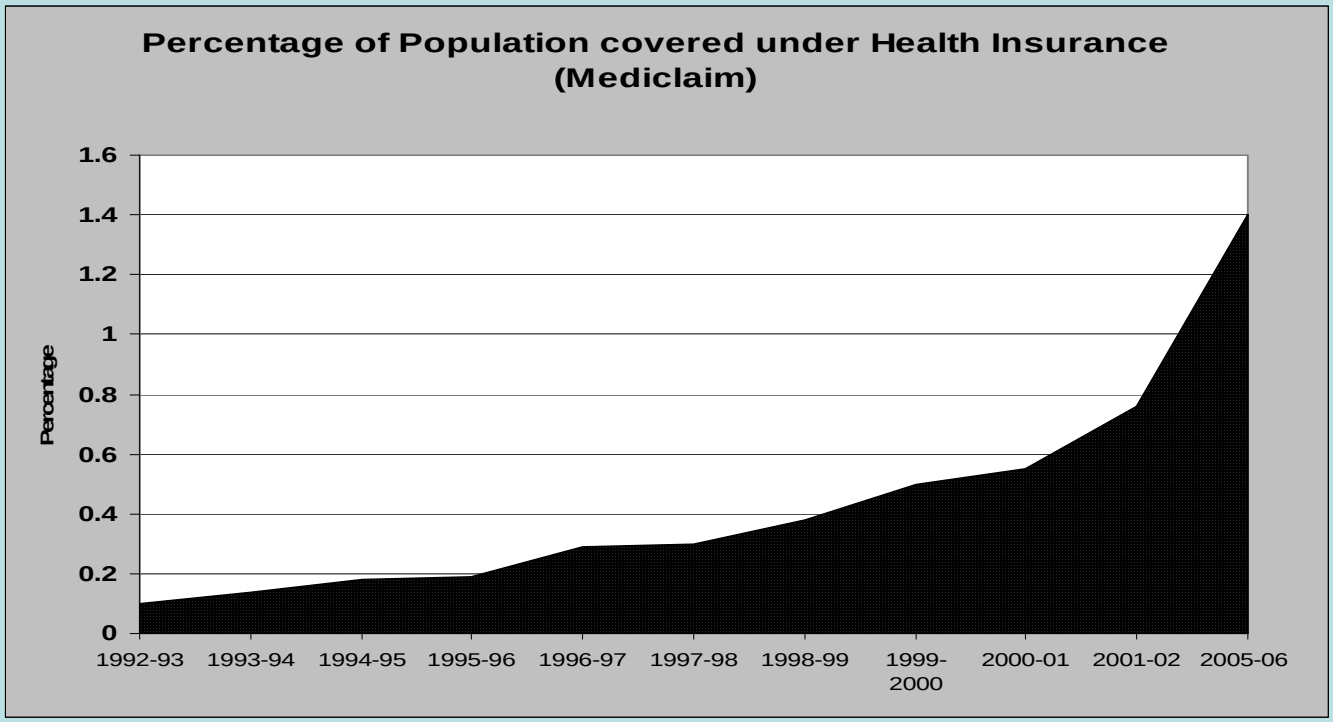


Source: 1. Ellis Annual Report
2. McKinsey Analysis

..of which Private Health Insurance forms a small fraction..

Private Heath Insurance Coverage ~ 1.4%*

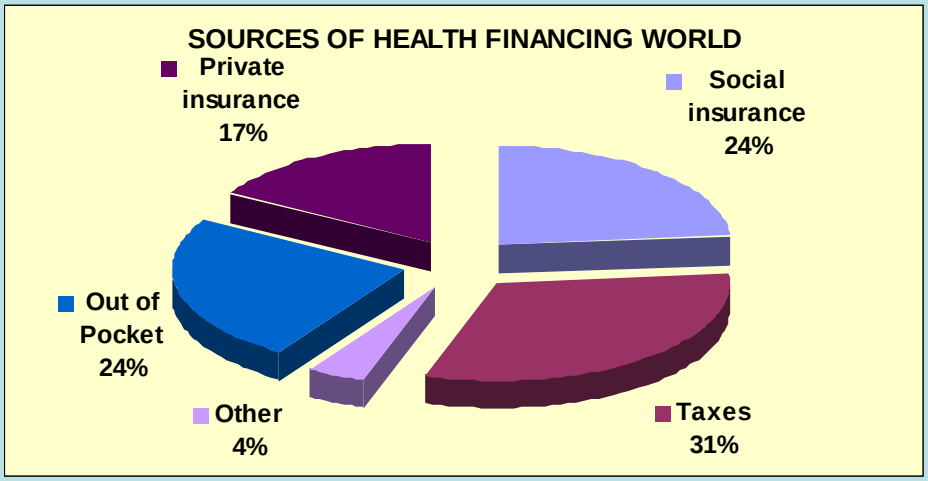
- Population covered under PHI = 16.34 million in a country of 1,123 Million
- Population covered under any Health Plan = ~15% (including beneficiaries of CGHS / ESI / Army / Railway / PSU's / self insured / covered by Insurance)
- % of population covered under Private Health Insurance has been gradually increasing from the early '90s – very gradually



Source: Health Economics Report (Ministry of Finance-Government of India). IRDA

.. Health Financing in the country is mainly Out of Pocket..

India depicts a Contrast to Rest of the World…



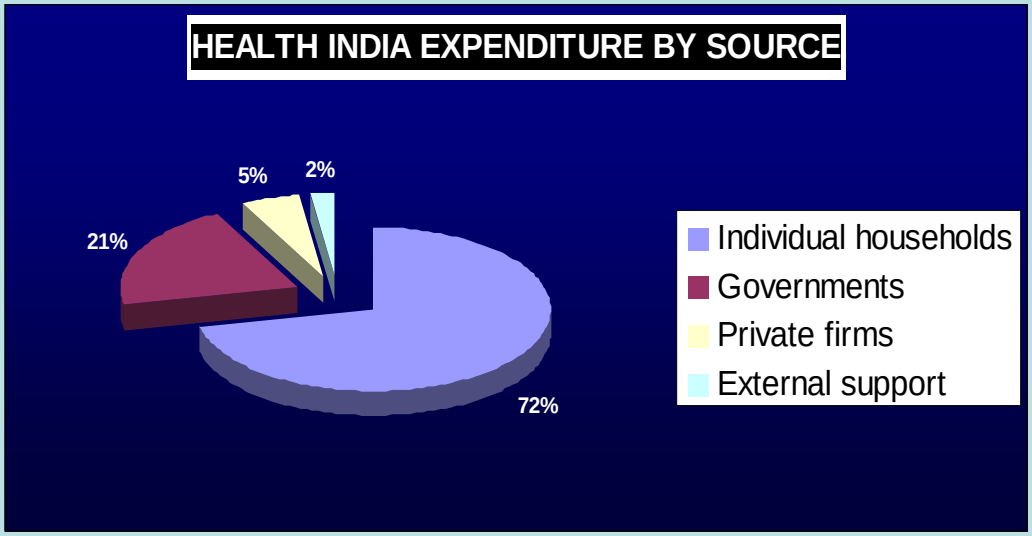
S0URCE: W.Hsiao et al 2006

World

- Out of Pocket health financing is less than a quarter of the total expenditure on Health

India

- 72% of health spend is Out of Pocket
- High cost of hospitalization is a major factor for Indebtedness amongst the Vulnerable – 9th Plan



Source: India National Health Accounts 2001-02, Ministry of Health, Government of India 2006.

This is despite the vast Government Provider Network

Health Care Infrastructure– Vast but Insufficient

To cover a population of 1,123 million (July '2006) ~1/6 World

(Average Growth – 1.3% P.A (1996 – 2003)

- Doctors – 5,03,900
- Beds – 8,70,161
- Nurses – 7,37,000

- Low bed ratio 1.5 bed per 1000 population (including Pvt.)

(WHO Norm – Pop : Bed :1: 300) TIER II CITIES-V. Adverse

Almost 80,000 additional hospital bed required every year to meet growing healthcare demands.

– Public healthcare system will add 8000 beds per year,

- Government as a Care Provider
  - High Geographical Spread
  - 60% Govt Network

High Growth Rate of Health Care

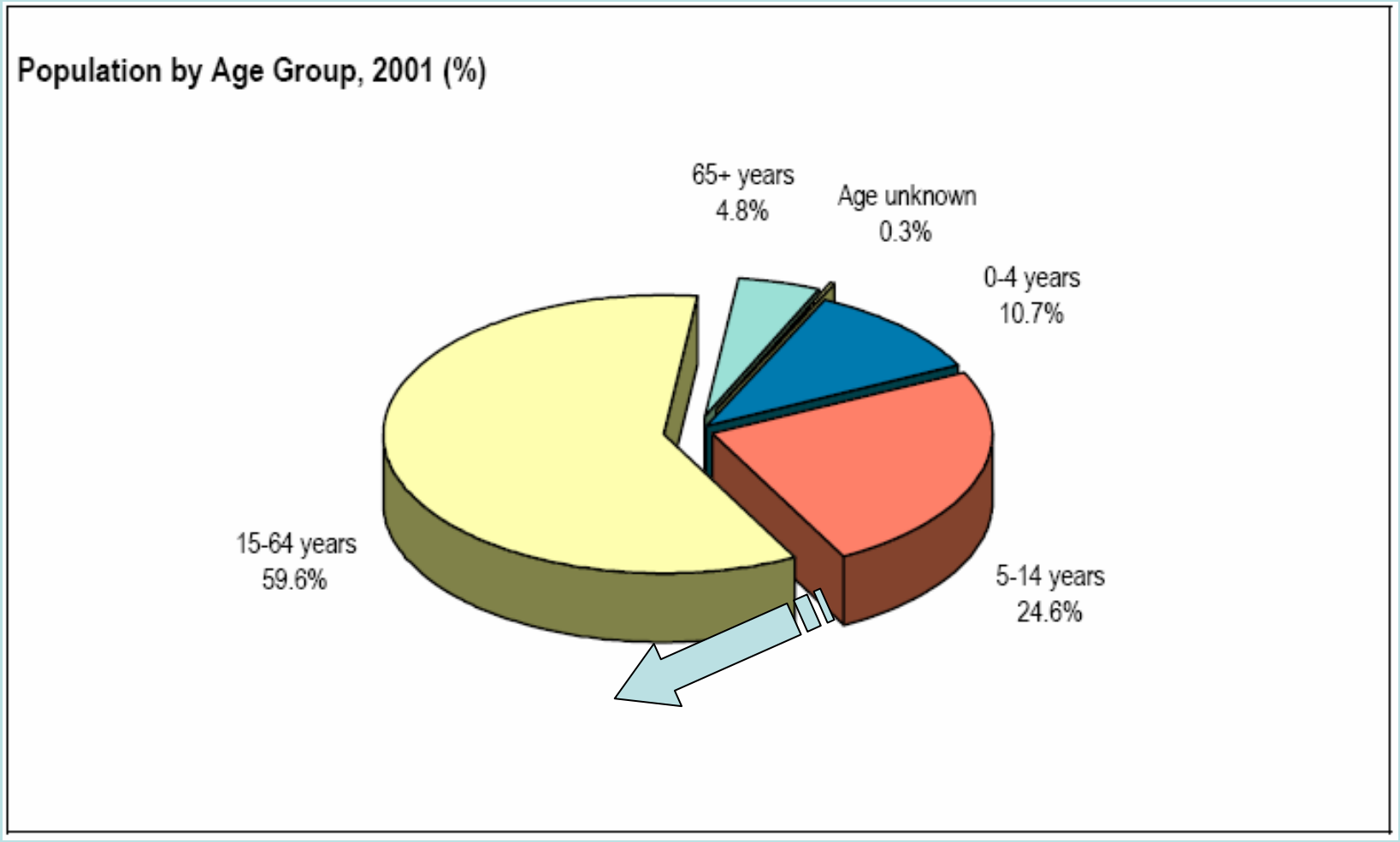
Public healthcare infrastructure

Urban	
Tertiary Medical Colleges & Hospitals	117
ESI and PSU Hospitals	1200
Urban Health Posts	1500
Rural	
District and Taluk Hospitals	4400
Community Health Centres	2400
Primary Health Centres	23,000
Sub Centres	132,000

Source: ICRA

…….for a vast country with a population of 1.123 Billion……

Demographically, India is a Young Country

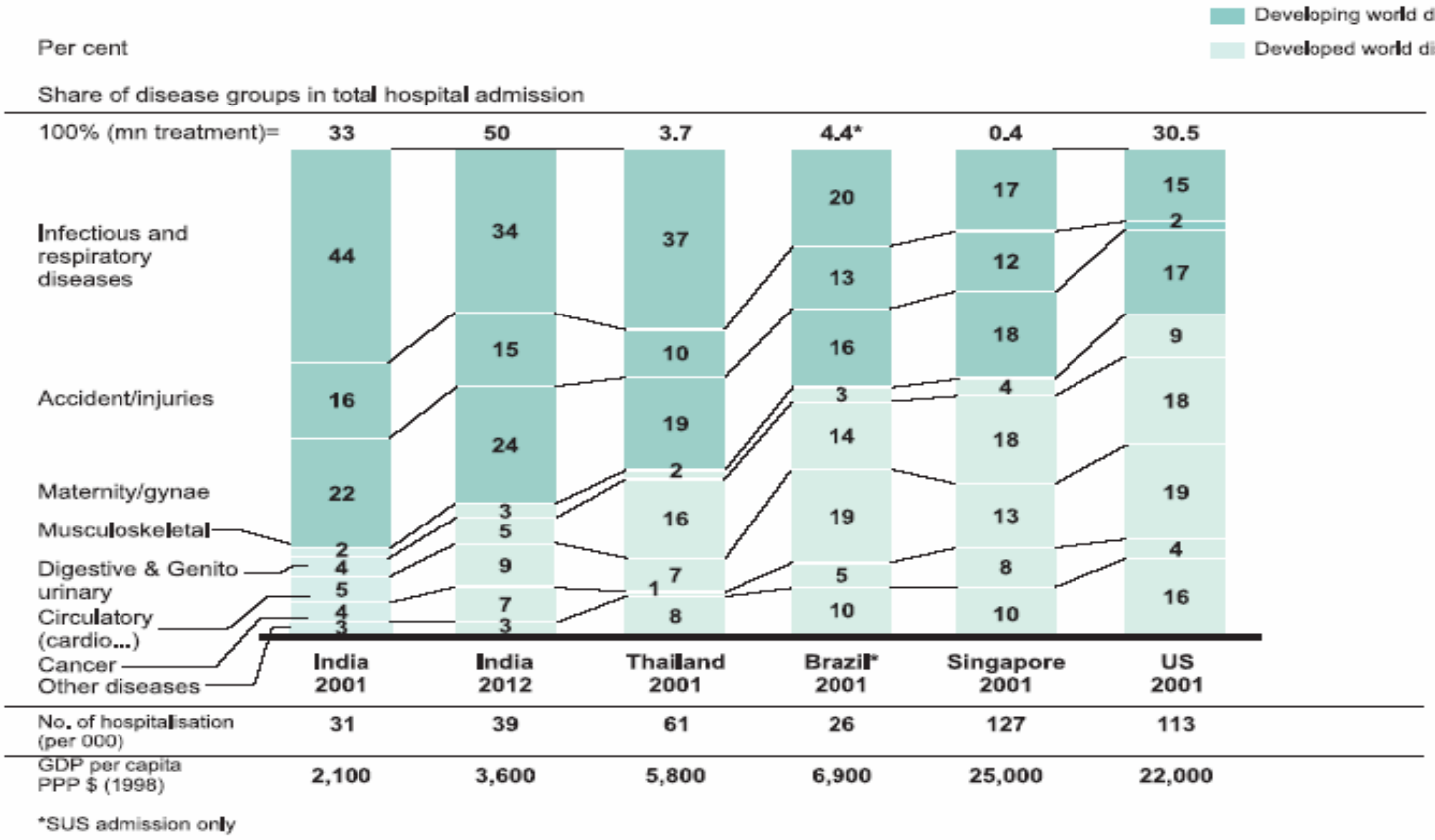


Almost 25% of the population is below 14 years of age

…But an Aging Population (greater life expectancy) will Drive demand for Hospitalization

...As will the increasing trend to 'Lifestyle' Diseases

The shift from infectious diseases to lifestyle diseases is in line with trends in more developed economies



	India 2001	India 2012	Thailand 2001	Brazil* 2001	Singapore 2001	US 2001
100% (mn treatment)=	33	50	3.7	4.4*	0.4	30.5
Infectious and respiratory diseases	44	34	37	20	17	15
				13	12	2
		15	10	16	18	17
Accident/injuries	16			3	4	9
		24	19	14	18	18
Maternity/gynae	22		2			
		3		19	13	19
Musculoskeletal	2	5	16			4
Digestive & Genito urinary	4	9	7	5	8	16
	5		1			
Circulatory (cardio...)	4	7		10	10	
Cancer	3	3	8			
Other diseases						
No. of hospitalisation (per 000)	31	39	61	26	127	113
GDP per capita PPP $ (1998)	2,100	3,600	5,800	6,900	25,000	22,000

*SUS admission only

Source: Ministry of Public Health., Thailand; Datasus, Brazil; Ministry of Health, Singapore; US Agency for Healthcare Policy & Research; World Development Report, 2001; McKinsey & Co. analysis

High incidence of diabetes …and obesity.. predisposes Indians to Cardiac diseases

….and a growing demand for Quality Care (perceived fee for service Care)

To sum up…the Opportunity is Large!

