MICROHEALTHINSURANCE UPDATE,
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Issue 2

UPDATE

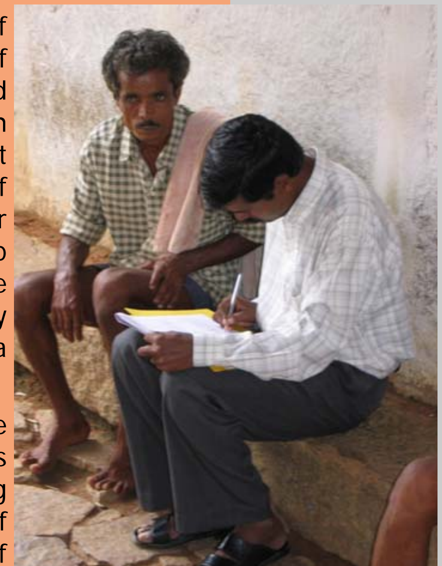
Editorial

We have moved a step closer to detailed knowledge about supply and demand of micro health insurance in India. We have completed a household survey that contains data about utilization of health services, costs of care and willingness to pay for health insurance. This information is complemented by spatial data affecting demand in a huge country like India. We have also started analysing the functioning of existing micro schemes.

In this issue of MICROHEALTHINSURANCE UPDATE we share with you some initial insights. We also introduce two successful micro health insurance partners: Yeshasvini Trust (p. 2) and Karuna Trust (p. 3). Both examples illustrate that relevant products and adapted distribution can make health insurance accessible to the target populations.

The information we collected and the analysis that will follow serve to help our partner schemes, other existing micro schemes and groups planning to start new schemes. And we trust that better information can enhance the development of sustainable and efficient microinsurance and reinsurance arrangements.

India's huge market for low-cost health insurance!



The market for health insurance at the "bottom of the pyramid" includes hundreds of millions of people! A brand-new household survey, completed by the project "Strengthening Micro Health Insurance Units for the Poor in India", reveals that more than half of the households at the "bottom of the pyramid" spend more than Rs. 2,400 ($54) per year on health care. When aggregated, this adds up to a huge amount. If only a fraction of it were pooled through insurance, households would enjoy better financial protection, and insurers could run a sustainable business.

Our study reveals that even poorer households are willing to pay for insurance. Examples of products that have encountered receptive markets among poor sections of Indian society include coverage of hospitalization costs, drug costs, and loss of earnings due to hospitalization. Our survey corroborates that these are the most preferred types of benefits.

Insurance penetration to populations at "the bottom of the pyramid" depends on convincing clients that the products represent value-for-money. The household survey offers insights how to design relevant health insurance products, gives data on the health expenditure of households and what they would agree to pay for insurance, and offers additional evidence on the effectiveness and equity of the micro insurance schemes already in existence.

The household survey has been conducted with support from the Indo-German Health Programme through German Technical Cooperation (GTZ). With seven locations where micro schemes are operating, and some 4,900 households interviewed, this is the largest comparative survey of micro health insurance schemes completed in India so far. We now have almost 150,000 pages of information that enables us complete both qualitative and quantitative analysis of micro health insurance, and to establish the case for the establishment of reinsurance for micro insurance in India.

More topics:

Insuring Karnataka's farmer: Yeshasvini Trust	2
Compensating wage loss: Karuna Trust's innovative insurance product	3
How far is too far?	4
Collaboration for development of new information system started	4
AIDS and insurance	4
Useful Weblinks	4

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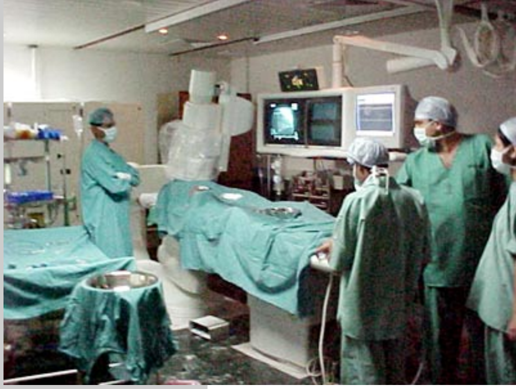
Insuring Karnataka's Farmers: Yeshasvini Trust

The Yeshasvini Co-Operative Farmers Health Scheme in Karnataka started in 2003 when the Department of Cooperation (Government of Karnataka) and Yeshasvini Trust agreed to collaborate in creating a health insurance plan for the cooperative sector. The Department used its influence with the cooperative societies to actively promote the plan, and in parallel it injected a premium subsidy matching members' annual premiums of R. 60 ($1.40) by an additional 50%. Consequently, 1.6 million farmers joined from inception. The Trust finished the first year with an operational surplus. In the second year, the scheme reached a peak of 2.2 million insureds, but the state subsidy was reduced to about 30% above members' premiums. In year three (the current year), the state subsidy was stopped, and the scheme had to increase premiums; the Trust decided to collect Rs. 120 ($2.70) for each adult, and half that amount for each child. Membership has dropped to about 1.5 million insured. With the increased premium in this third year of operation, the scheme is expected to be financially viable.