- Favorable State of Indian Economy - Offers large opportunities due to
  - High & stable GDP growth
  - Buoyant economy
  - High spends on health
- Favorable Demography
  - Shift to higher income categories
  - Increasing working age population
  - High Propensity To Save
- Low Penetration of Health Insurance & lack of Social Security
- Demand Dynamics with regard to Health Care needs and health spend are conducive for a viable Health Insurance Market
- Source of health financing is mainly “out-of-pocket” by Households
- The Regulatory Environment is conducive to growth of Health Insurance with 2007-2008 being the tipping point

…and the Market Timing is Right!

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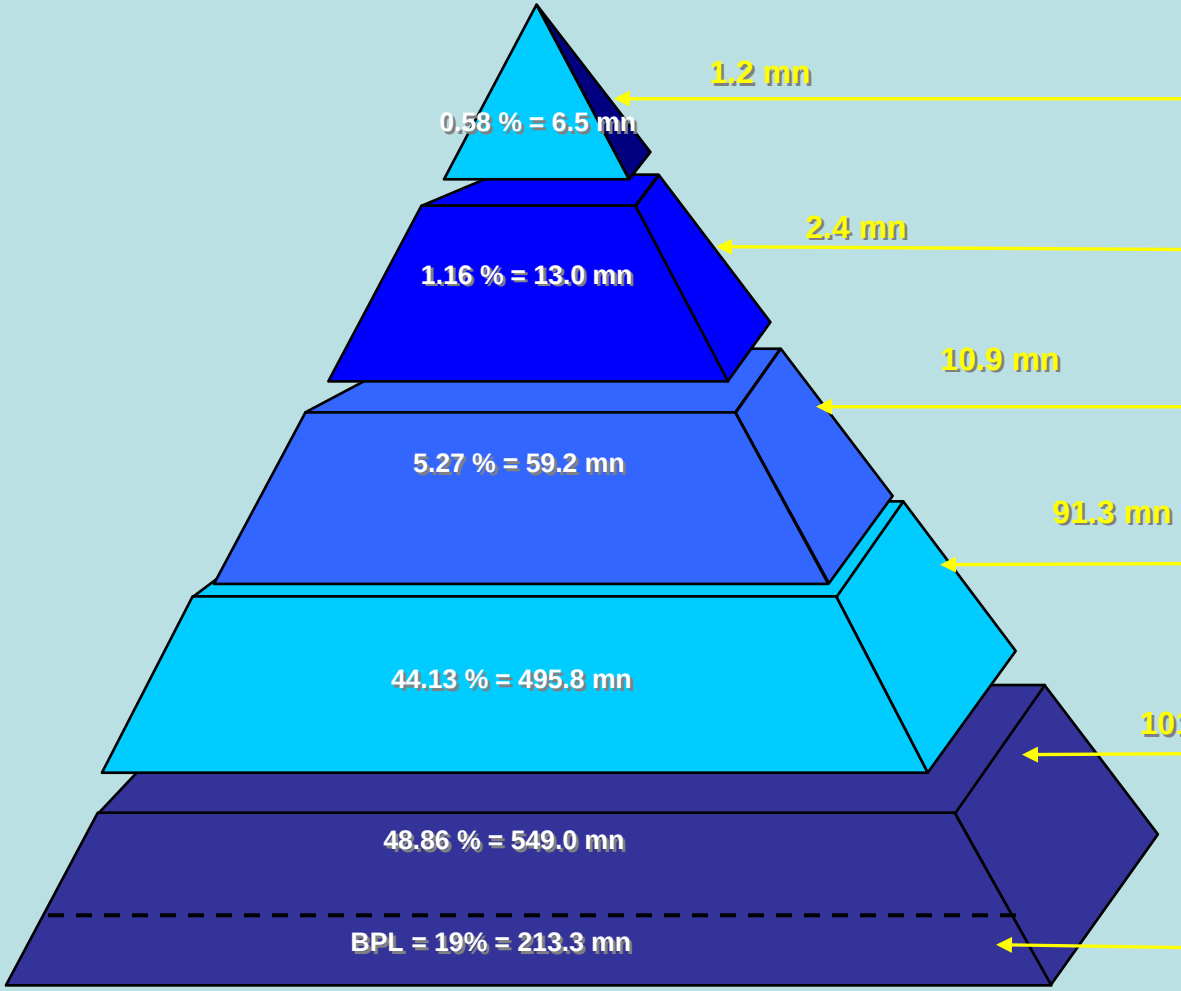
The Indian Market…….1.123 Billion



1.2 mn — Tip of the Pyramid 1000K>

2.4 mn — Upper Middle 500K-1000K

10.9 mn — Upwardly Mobile 200K-500K

91.3 mn — Middle Class 90K-200K

101.1 mn — Vulnerable <90K

39.3 mn — Deprived BPL

Source: Registrar General; NCAER; McKinsey

…with different health financing needs even within the same income segments.

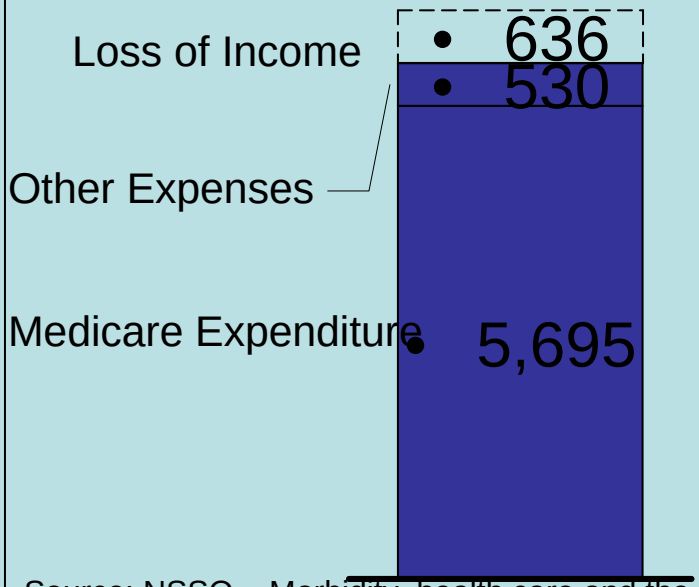
Financing Inpatient Care makes households more vulnerable

Average expenditure per hospitalisation case

All India Rural

Rs. 6,225

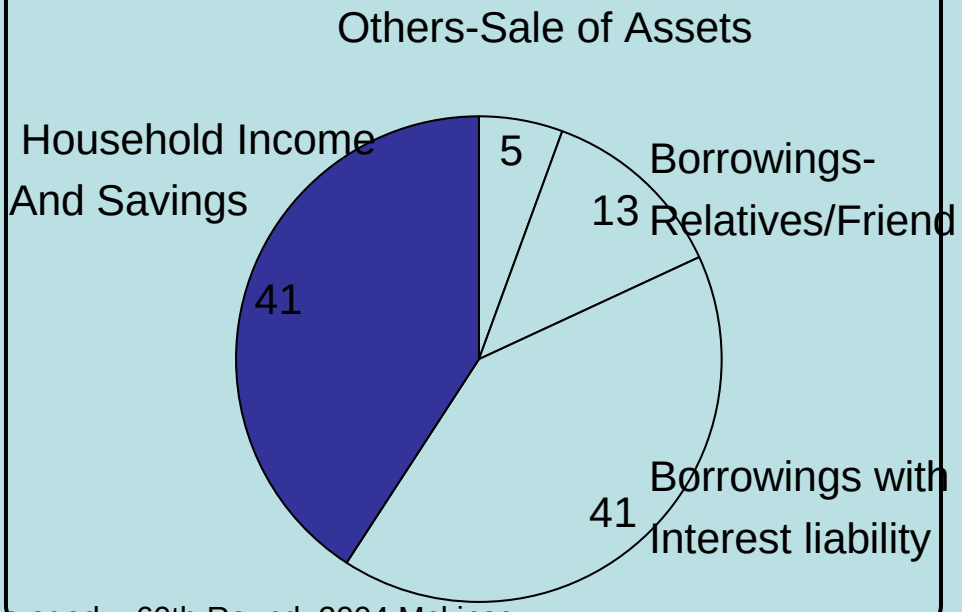
Direct expenses



Source of funding for household hospitalisation case

All India Rural

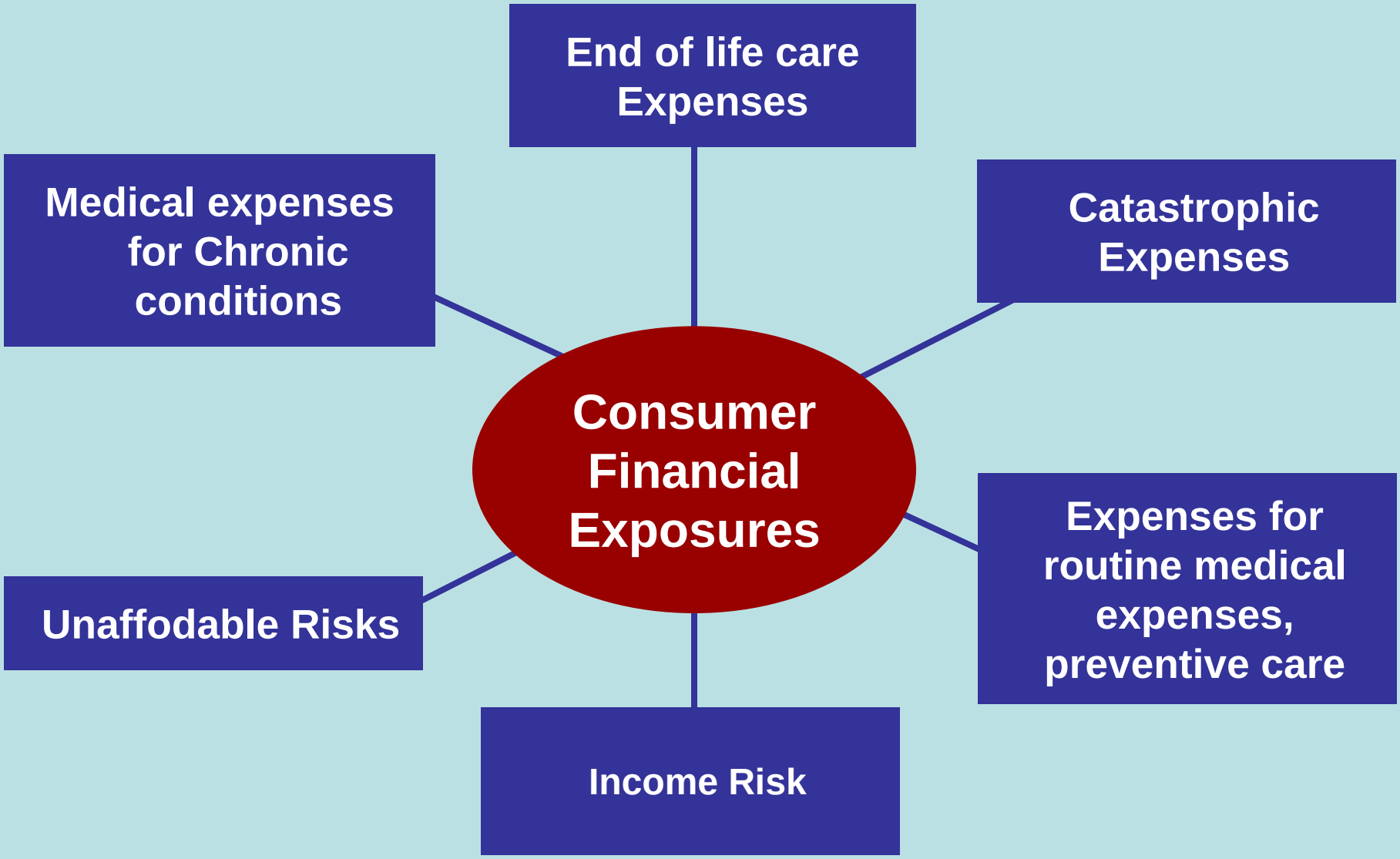
100% = ~12,000 Crore



Source: NSSO – Morbidity, health care and the condition of the aged – 60th Round, 2004 Mckinsey

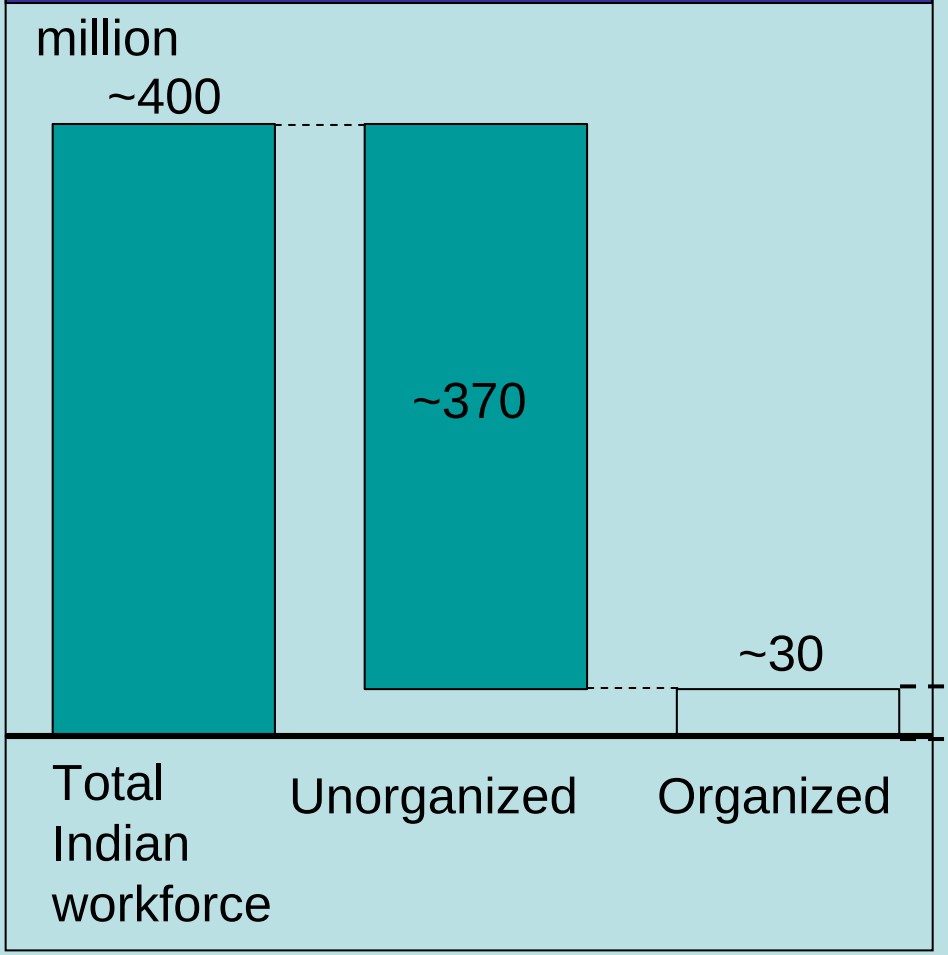
.....those at the bottom of the pyramid need to borrow in ~60% of cases

Financial Exposure

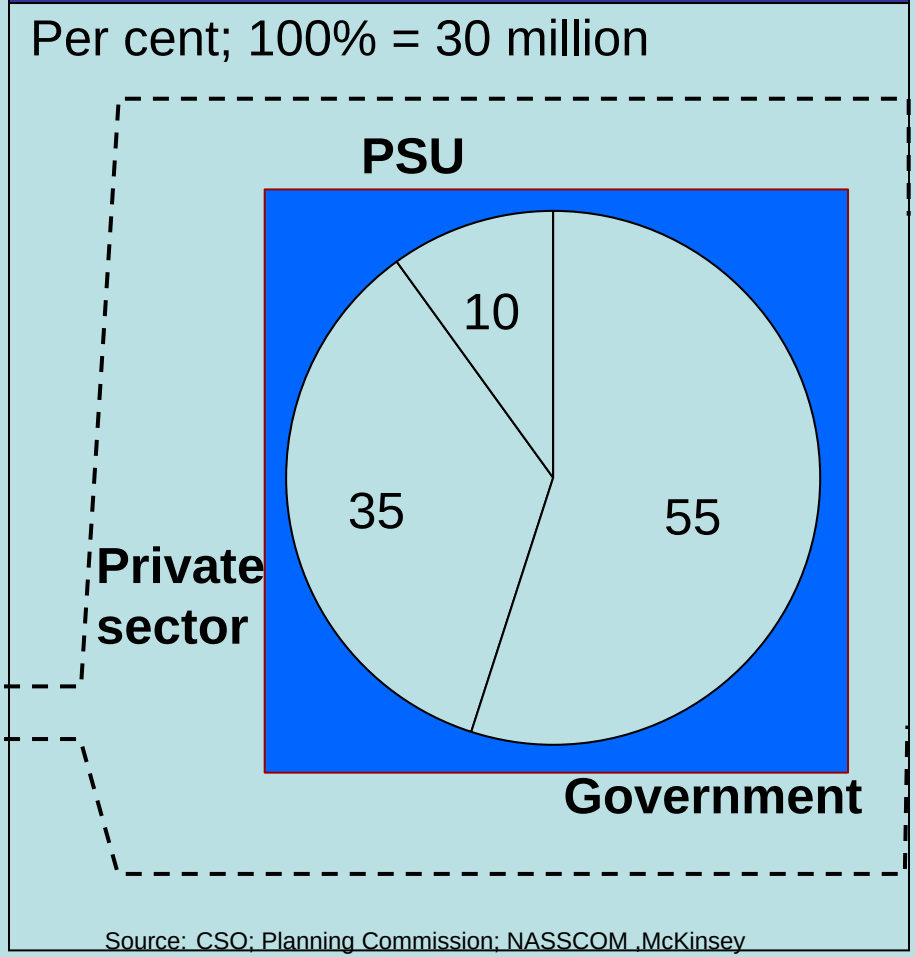


Less than 10% of the workforce is in the Organized Sector

Share of workforce in organised and unorganized economy



Organised workforce employment by sector



Source: CSO; Planning Commission; NASSCOM ,McKinsey

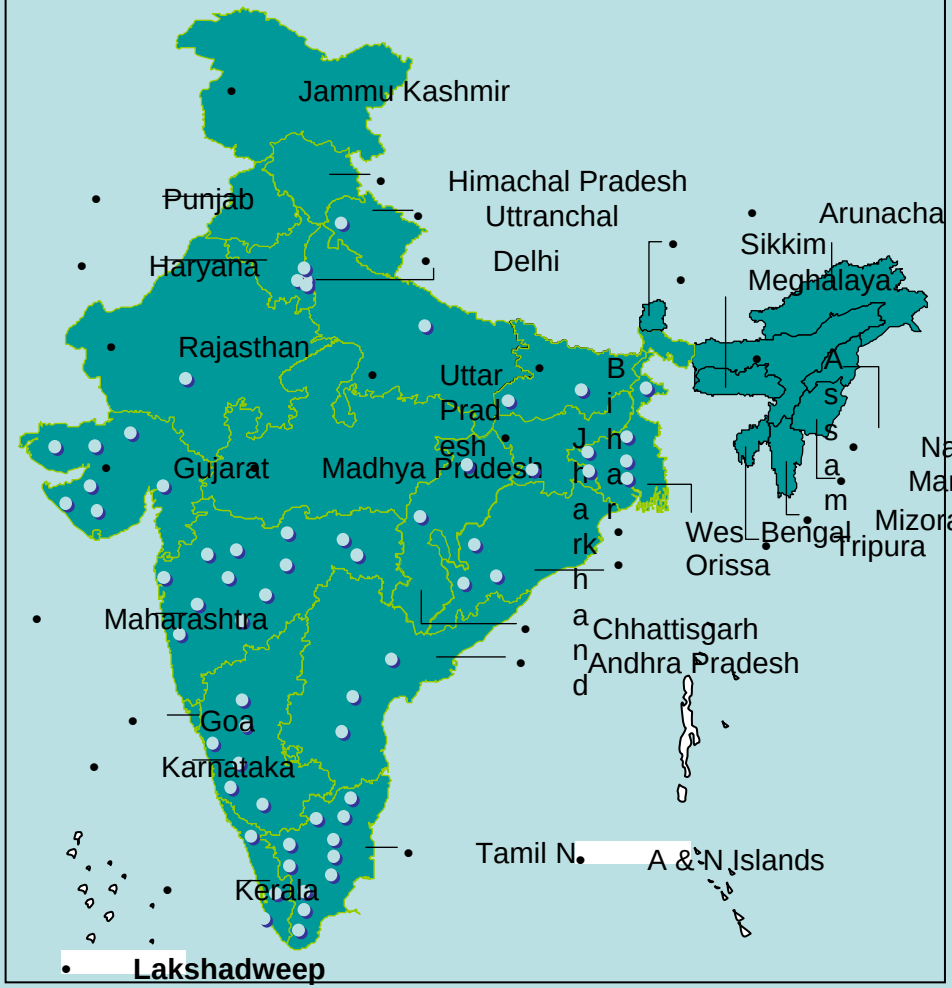
….The hitherto unmet Health Needs of the Unorganised Sector recognized by GOI

Resulting in CBHI schemes for the unorganised secto

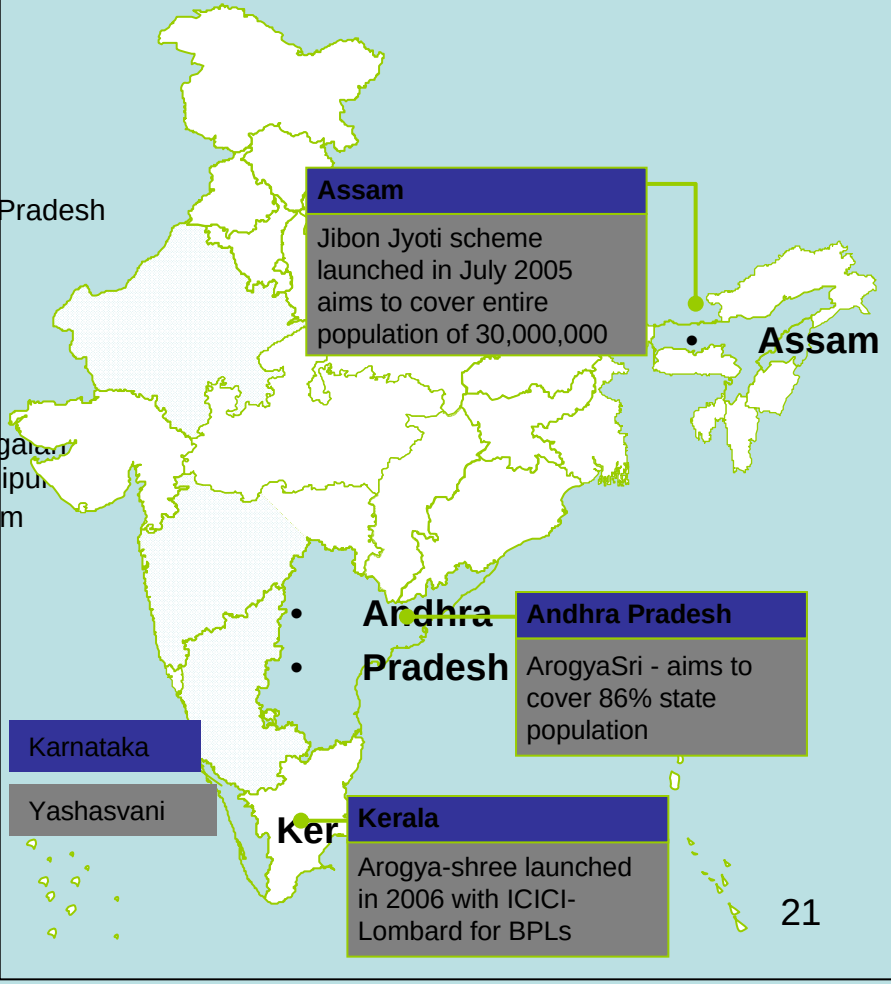
…….a great deal remains to be done…….

Community-based health insurance schemes

- ~ 8-10 million people covered



State government schemes



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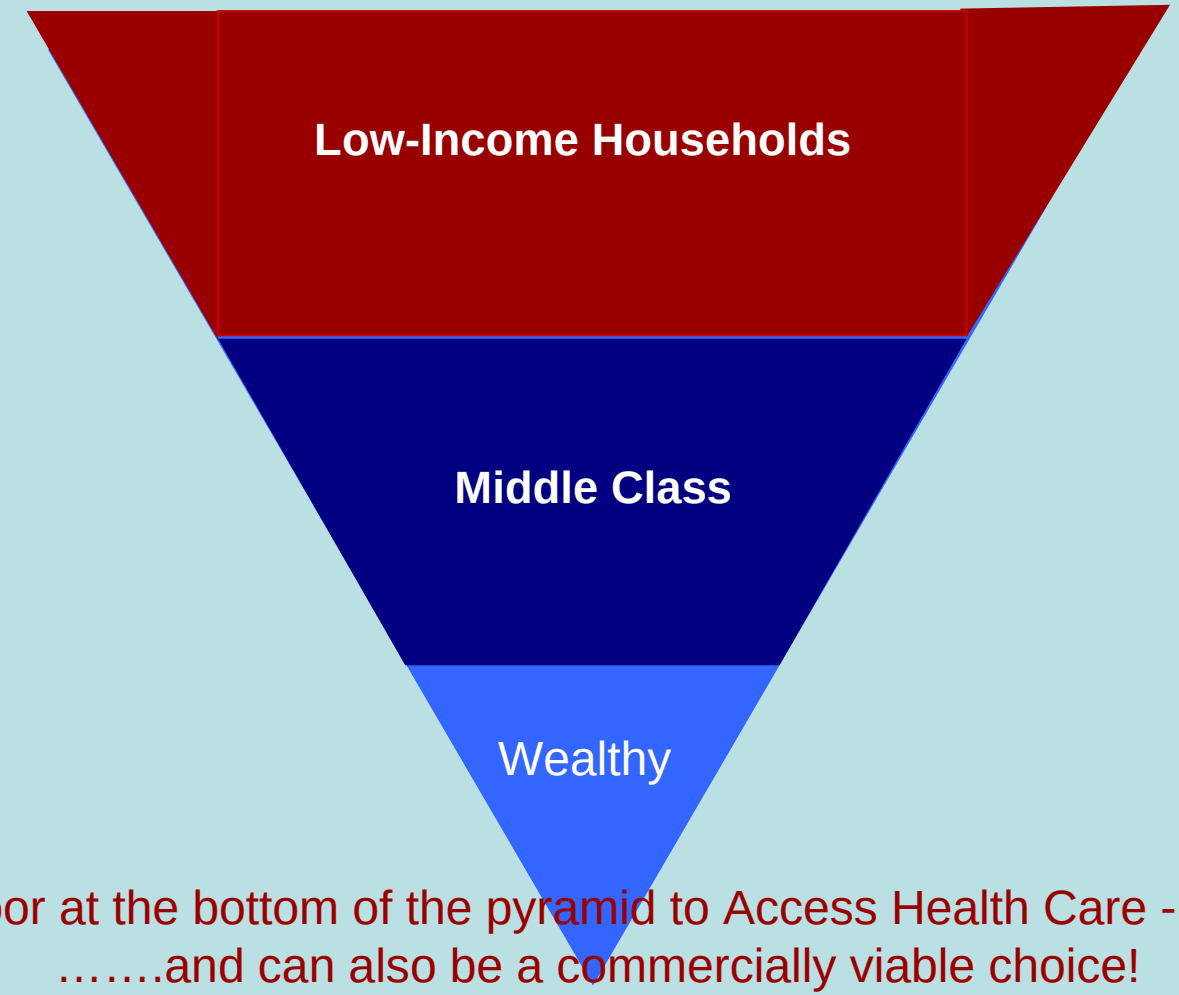
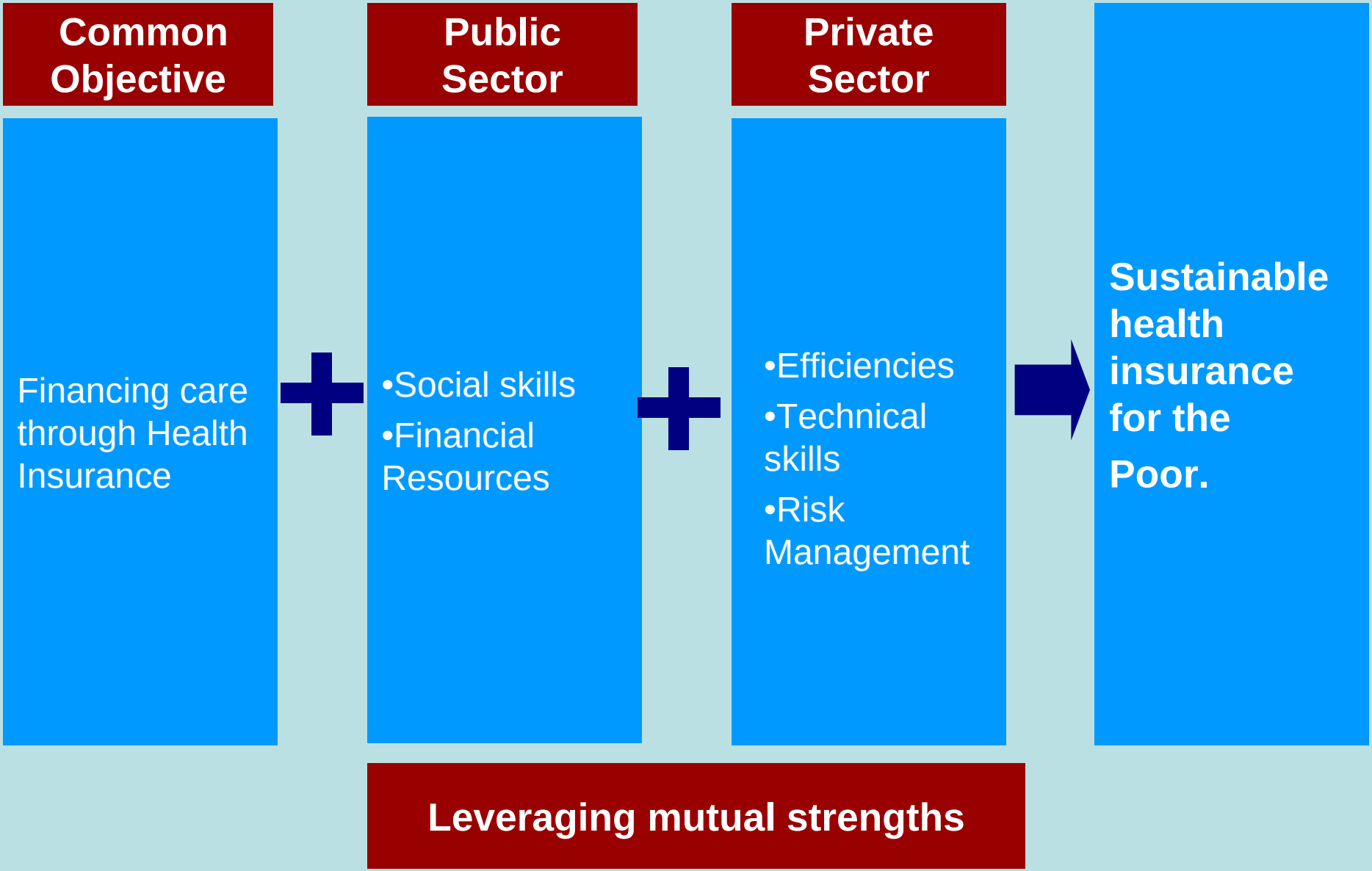
Building Systems that give the Poor Top Priority