The benefit package covers high cost & low frequency events and free OPD treatment (excluding lab or drugs). More than 1,600 different surgical procedures are included, with maximum coverage set at R. 200,000 ($4,545) per person per year.

www.yeshasvini.org

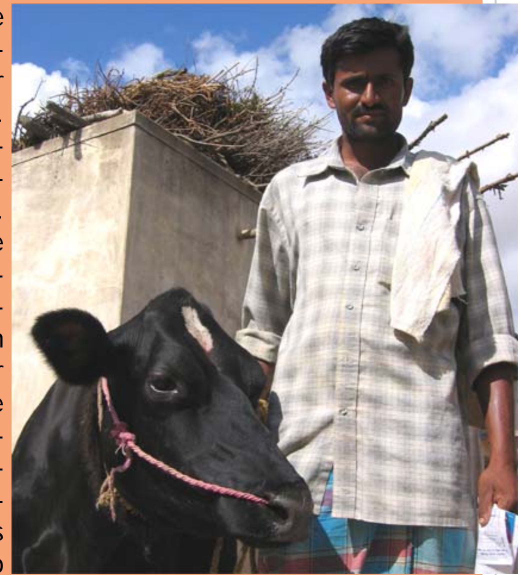
The insurance scheme entered into flat-fee rates (for each surgery) with 150 private Network Hospitals to ensure sufficient supply and choice. The lead hospital is Narayana Hrudayalaya hospital (Bangalore). Insured members do not need to pay anything at the point of service ("cashless service").

The Yeshasvini Health Scheme is self-funded, and not linked to any insurance company. It outsourced the administration to a for-profit Third Party Administrator. This TPA authorizes surgeries, processes claims and maintains a register of the members.

The Yeshasvini Health Scheme is considered to be the most success in terms of signing up members.

Paying for insurance in milk

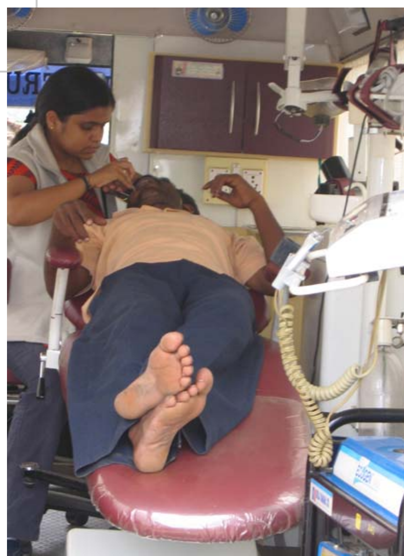
Mangsandra, a little village with about 1,000 inhabitants, is located in Kolar district near Bangalore. Dairy is an important economic activity in Mangsandra and in Kolar district. About 200 families are members of the Mangsandra Co-Operative Milk Society. Krishnamoti has been the society's secretary for seven years, and since 2003 he also provides information about Yeshasvini's health insurance, enrols members and collects their premiums. He tries to convince people to join the scheme because he thinks that it will be beneficial for their health.



Krishnamoti reports that it is difficult to pay the premium for an entire family in a single payment. But the Milk Union developed a solution for this problem: every morning the members of Mangsandra Co-Operative Milk Society bring the milk to the society and Krishnamoti records each member's contribution in his books. Every day the milk of the Society is transported to the Milk Union for further processing and marketing. When the union pays for the milk on a monthly basis, members of the Society get paid as well. Krishnamoti pays them according to the amount of milk they delivered during the month.

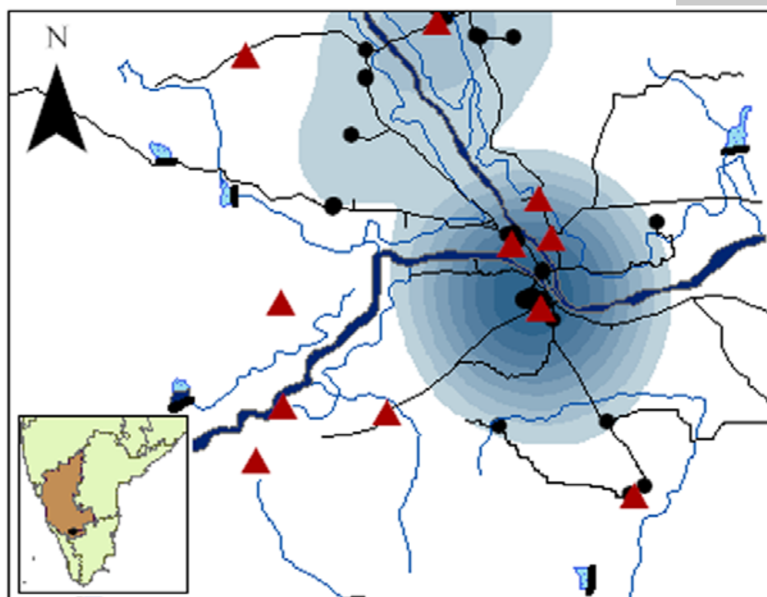
Members who are signed up to Yeshasvini can arrange to have their premium deducted from the proceeds at source. Krishnamoti then informs the Milk Union who opted for deduction of their premium, and the Milk Union then forwards the premium directly to Yeshasvini Trust and deducts that amount from the monthly payment to the Society, which in turn deducts it from the share of the respective member. This way, the Milk Society enables the members to pay their insurance premiums in instalments ... of milk.