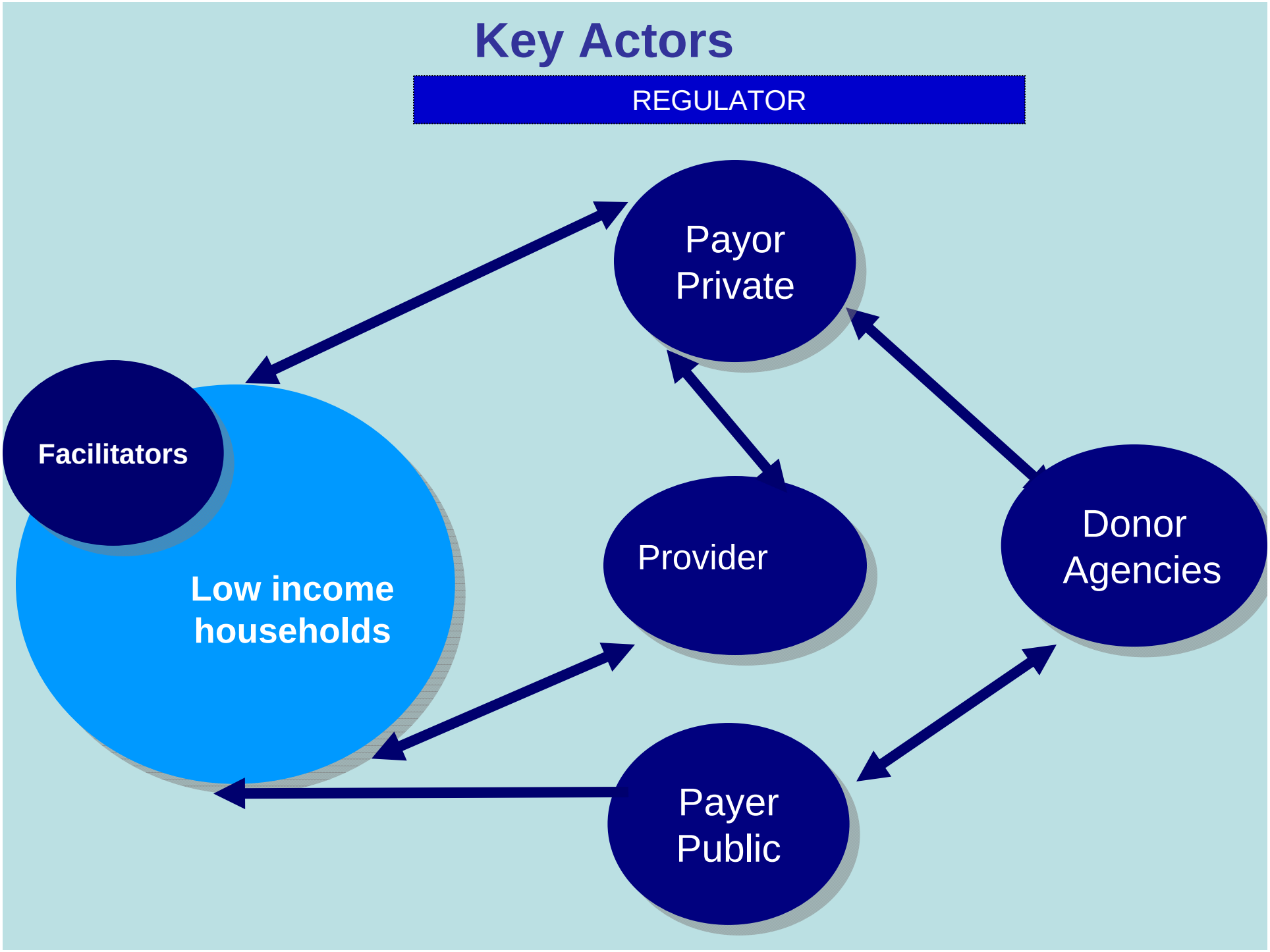
Enabling the Poor at the bottom of the pyramid to Access Health Care - social obligation
…….and can also be a commercially viable choice!

PRIVATE PUBLIC PARTNERSHIP- KEY TO SUSTAINABILITY

What is Private - Public Partnership?



Key Actors


REGULATOR
Payor
Private
Facilitators
Low income
households
Provider
Donor
Agencies
Payer
Public

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- PPP -The Current Approach
- Myths and Realities
- Sustainable provision of health Insurance

Myths and Realities – Public Sector

Mutual Mistrust

Myths	Realities
Private approach not fit for Poor	Skilled financial prudence for Effective Sustainability
Product selection Process – L1	Donor support for holistic technical evaluation
Top down approach	Localized Needs of a Homogenous Group
“One shoe fits all”	Concrete solutions – Best practices
Big Bang Approach	Build islands of excellence! Launch, Learn and Replicate

Myths and Realities – Private Sector

Mutual Mistrust

Myths	Realities
Disease profile of Poor High Risk Uninsurable	Volume of pool spreads the Risk
PPP not profitable	Innovative approach - key to profitability
“A sweet heart deal” – opaque selection	In-built transparency - Though with stringent conditions
Target group unfamiliar- Difficult to service	Innovative approach- Opportunity
Govt. difficult to work with - Bureaucratic procedures	Common objective. Negotiated agreement

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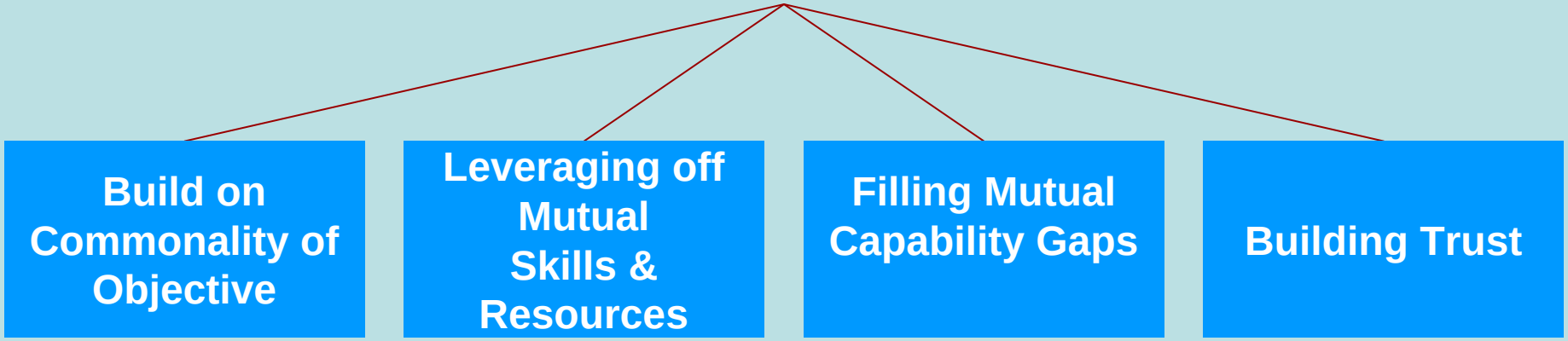
Essentials of an Effective PPP



…**Sustainable provision of health insurance**

HISTORICAL PARALLELS:
- Communication Revolution Through Telephony
- NHAI Road Policy-Building Infrastructure- Enhancing Access and Connectivity

How PPP works- for the Public Sector?

Innovative approach to Improving the quality and access to healthcare

Meeting the Social Objective
-Access of Health to
a vulnerable population

A greater explicitness and visibility of spending on health services occurs as a result of insurance.

Building Efficiencies-Leveraging off the Private Sector skills :

- Actuarial Skills
- Skilful under writing
- Product Design &Pricing
- Effective Policy Administration
- Efficient Service Delivery

Attracting additional money for health
-Additional resources available

Getting better value for money
-Increasing efficiency
-Engagement of Consumers
-Demand better Quality Care

Fiscal Deficits→ Reduced Health Spend on Care Delivery →Subsidized Security Cover for the Vulnerable

Why PPP makes sense for the Private Sector?

Large pool – spread of Risk

Reduced Opex
• Negligible marketing costs
•Nil distribution cost

Skillful underwriting

Critical Volume available for negotiating costs with provider network.

Access of volumes – health insurance being a low profit and large volume business.

actuarial skills to meet consumer needs effectively :

- Simple products
- No fine printing
- Language barriers
- Transparency
- Exclusion

Innovative approach to effective service delivery.

What needs to be done?

Differentiated private& public care providers

Focused Approach

Rational Segmentation

Investment in
•Care pathways
• Cost products,

Homogeneous groups:

- Overlapping care needs
- Efficiency in service delivery
- Effective care management

•Girl child – preventive/ holistic /PMI - Women & Child Development/Education/UNIFEM

•Unorganized Labour – Bundled Accident and health – Ministry of Labour/ILO/USAID

•Weavers- artisans – Handloom and Handicrafts

•School going children – Education/UNICEF

Towards Implementation- An Industry Wish List

Allocate appropriate funding

–Premium subsidies

–Capacity-building grants

–Invest in data → disease manuals, morbidity tables

–Invest in relevant Cost and Care Protocols

Build required infrastructure

–Improving quality of public healthcare facilities

–State-level independent regulators

–Data institute

–Privatize management of Public Care facilities

–Introduce rating & credentialing of Providers

Launch reforms of supporting systems

--Coordination with Health Policy

–Introduce minimum standards for providers

–Encourage competition, capacity building and innovation

–Regulations for Providers to meet performance standards

–Regulation of private healthcare

- Creation and enforcement of licensing procedures
- Standardization of fees structures

Towards Implementation- An Industry Wish List

Enabling Policy Formulation

-Create policies, regulations and legal structures that encourage sustainable Health Insurance
-Promote PPP as a key vehicle in tackling Access to Care through health insurance
-Permit entry of new players into the market by
- reducing minimum capital norms
- adopting appropriate solvency margins and
- reinsurance requirements.

-Risk based capital model for insurance companies

Government as a Facilitator

-Directly providing /subsidizing insurance / by regulation.
-Portability across players and schemes
-Creation of standards for diseases and treatment procedures
-Information bank on insurance, diseases, and treatment
- Data warehouse –Provide desensitized raw data.
- Enforcement of standardized billing, claims/proposal forms
-Evaluate on basis of deliverables and performance- not L1
- Reform of the ESIS and CGHS schemes

THANK YOU

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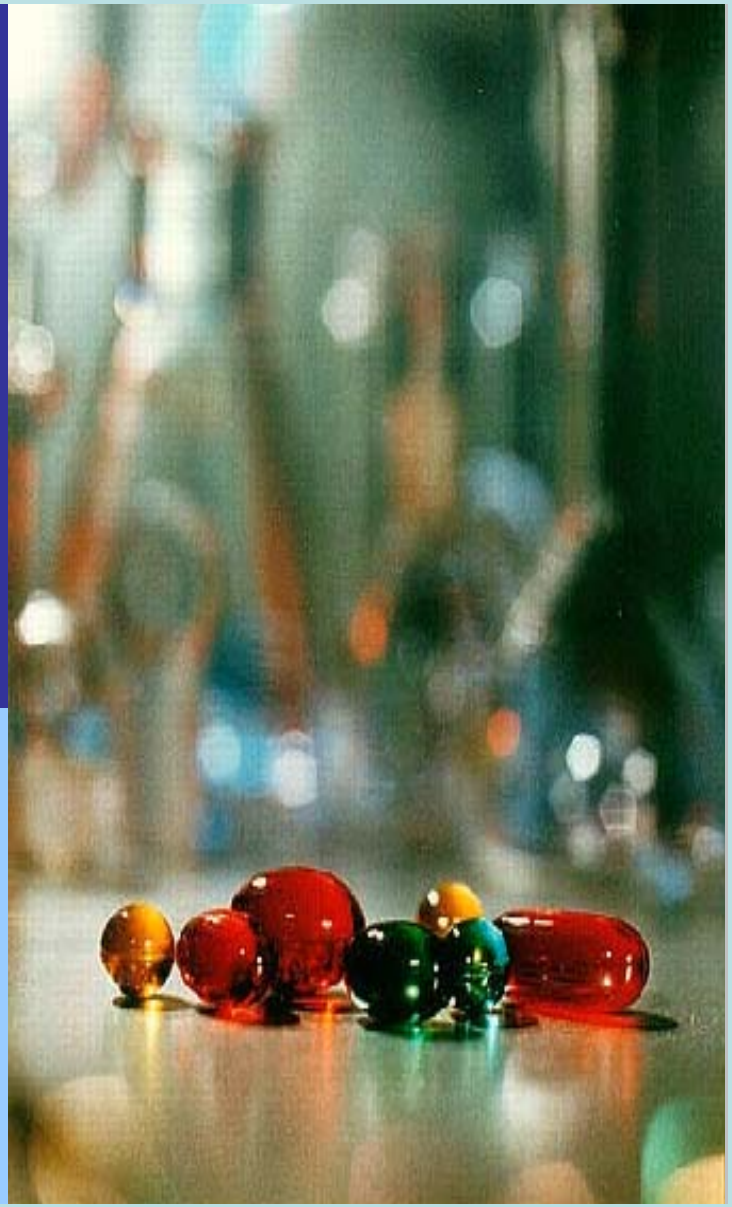

Health Insurance for the underprivileged: Challenges & Learnings

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Agenda

Health Care Space

The Handloom Weavers' Health Insurance

Going forward : The Challenges

National Health Policy-2002

The Policy also encourages the setting up of private Insurance Instruments for increasing the scope of the coverage of secondary and tertiary sector under private health insurance packages.

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Health Care Initiatives

- 1923 – W.C. Act
- 1948 – E.S.I. Act
- 1954 – CGHS Scheme
- 1981 – GIC offers limited Hospitalisation Cover
- 1986 – Mediclaim introduced
- 1990 – Bhavishya Arogya introduced : Retirees

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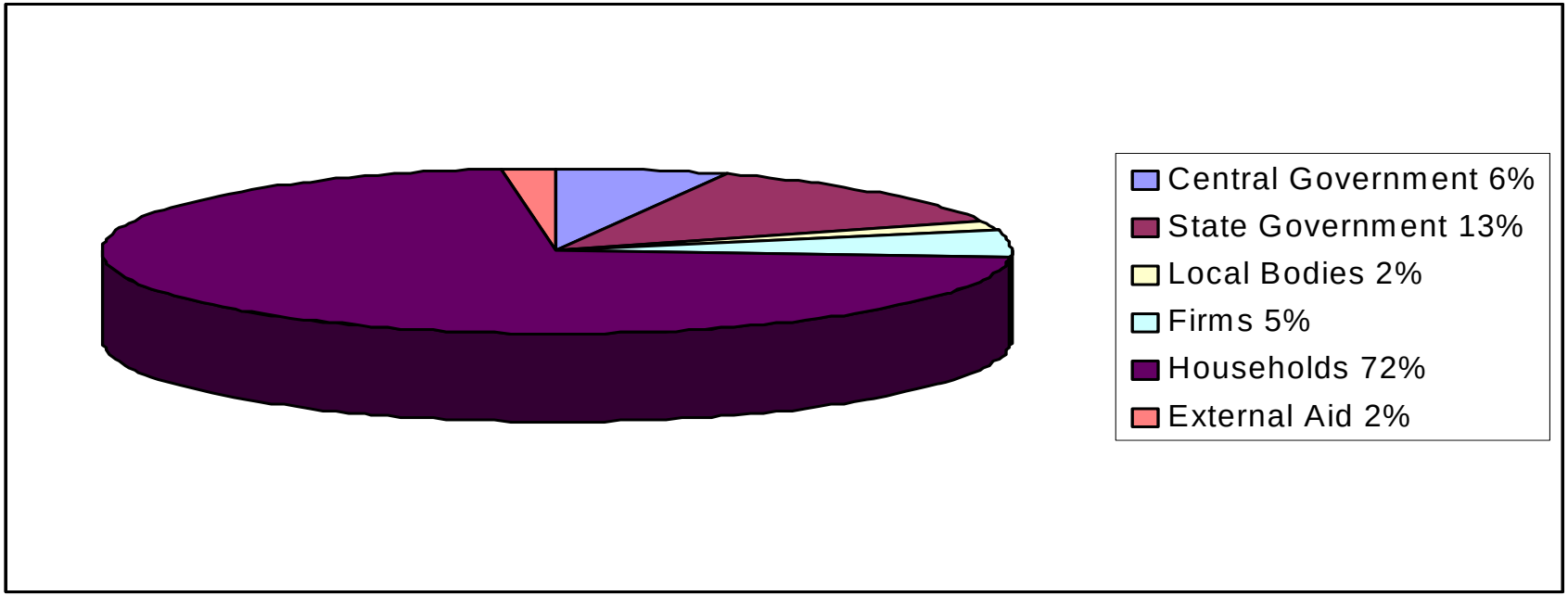
Health Care Initiatives

- 1996 – Mediclaim modified
- 1998 – Jan Arogya introduced for poor
- 2003- UHIS introduced for BPL
- 2005 – Handloom Weavers' Health Insurance Scheme
- 2006 – NRHM introduced
- 2007 – Artisans ' Health Insurance Scheme
- 2007 - RSBY

Health Expenditure in India

Proportion of Health Expenditure by Financing Source



Source: National Health Accounts 2001-2002, MoHFW, GOI

Beneficiaries under various Schemes

(million)

Employment-based Schemes (ESIS , CGHS , Railways , Defense , Employers in Public / Pvt sector)	70
Welfare Initiatives-Insurance (UHIS , RGAS , HWHIS , other state sponsored schemes)	20
Commercial Schemes (Marketed by Public / Pvt Insurers , Health segment of LIC)	11
Community Health Schemes	5
Estimated Total	106

Some Facts

- Orwellian projections of an International Health Insurance Major
  - Indian Health Insurance to reach US $ 5 billion by 2006
  - Its 2008 : Market Size appx US $ 1 billion
- **Today**
  - Only two stand-alone Health Underwriters
  - Claims Ratio : 120 % to 135 %
  - Commercial Schemes : 89 % of market in value terms
  - Rural / Mass Insurance : mere 11 %

Some Facts

- Lives covered under some kind of Health Scheme
  - Only 9 % of 1.08 billion
  - Predominantly urban & economically well-off
- **Today**
  - 40 % of hospitalized Indians borrow or sell assets
  - Hospitalized Indians spend 58 % of their annual expenditure on health care
  - 72 % of Health Care expenditure is out-of-pocket
  - 72 % of population is in Rural India
  - 26 % lives below Poverty Line

Rural-Urban Disparities

- RURAL (per 1000 population)
  - Hospital Beds = 0.2
  - Doctors = 0.6
  - Public Expenditures = US $ 2,000
  - Out of pocket = US $ 18,750

  - IMR = 69/1000 LB
  - U5MR = 21.5/1000 LB
  - Births Attended = 33.5%
  - Full Immunz.=37%

- URBAN (per 1000 population)
  - Hospital Beds = 3.0
  - Doctors = 3.4
  - Public Expenditures = US $ 14,000
  - Out of Pocket = US $ 28,750

  - IMR = 40/1000 LB
  - U5MR = 11.2/1000 LB
  - Births Attended = 73.3%
  - Full Immunz.= 61%

Delivery Exemplified

Health Insurance Scheme for the Handloom Weavers

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The Weavers' Experience : Demographics

- Sponsor : Ministry of Textiles , Govt of India
- Beneficiaries : Handloom weavers and their families
- Families Insured : 1.8 million
- Lives Insured : approx 6.2 million
- Spread over : 21 states
- Covering : 461 handloom clusters
- In rural and semi-urban geographies

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The Weavers' Experience : Product

- Health Insurance Policy on floater basis
- Covers
  - OPD
  - Dental / Eye / Maternity Benefits
  - Alternative forms : Ayurved , Unani , Homeopathy , Siddha
  - Pre / Post-natal Coverage
  - Pre-existing diseases
  - Up to 80 yrs

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The Weavers' Experience : Enrollments

- 100 % enrollment driven
  - Through 300 Cluster Coordinators
  - State Govt's Textiles officials in districts
  - Weavers' Cooperatives / NGOs
- Final certification by Textiles officials at districts
- Bar-coding / data-entry at State Capitals
- Family Health Cards , with unique ID , issued at State Capitals
- Health Cards distributed by CCs / Distt Officials / Sardars
- Awareness
  - Local dailies / radio
  - Local events / religious gatherings / Sardari system

The Weavers' Experience : Service Network

- Insurer's Offices : 251
  - In 190 locations
- State Service Coordinators : 50
- Cluster Coordinators : 300
  - Mapping 496 Handloom Clusters
- Cashless Network hospitals : 1,700
  - In 396 locations
- OPD Centers : 505
  - Managed by Insurers
  - In addition to Network Hospitals

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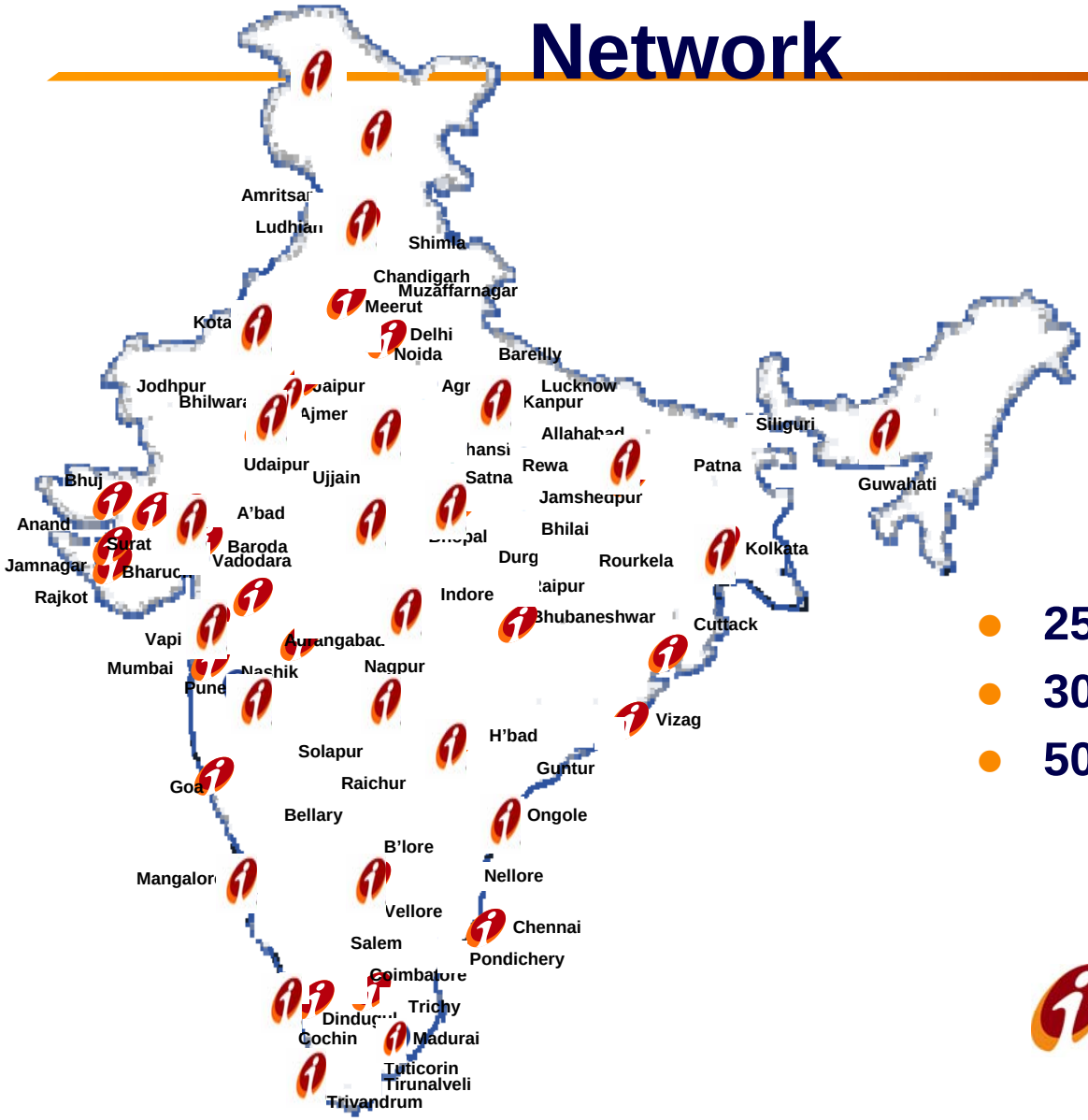
Countrywide Service Network



- 251 Servicing offices
- 300 Cluster Coordinators
- 50 State Coordinators

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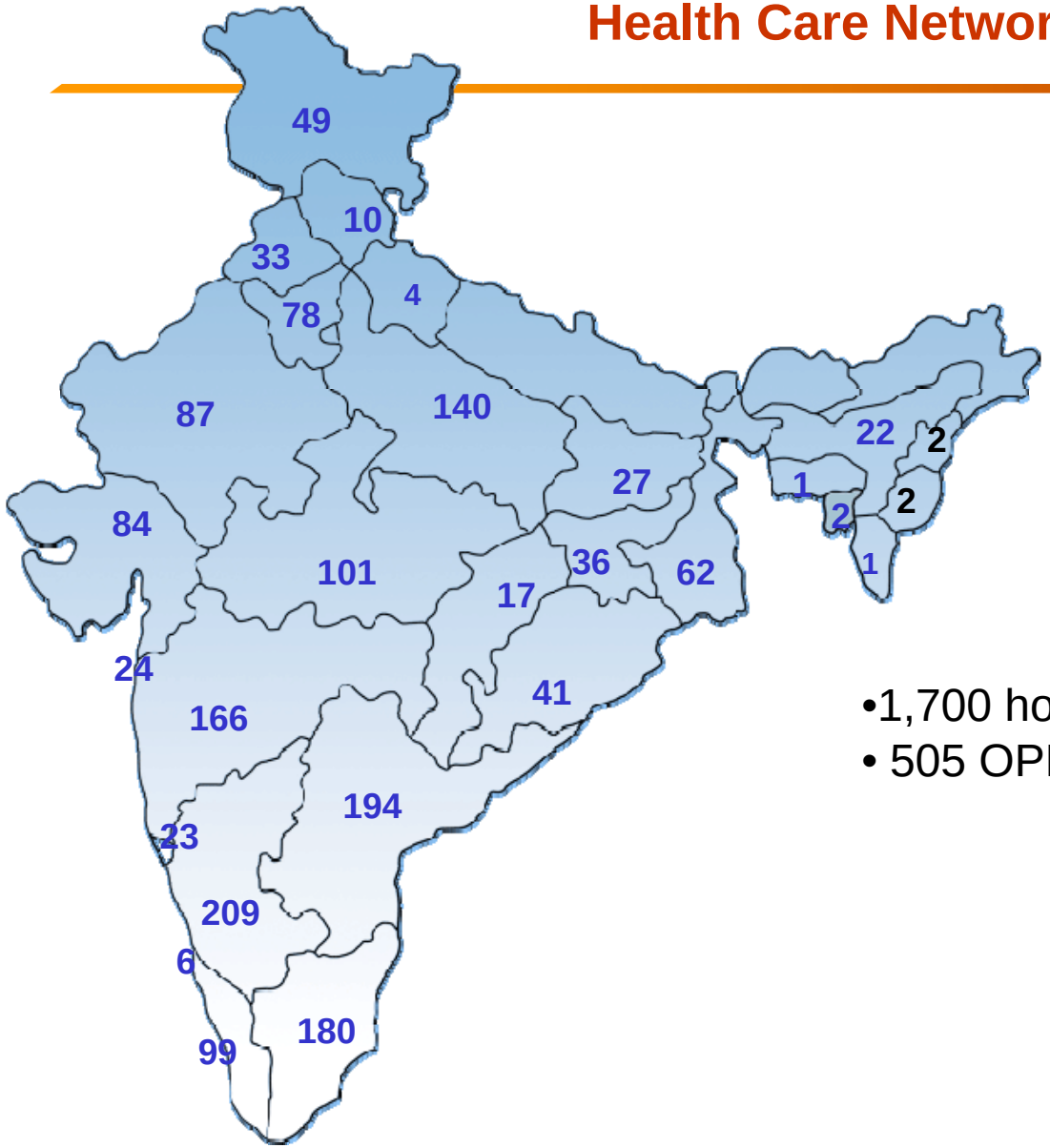
Health Care Network for the Scheme



- 1,700 hospitals in 396 locations
- 505 OPD centers

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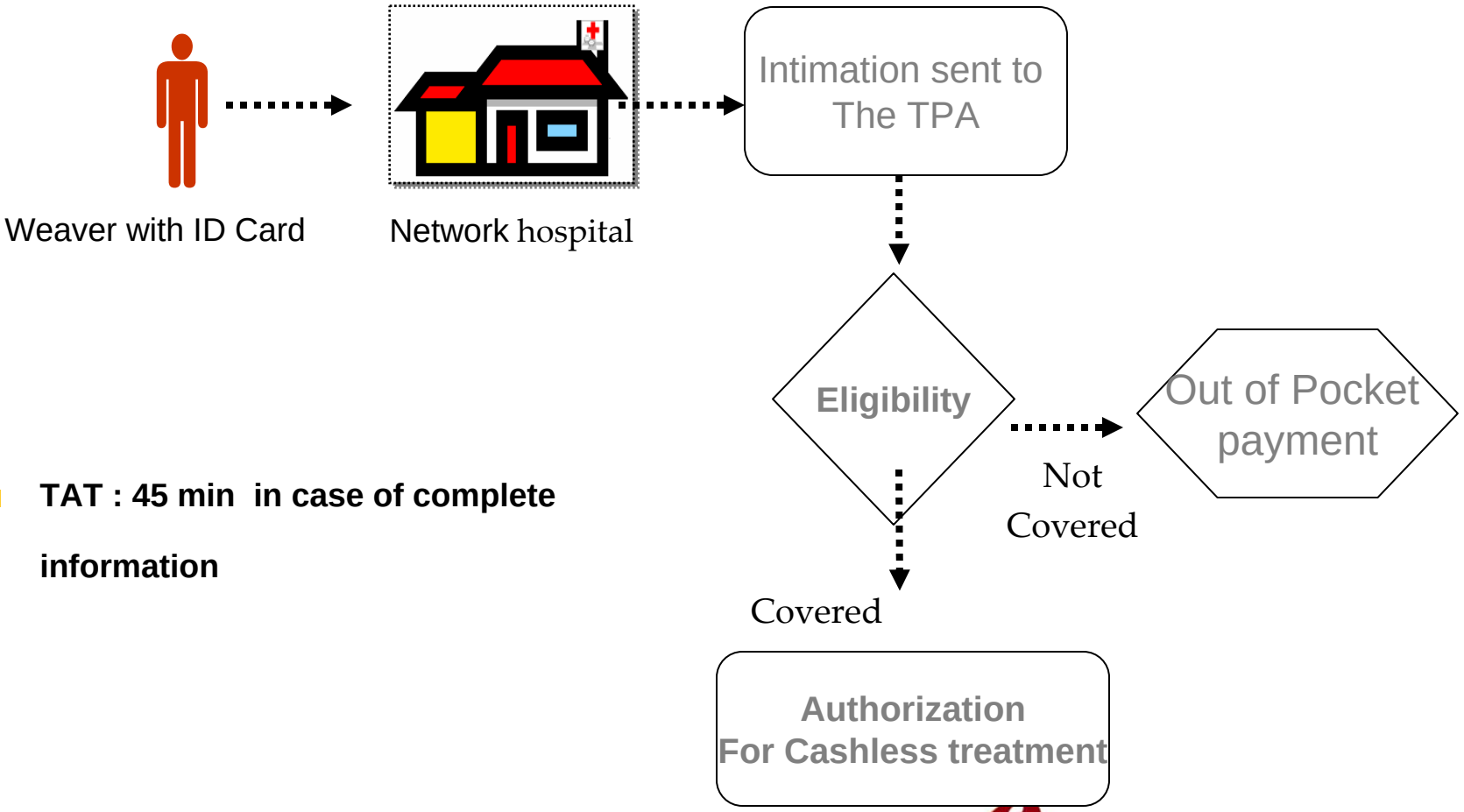
The Weavers' Policy experience : Claims

Year		Claim Counts
2005-06	IPD	50,441
	OPD	200,440
2006-07	IPD	18,672
	OPD	176,554
Till April-08	IPD	2,147
	OPD	49,240
Total	IPD	71,260
	OPD	426,224

Claims Procedure : Network Hospitals



- **TAT : 45 min in case of complete information**

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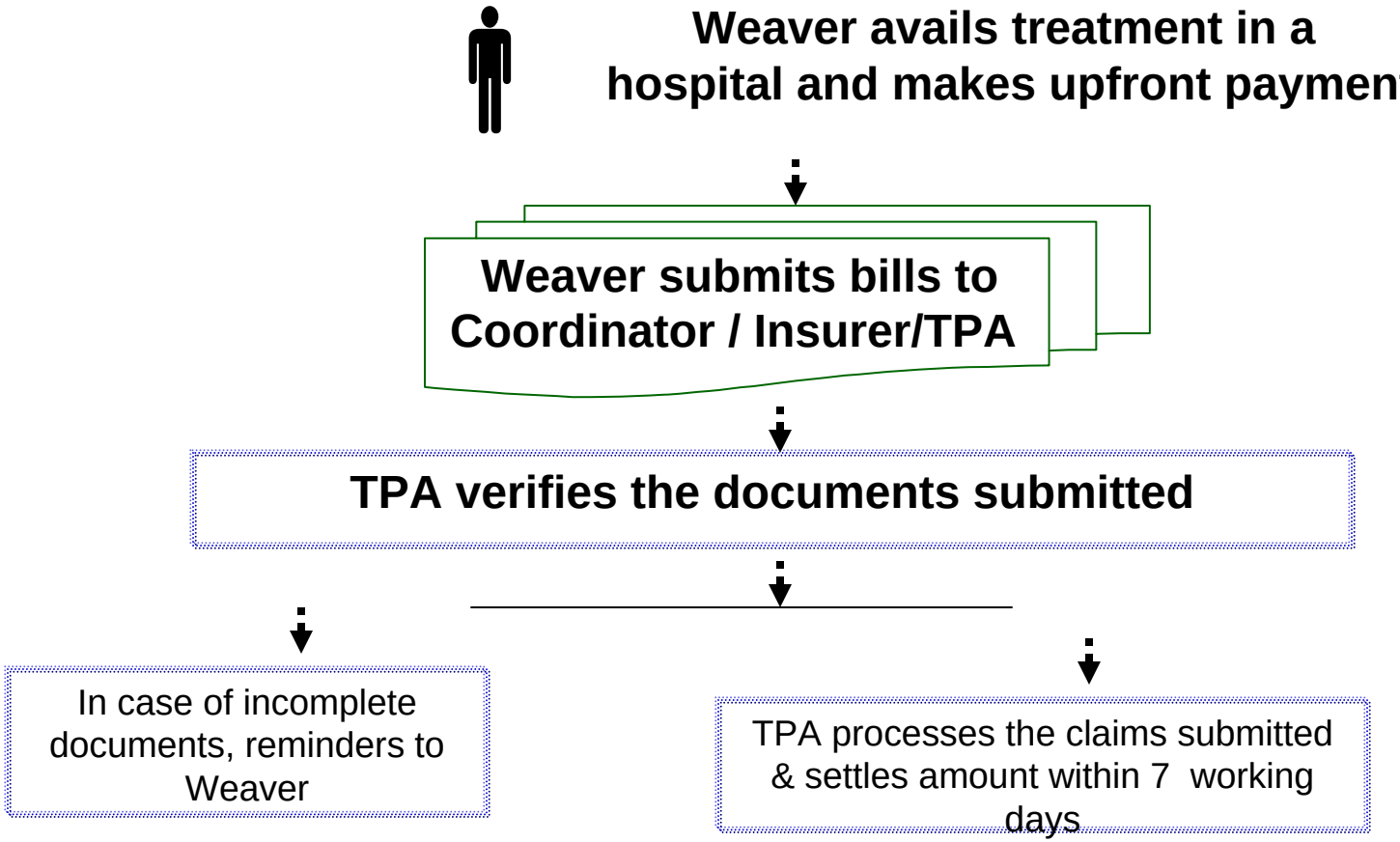
Claims Procedure : Non-Network Hospitals



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The Challenges : Demand-side

- Enrolments
  - Mapping geographies
  - Prohibitive costs
  - Riding piggy-back on the existing systems
- Pricing decisions
  - Lack of firm supply-side inputs
  - Additional , un-profiled geographies
  - Absence of long-terms insurance contracts affects
    - Capex
    - Manpower
- Awareness
  - Local flavours

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Supply-side Issues

- Inadequate geographical mapping by private healthcare providers
  - Concentration in select economically well-off locations
  - C & D locations
- Aligning public hospitals with Cashless network
  - Better reach
  - Financially enabling them to upgrade
- Accreditation / Credentialisation
  - Quality Service and Competence as differentiators
  - Shall help fixing differential charges for procedures

Supply-side Issues

- Standardizing procedures / ICD Coding
  - Shall help build a sustainable pricing mechanism
  - Will help remove supply-side moral hazards
- Tie-up with implants manufacturers and pharma companies
  - Quality implants
  - Economy of scales
- Regulatory mechanism in Insurance space
  - Structured vs. Informal
  - Quicker , local , empowered self-regulators

Supply-side Issues

- Inadequate investment in TPA space
  - Manpower
  - Use of technology
  - Sub-optimal utilization of Technology e.g. Tele-medicine
- Alternative Therapies
  - Ayurveda, Unani, Homeopathy
- Lack of standard treatment protocol
  - Variances lead to moral hazard
  - Resultant impact on pricing

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Some Challenges

- Contingent Capital
  - Inaccessibility to global reinsurance options
- Subsidy
  - Mass-based policies for poorer sections
  - Full subsidy with a sunset clause
- Product variants
  - OPD , women & children specific , old-aged , major diseases , long-tail ailments
- Delivery issues in rural space
  - Non-conventional distribution
  - Claims logistics

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Thank you

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Make It Your Business.

Fight HIV/AIDS.

USAID

FICCI SEDF

KHPT Karnataka Health Promotion Trust

ILO

Facilitating India's First Group Health Insurance Scheme for PLHIV

A Social Marketing Experience

Population Services International (PSI)

PSI
Population Services International

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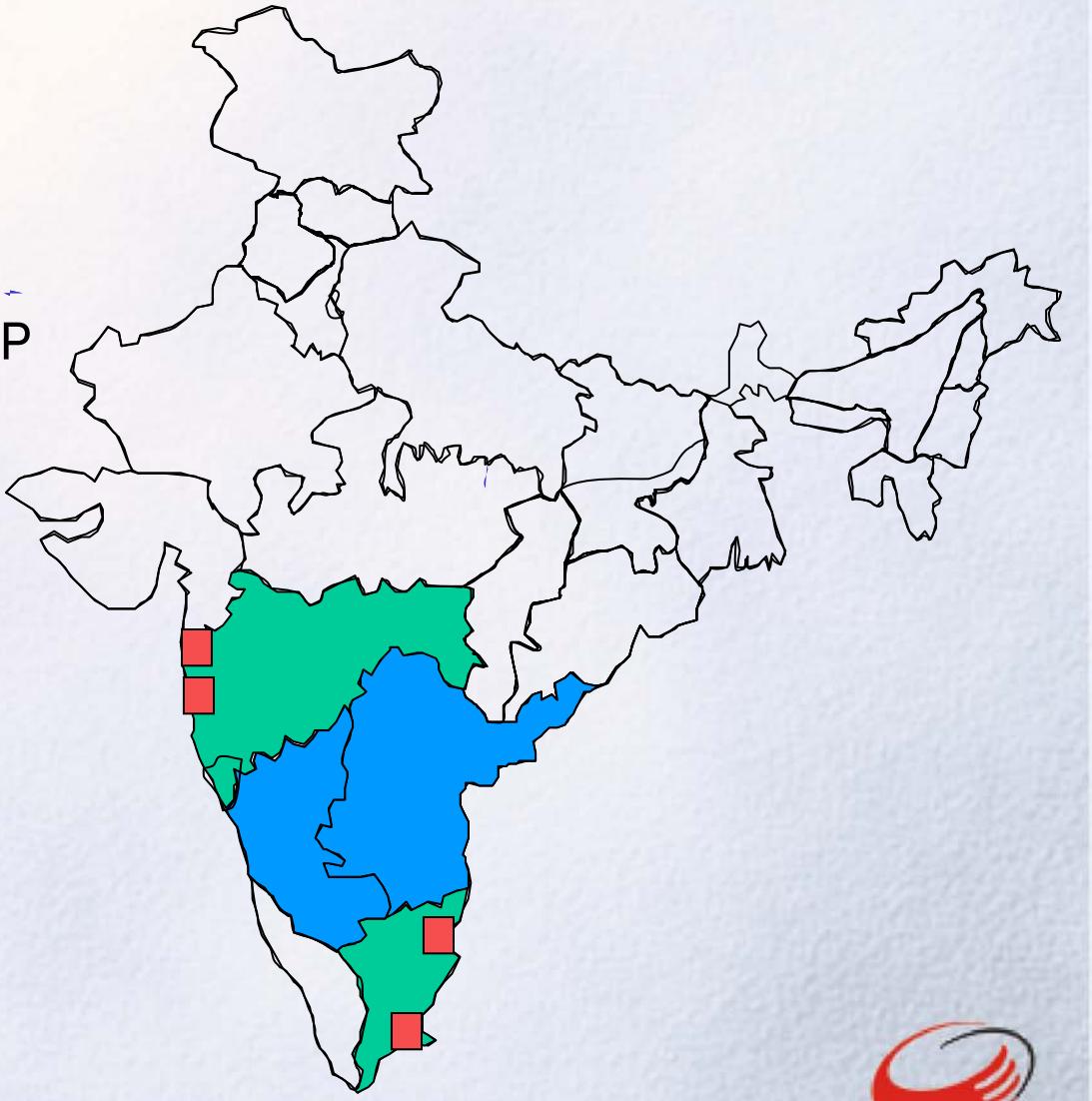
Public Private Partnerships in HIV/AIDS

Structure of Presentation

- Background
- Role of CONNECT
- Lessons Learned
- Next Steps

Background

- Funded by USAID
- Build Models and Strengthen systems in PPP in HIV/AIDS and TB
- Karnataka & Coastal AP
- Four port towns
- Support NACP III
  - PPP
  - Mainstreaming



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NACP – III: FOCUS

- Mobilize private sector insurance companies and pharmaceutical companies to define their role and contribution in the National AIDS Control Programme

Insurance Scenario

- No major insurance company in India addressing HIV

- Star Insurance
  - Specialized Health Insurance Company
  - Developed a policy for PLHIV
  - No takers for policy

Star Health Original Policy

- Group Insurance (Group size > 500)
- One time benefit at AIDS stage (CD4 < 150)
- Annual Premium & Sum Insured
  - Rs.2,500/- (for Rs.30,000/-) &
  - Rs.4,000/- (for Rs.50,000/-)
- Optional hospitalization additional cover
  - Rs.390/- (for Rs.30,000/-) &
  - Rs.650/- (for Rs.50,000/-)

So, What did CONNECT Do?

- **Social Marketing** of the policy
- **Facilitated** the release of the policy

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1. Product:

Developed New Insurance Product

- Facilitated discussion between KNP+ and Star

- Key concerns raised by KNP+:
  - Reduction in the annual premium
  - Inclusion of hospitalization cover
  - CD4 count not to be sole criteria for enrollment and claim settlement

Insurance Policy (Before and After)

Element of the Policy	Original Policy	Present Policy
1. Group Size	500	300
2. CD4 for enrollment	350	300
3. Pre- screening & Claim eligibility	CD4 count sole criteria to ascertain eligibility	Clinical condition will also be considered
4. Policy benefit	One time benefit on reaching AIDS stage	Hospitalization included in the cover
5. Premium	Rs. **2500/- for Rs. 30,000** Rs. 4000/- for 50,000	Rs. **1511/- for Rs. 30,000/-** Rs. 1919/- for Rs. 40,000/- Rs. 2545/- for Rs. 60,000/-

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2. Promotion & Place:

Supporting Enrolment & Screening

- TA to KNP+ to mobilize members for pilot from 6 districts
- Facilitated pre-insurance screening through NIMHANS
- 335 PLHIV screened (out of 345 enrolled)
- **The Group Policy issued to 258** PLHIV in KNP+

3. Price:

Voucher- Individual Premiums

- PLHIV to contribute 50% premium amount
- Connect/USAID to provide 50% of the premium amount for the pilot phase

To Summarize, CONNECT:

- **Product**:
  - Brought together Star and KNP+
  - Modified policy as per needs

- **Promotion & Place**:
  - Supported awareness/motivated State and District Network members to sign up

- **Price**:
  - Provided cost-share for individual premiums (Voucher)

Lessons Learned

- Match the corporate needs with health issue/HIV – Companies are not donors but investors

- Need to build trust (to facilitate)
  - Both private sector entity and grass-root NGO need significant hand-holding

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Next Steps

- Monitor implementation of pilot – claim settlements
- Document experiences and disseminate
- Future Expansion Options:
  - Expand KN experience pan India
  - Get other companies to replicate Star policy
  - Advocate with insurance companies to cover HIV under general health insurance

Thank you

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Welcome to the presentation of PREM

People's Rural Health Promotion Scheme

www.prem.org.in

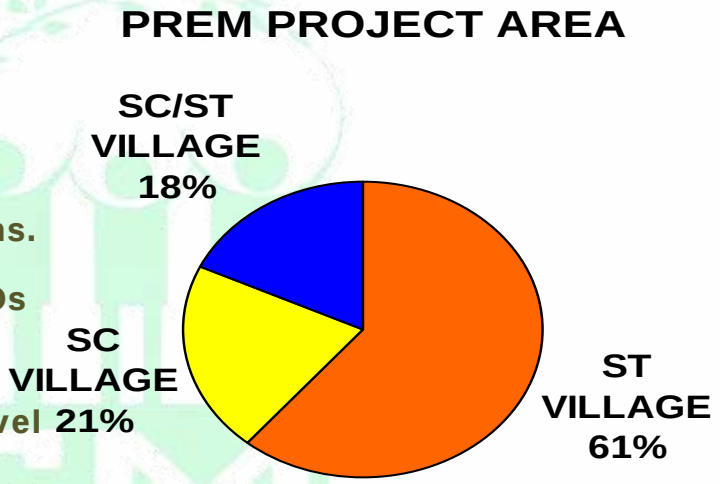

BACKGROUND OF PREM

- PREM (Peoples Rural Education Movement) is a humanitarian, non political secular voluntary organization working in Orissa and Andhra Pradesh for past two decades.
- Its primary objective is to work with community organizations through Networks, Advocacy & Lobby for the rights of the marginalized people i.e Tribal,Dalits & fisher people communities.

.

PREM WORKS WITH

- TRIBALS
- DALITS
- FISHERMEN COMMUNITY
- MARGINALISED FARMERS
- Net working with NGOs who are having similar concerns.
- At present PREM is collaborating with around 225 NGOs across the country.
- Tribal groups such as Orissa Adivasi Manch at state level
- NACDIP at national level which is promoted by PREM for the rights of tribal's in 18 states of India.
- East Coast Fisher People for the rights of fisher community in 7 states of the East Coast.



Why People's Rural Health Promotion Scheme (PRHPS)?

- **PREM's works for communities of Tribals and Dalits who live in**
  - **Inaccessible and malaria endemic area.**
  - **High infant and maternity mortality rate.**
  - **Suffering with TB, Sickle cell, diarrhea and typhoid.**
  - **Difficult to acess health services.**
  - **Government facilities do not reachable.**
  - **Insurance Companies are not interested in providing services.**
  - Cont...

Why PRHPS? Cont…

- **PREM's spends Rs 25,00,000 for referral medical care every year.**
- **How to provide medical care in inaccessible areas and at the same time raise funds to support for treatment**
- **PREM tried to convince several insurance companies in order to support health service for children of the community but the main difference between both the institutions was the companies were looking at commercial point of view and we were interested in the service part, which was to include some of the diseases like malaria, tuberculosis etc & also the problem of reimbursement.**

One for all & All for one…

- Tribals have a rich social value system of **‘One for all and all for One’** and **‘Caring and Sharing’** common resource mobilization is also a part of the tribal culture.
- Basing on this philosophy the scheme was intiaited.
- The rational of the scheme is based on collecting a small amount as annual membership fees from each and every member of the family.

People's Rural Health Promotion Scheme

- Is implemented in 500 villages with 1,00,000 members.
- The annual membership fees is Rs. 30 per year
- A sum of Rs. 30,00,0000 is collected every year, where as Rs. 25,00,000 spent for healthcare facilities
- Rest Rs 5,00,000 is put as Corpus which is utilized for other income generation activities for Self Help Groups.

Benefits from PRHPS

- **Level I: First aid treatment at village level**
  - **Each village has a village pharmacy that dispenses medication for basic and common diseases. It is managed by a trained voluntary health worker, whereby 75% of the day to day health hazards are addressed at the village level.**
- **Level II: Treatment at the Public Health Centre (PHC) level**
  - **The sickness which goes beyond the reach of the village pharmacy is recommended to the PHC which covers around 100,000 population and provides treatments to patients recommended by the self-help groups. This type of participation generate a demand for asserting the rights of the masses in the government institutions.**
- **Level III: Referral cases at district level**
- **The critical and serious cases are referred by the PHC's doctor to the District Health Care Hospital's and the Medical College Hospital's.**

Referral Expenses per member

- **A maximum support for each member is up to Rs 5,000(which includes the medicines which govt. doesn't provide free, user's fees charged by the govt., investigations fees, in some cases travel costs etc)**
- **Emergency cases which are referred by the specialist's are also taken care where the cost is not a bar compared to life.**

Outcomes

- Bringing medical services the door steps in inaccessible areas.
- As the communities manage the program, each and every member's health is taken care.They own the decisions, the process and the resources.
- Immunization of the entire population has become a reality.
- IMR and MMR has decreased.
- This process has activated the defunct health care institutions and the rights based approach has forced them to deliver the services.
- Accessibility of the marginalized communities to urban hospitals.


Learning's

- To provide health care to rural poor in inaccessible area's is a challenge.
- A sense of community feeling and concern for "One for all and All for one" is pre-condition.
- Motivated and established CBO's are most supportive factor for such kind of scheme.
- It is a strictly community based approach where people are responsible for their decision.
- Large number of members are needed in a specified geographical area for the viability of management and other expenses of the scheme.

Future Plan

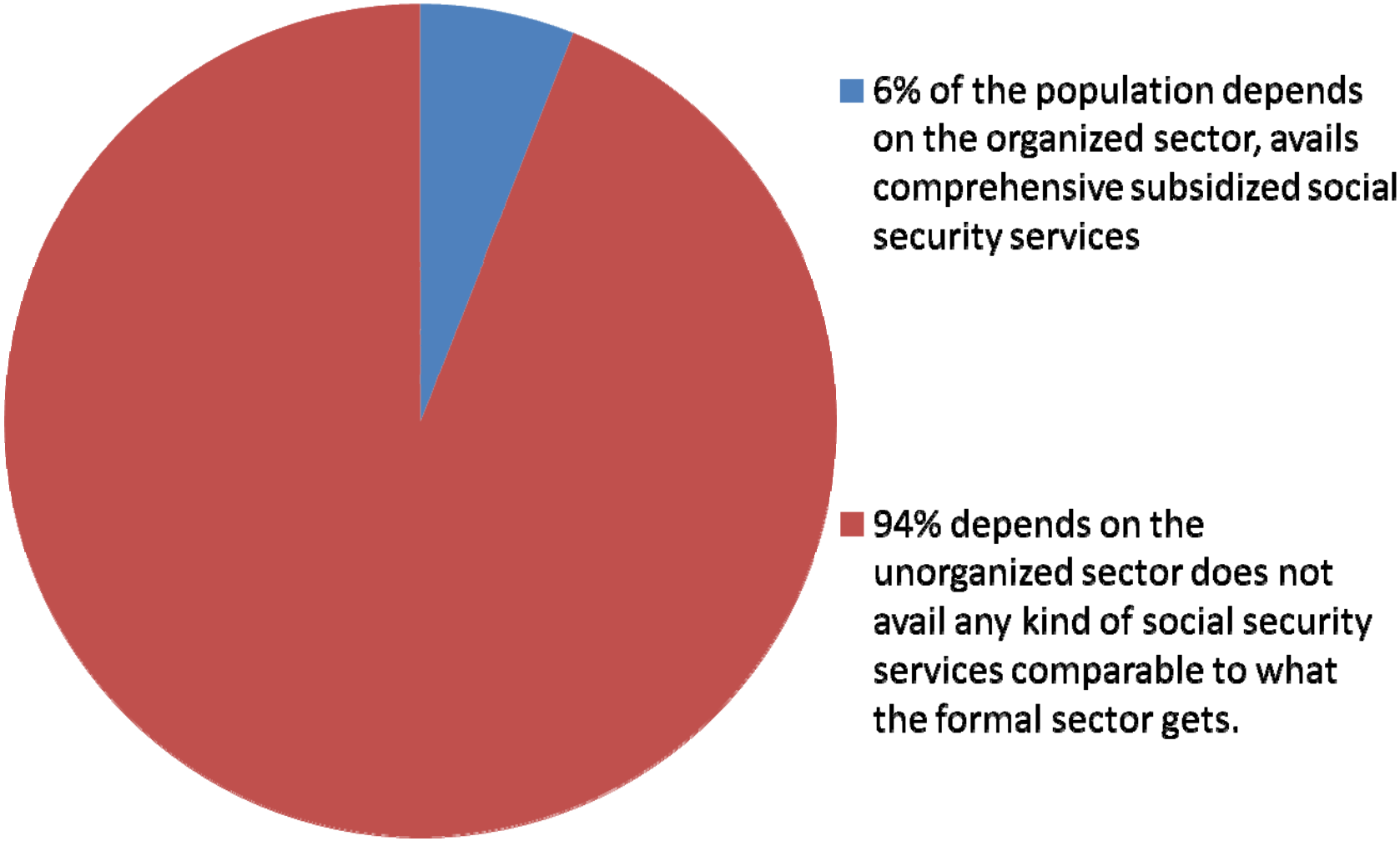
- PREM has planed to include another 50,000 people in future.
- It has been decided to involve another 5,00,000 people through its network partners.
- The Labor Department, Government of India has introduced Health Insurance Scheme for BPL families very similar to our approach and module and planning to provide services through insurance companies.
- As the process is not owned by the people and community is not involved in the decision making process, This is a challenge for the Government and the Corporate players to implement the program.

I too contribute my share for your health

Community Led Association for Social Security (CLASS)

A people owned initiative to catalyze social security to the grassroots by joining hands together

Social Security is a right that 1 billion people do not avail in India

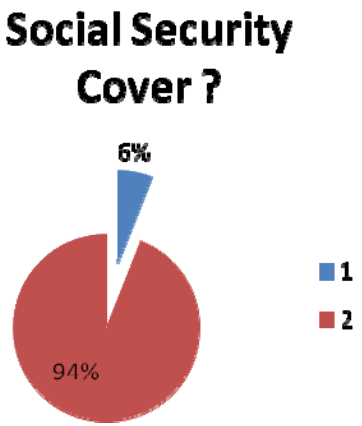


Context of Social Security Provision- Govt and the grassroots

- Govt has been proactive on providing Social Security
- Has ambitious programmes and resources for it
- ***Effective Delivery at grassroots however remains a critical issue in such state initiatives***
- CBOs are doing tremendous work
- Effectively delivering need based social security solutions at the grass roots.
- ***Outreach still low (compared to the population) and require much more resources***

?

How to reach the unorganized Professionally, efficiently, sustainably...

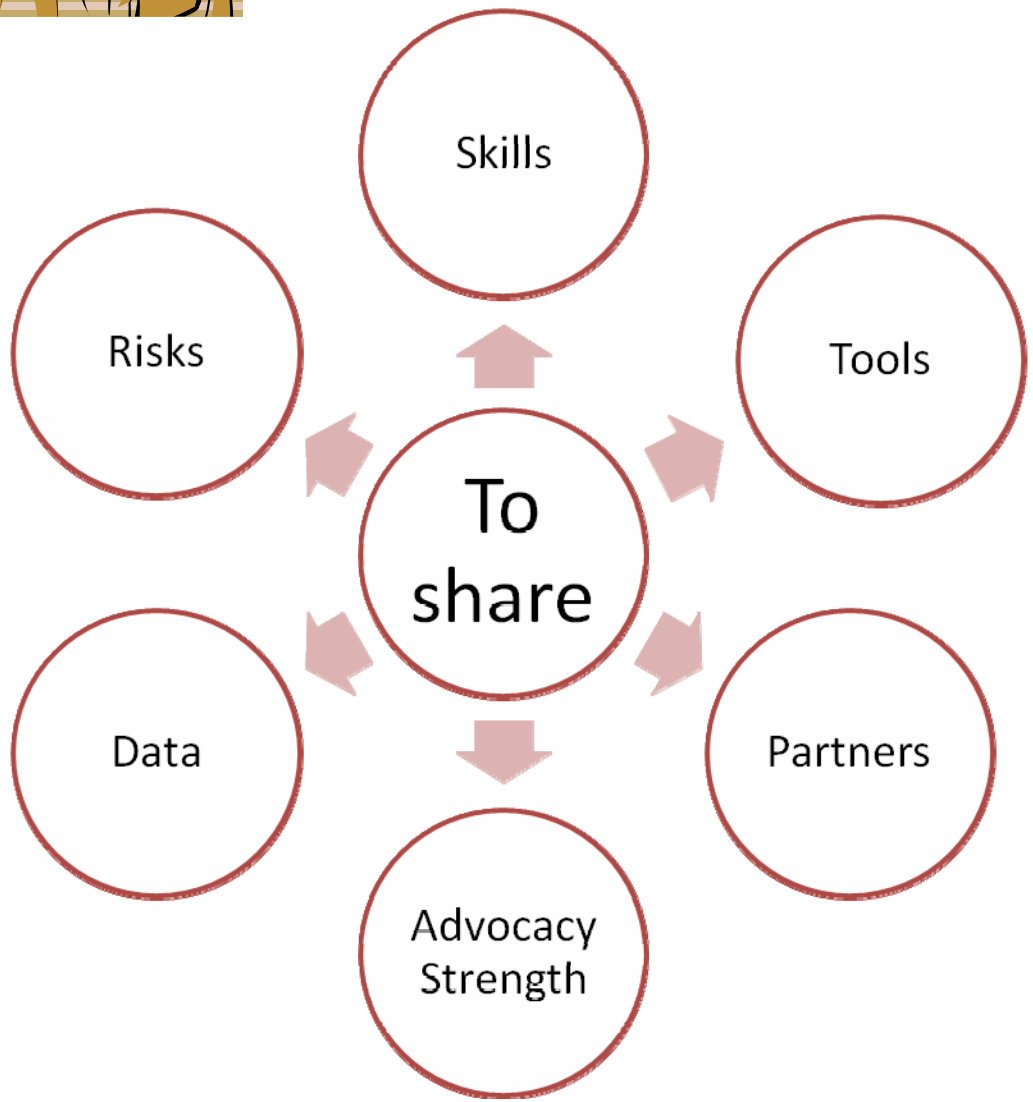


With equitable social security services...

And a people based governance...

... using the stakeholders available???

Organizations & Communities decide to work together:



To collate assets

To upscale equitable social security to communities

…And form together

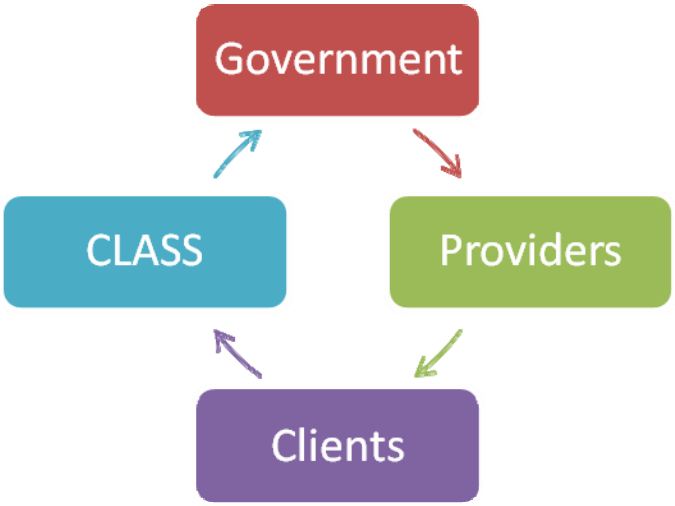
Communities-Led Association for Social Security

- A public Section 25 company, owned and democratically managed by communities and organizations working with communities
- With a Vision of “Social Protection for All”,
- And a Mission to cooperate in providing Communities with need based, easy to implement, equitable, reliable, quality controlled social security risk management solutions.

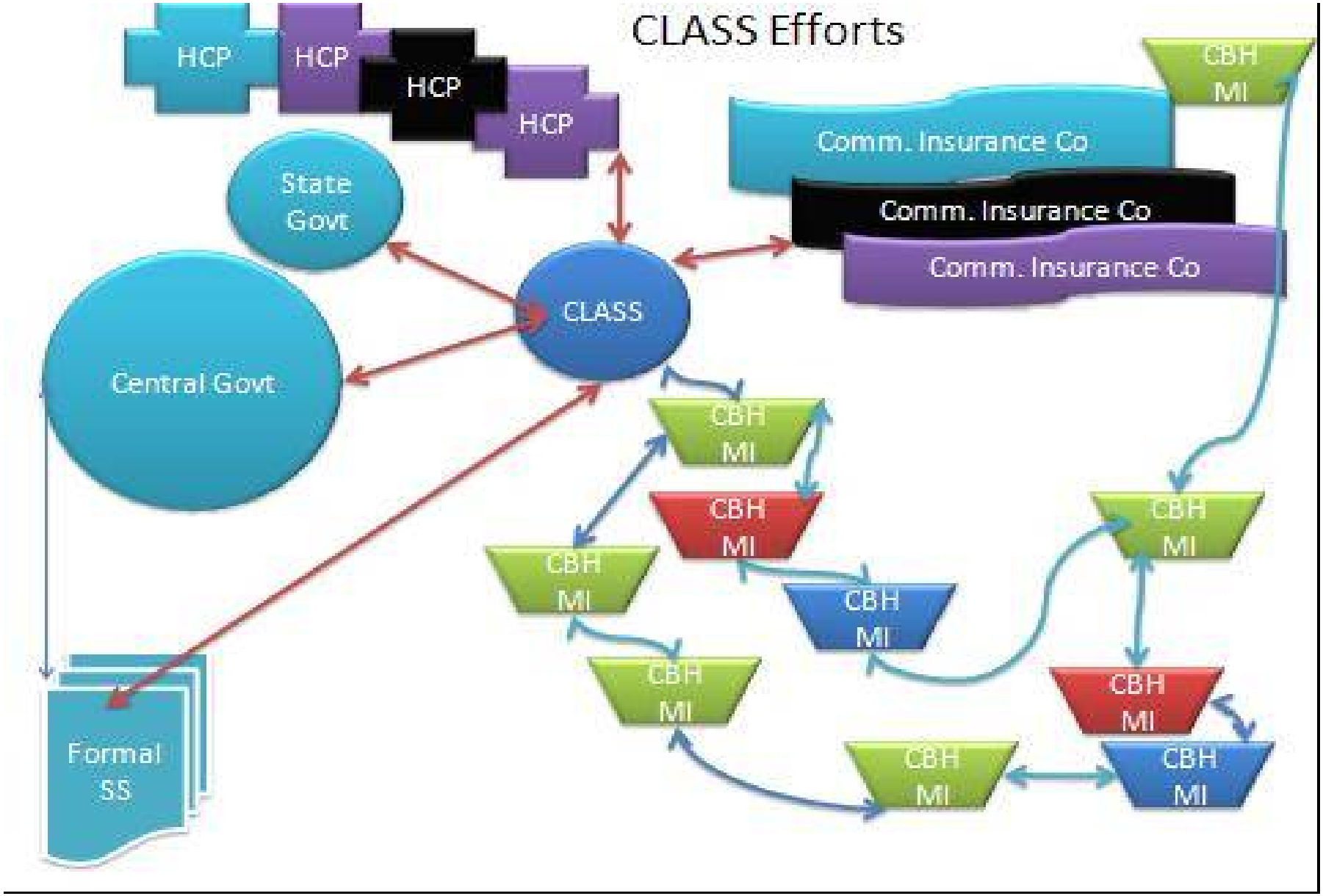
Communities-Led Association for Social Security Organization's rationale

CLASS *functions*

CLASS functions will be to fill in the missing link between clients and initiators in the social security value chain.



- To offer comprehensive technical support for developing access to social security for the informal sector.
- To gather and SHARE -data and evidence
- To advocate social security framework for inclusion and transparency


CLASS Efforts
HCP
HCP
HCP
HCP
State Govt
Central Govt
CLASS
Comm. Insurance Co
Comm. Insurance Co
Comm. Insurance Co
CBH MI
CBH MI
CBH MI
CBH MI
CBH MI
CBH MI
CBH MI
CBH MI
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CBH MI
Formal SS

CLASS Membership

Core Members

- Membership >= 5000 2 years of existence,
  Professional standard (MIS, Audited accounts &activities,…)
  Signatory of the Charter, transparent governance/ mgt.
  Membership fee : Yearly contribution: Rs. 0.1 per live/head insured. Voting rights
  Eligible if 1 individual representative member

Individual Associate Member

- Members who would work as catalyst in delivering and evolving the CLASS processes locally.
- Membership fee : 1 000 per year
- No Voting rights

Institutional Associate Member

- Organization providing technical /financial service / support
- Yearly Membership fees : Rs 10.000
- No Voting rights

CLASS Members

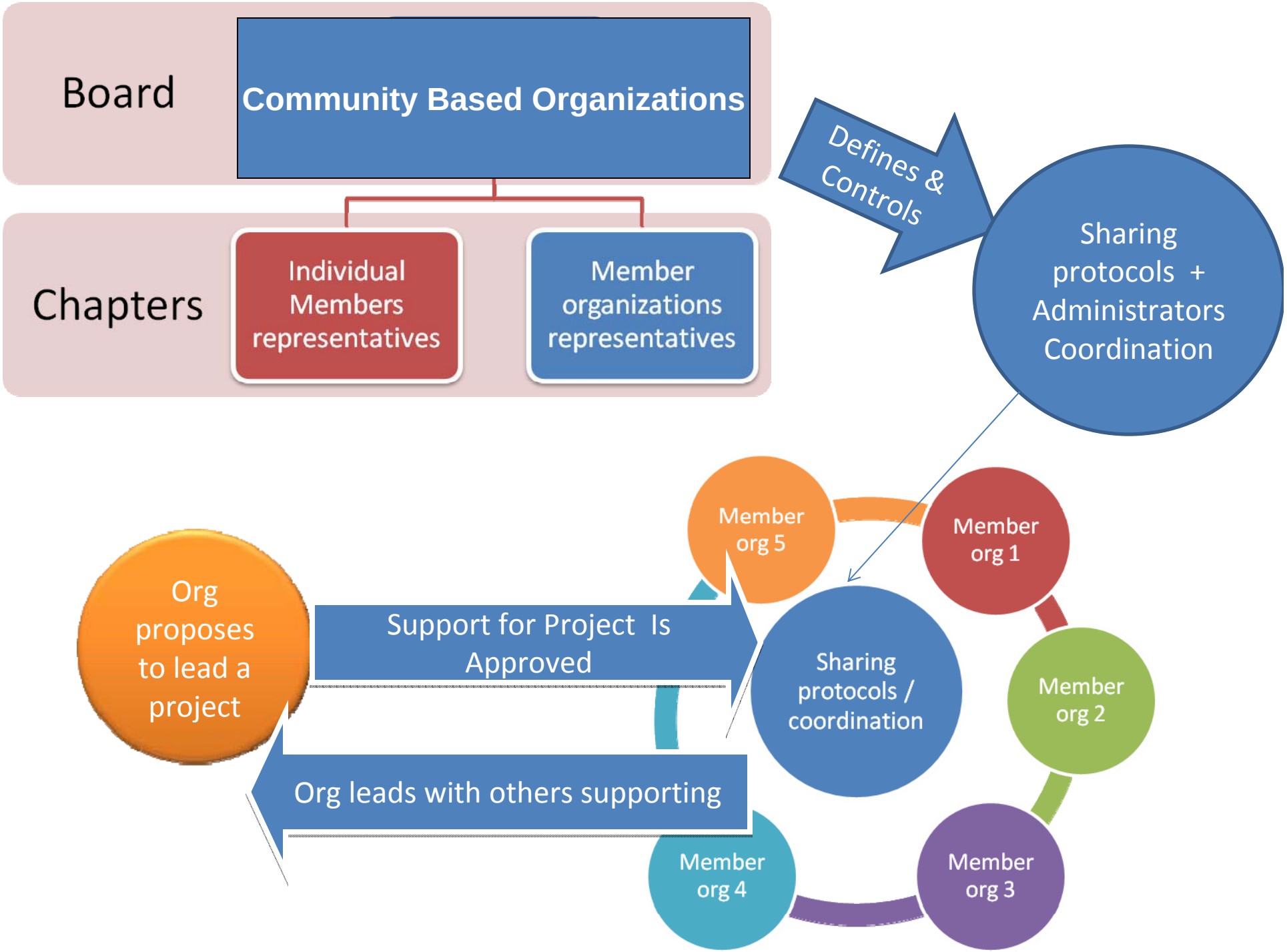
- Tamil Nadu- SHEPHERD
- Karnataka- IPH, Karuna Trust
- Orissa- PREM
- Chattisgarh-RAHA
- Gujarat- VIMO SEWA
- Maharashtra- Annapurna ,PSW,BAIF,UPLIFT,CHAITANYA, FRCH,SSP, BUCCS
- Expected to Join-SIFFS, Kerala

Governance at CLASS

- CLASS Board Of Directors- Community Based Organisations and community representatives

- CHAPTERS to be organised at the State Level

- CLASS SECRETARIAT to coordinate activities– for 2008 -Uplift Pune


Board
Community Based Organizations
Chapters
Individual Members representatives
Member organizations representatives
Defines & Controls
Sharing protocols + Administrators Coordination
Member org 5
Member org 1
Member org 2
Member org 3
Member org 4
Sharing protocols / coordination
Org proposes to lead a project
Support for Project Is Approved
Org leads with others supporting

CLASS is supported by

- GTZ
- ILO STEP
- PLAN International
- AMIN
- GIMI

CLASS Membership is OPEN

For further details or information

You can write to the CLASS Secretariat

at

krshailabh@gmail.com

Microinsurance Resource Center: A Stakeholder Initiative

RNK Prasad, MIRC

Kimberly Switlick, BearingPoint

India's Insurance Market is Growing Rapidly

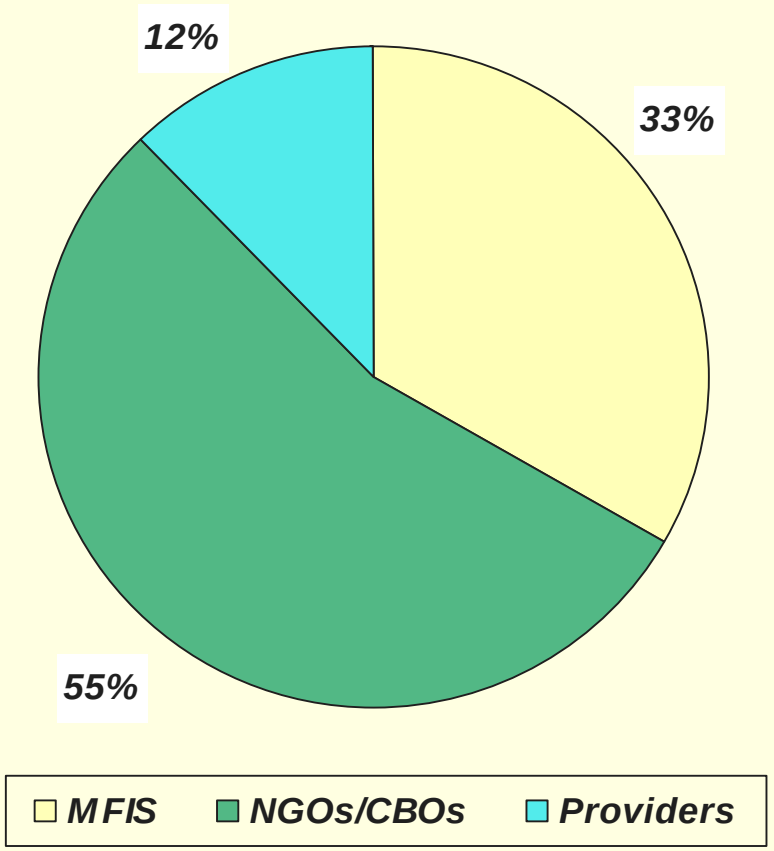
	2000	2007
No. of insurance companies	5*	35
Insurance premium (in $b)	8	42
Insurance premium as % of GDP	1.9	4.6% (L) 0.6% (NL)
India's share in world insurance market	0.5	1.0

But the Growth is not Inclusive

- **Benefits of growth restricted largely to urban areas and organized sector.**
- **About 90% of India's population not able to participate in the insurance market – particularly the Health Insurance Market**

INDIA: Microinsurance Experience

- Diverse population and risks
- Variety of players – MFIs, NGOs, CBOs, Insurers and the Government
- Various models being tried
- But the coverage is just about – 10-15 million people!



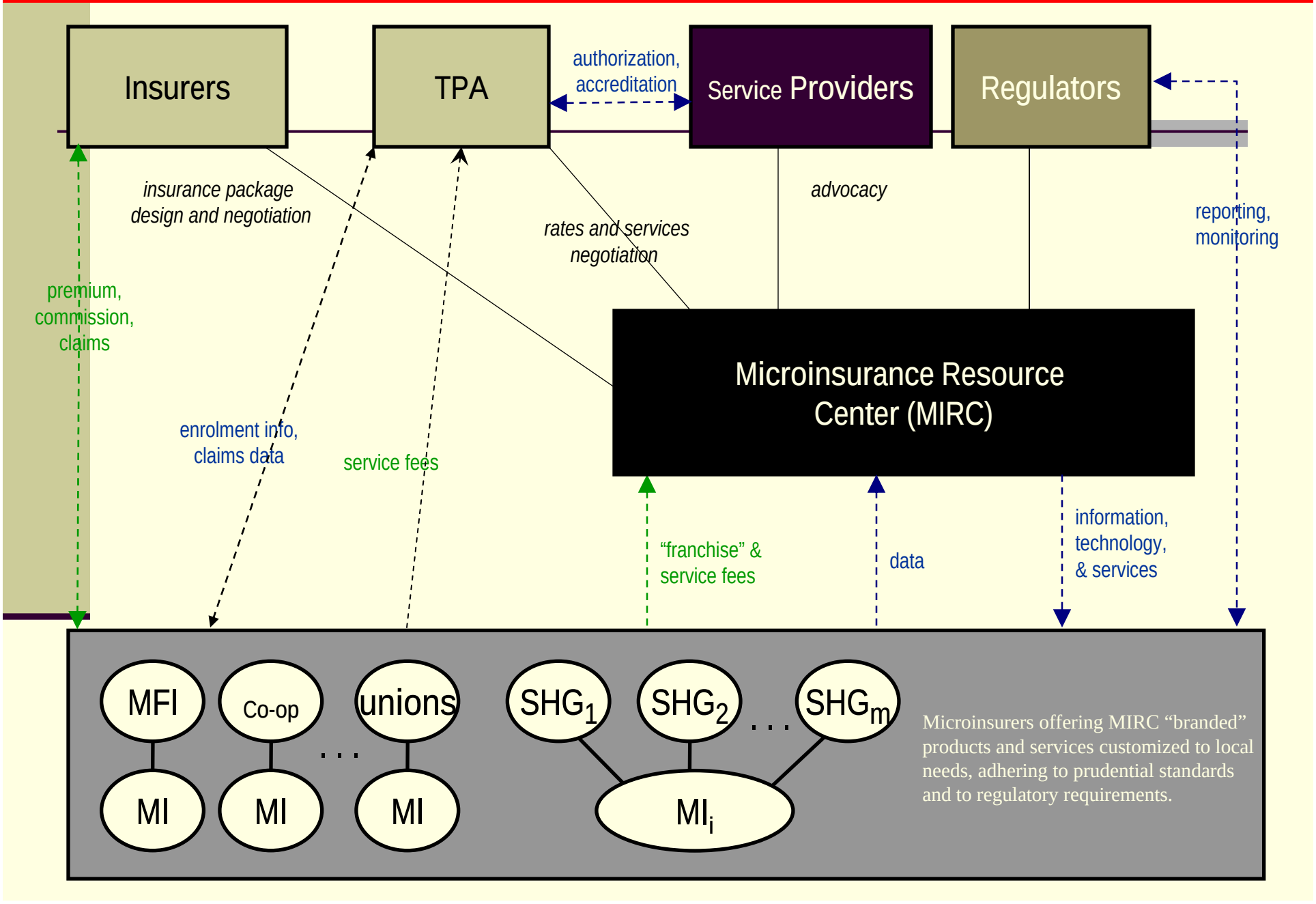
Barriers to Microinsurance

- Lack of technical and managerial capacity to manage insurance programs
  - No knowledge of “industry standards” or “best practices” in insurance processes
- Small risk pools – little data to properly cost benefits
- Data and information constraints
- Insufficient providers to participate in scheme
- Lack of consumer awareness/demand
- Insurance companies (who are bearing risk) do not offer products that are needed by MI beneficiaries

MIRC – A NEW INITIATIVE TO PROMOTE MICROINSURANCE

- Established by India's leading MFIs, Health Care NGOs to access technical and managerial expertise in micro insurance (Financial support from USAID)
- Overarching theme of MIRC is Knowledge Development; Knowledge Management and Knowledge Transfer
- Current Institutional Membership – Basix; SHARE; PREM; Karuna Trust; FWWB; Cashpor; Mimo Finance

MIRC Model for Providing Technical Interventions



MIRC – Vision & Mission

VISION

To build a **collaborative**, **robust**, and **sustainable** Microinsurance (MI) industry so people, particularly the economically disadvantaged, have access to affordable, comprehensive, quality risk management and risk protection programs.

MISSION

Develop and Build capacities of MI industry stakeholders to enable delivery of sustainable programs and solutions; Build a collaborative network for mutual benefit

MIRC Broad Goals – Short to Medium Term

1. Develop Microinsurance capacity of Members of MIRC to deliver effective risk management solutions to their clientele;

2. Recommend and Promote best practices in the areas of MI;

3. Provide a platform for MI policy and advocacy.

4. Make MIRC as a repository of MI data and information

5. Build generic microinsurance consumer awareness

Activities to date

- Self Assessment of Member Programs and documentation leading to a gap analysis
- Developed Preliminary MI standards.
- Build a pilot scale data repository using standardized data templates and samples from Members' databases.
- Deputed Members to International conference on MI standards
- Conducted a field study on access and awareness of MI in two states Orissa and AP

MIRC – Services and Activities

1. Provide customized Technical Assistance to Members and their clientele for their MI needs:
    1. Set up community based risk management solutions
    2. Provide assistance in
        - Pricing and Risk Management
        - Product and Process Design
        - Donor Sourcing; Partner Identification; Facilitation/ Negotiation with Insurers
        - Management Information systems
        - Guidance and Training in implementing MI solutions
        - Product/Pricing reviews and assessment

MIRC – Services and Activities

2. Diagnostic reviews of Member operations for promoting best processes and practices:
   - Define, Recommend and Promote best business practices; Codes of Conduct
   - Review and Recommend cost effective processes and methodologies for various tasks;
   - Rating service for microinsurance business against the best practices of MIRC

3. Establish Network of providers for the benefit of Members and their clientele
   - Define, recommend and promote standards, best practices and codes of conduct for various levels of providers;
   - Facilitate/Negotiate with providers on behalf of members
   - Rating of providers services for Members

MIRC : Services and Activities

4. Interact with GoI, State Government and IRDA on policy matters relating to Microinsurance, for example
   - Empowering NGO networks for development of microinsurance and related activities
   - Addressing policy level barriers for members and other NGO networks
   - Creating and funding of risk pools
5. Build a repository of MI data and information
   - Members non proprietary data
   - Periodical Inventorisation of MI schemes, self-insured and PA models;
   - Demographics of state wise rural households – ultimate clientele of Members
   - Case Studies and Experience studies and result sharing

MIRC – Services and Activities

6. Design and implement MI awareness programs
   - Undertake nationwide microinsurance consumer awareness and utilization field studies
   - Design and Distribute education materials
   - Design and Develop other awareness materials
   - Train member staff for conducting such programs

MIRC – Management Structure

1. Governing Council – All Policy and Governance Matters
2. Permanent Functional Committees to support MIRC capacity
   - Advisory Committee
   - Best Practices Committee
   - Research and Training committee
3. Professional Staff
4. Access to Domestic and International Consultants and Actuaries
5. On board support of domain and technical experts as consultants