Compensating wage loss – Karuna Trust's innovative insurance product



Karuna Trust is an NGO working successfully on health issues for nearly two decades. In 2002, Karuna Trust teamed with UNDP to implement a pilot health insurance scheme which would complement the use of the public health care infrastructure, and thus make it more attractive. In cooperation with the National Insurance Company Ltd. (NIC) they designed a plan which compensates for loss of wages during hospitalization, and covers the cost of drugs needed during inpatient care. Clients – being poor – are not charged for hospitalization in the public health care facilities. Making use of this public provision, Karuna Trust and its insurance partner can keep the cost of this insurance product at an incredibly low Rs. 22 ($0.50) per person per year, and pay a benefit of Rs. 50 ($1.14) per day for wage loss per day of hospitalization up to an annual maximum of 30 days (maximum compensation for wage loss Rs. 1,500 per year). In addition, the same premium covers Rs 50 per day for drugs in case of hospitalization at one of the designated public facilities. This amount – and in case of surgery an additional Rs. 500 – are channelled through a drug fund at the hospital. And in case of surgery the patient as well receives an additional Rs. 500 as an incentive to take enough time to recover at home afterwards.

"We know we get value for our money"



A baseline study conducted before implementation of the scheme revealed that the target group had low understanding and knowledge of (health) insurance. It was therefore decided to fully subsidise the premium for most of the very poor people. UNDP funded the premium for two years, and NIC continues to settle bills representing a claim ratio of up to 150% as its contribution to the social character of the scheme. It was assumed that with time, acceptance of insurance and willingness to join and pay would rise among people experiencing the benefits of insurance. Extensive information and education was given during the pilot phase. In 2005, premiums were collected from all insured for the first time. About half the members of the subsidized scheme paid to renew their membership. "We know we get value for our money" was stated frequently. Others complained about having to pay for benefits which were free-of-charge in previous years.

The experience of Karuna Trust is a very interesting example of creating complementarities between insurance and public structures, and of using subsidies in order to introduce insurance to very-low income people. The awareness building process was affordable because external funding was available.

The case studies published

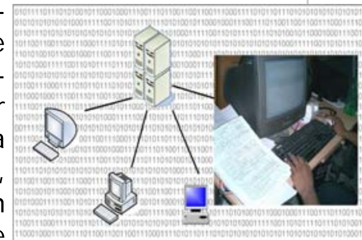
The results of the case studies on Karuna Trust and Yeshasvini Trust will be published in 2006 in the CGAP/ILO microinsurance working group series "Good and bad practices in microinsurance". Weblink to ILO site: www.ilo.org/public/english/employment/finance/vulnerab/micro/practice.htm

How far is too far?

How far would you agree to go to seek healthcare? Would you buy health insurance if providers were nowhere near your home? We tried to get an idea how spatial distance affects clients' acceptance of health insurance in India. For this purpose, we mapped the distance between location of providers and location of the population (or at least the epicentre of the village), by applying GIS techniques; our team – supported by geography students from the Universities of Cologne, Madras and Bangalore – mapped villages, health care providers and streets in four areas where we conducted our household survey. By cross-checking spatial distance between clients and providers (recorded in the GIS study) with demand for health care (recorded in the household survey) we hope to assess the impact of distance on affiliation into health insurance. To the best of our knowledge, this is the first time that the GIS component is used in a study of micro health insurance. We look forward to exciting insights when the in-depth analysis is completed in 2006.

Collaboration for development of new information system started

The Social Re/ECCP Project signed a Memorandum of Understanding with Uplift Health (Pune) on collaborating in the development and testing of a database for micro health insurance units (MIUs). Both partners to this MoU have previously developed a computer application - Social Re's Data Template has been at the level of pre-test development and Uplift's SysLift has been in use for sometime in the field. The purpose of these tools is to simplify and automate accounting and reporting operations at the level of single MIUs, starting from registration of newly enrolled members, and up to & including reinsurance calculations. Both partners recognize that their existing systems can be improved, so that SysLift would be the local-based system and the Data Template would evolve into a client-server version, it being understood that both systems would use an identical data exchange format. This configuration leaves the door open for other MIUs, which have their own data applications, to join our integrated information system, notably for the purpose of exchanging data with one and the same reinsurer. It will also allow each MIU to choose between a local-based application and a web-based hook-up. The integrated application would be known as "Information System for Insurance" (ISI).



AIDS and insurance

www.inpplus.net

The project "Strengthening Micro Health Insurance Units for the Poor in India" signed a Memorandum of Understanding with INP+ [www.inpplus.net], India's largest network of people living with HIV/AIDS, on collaboration in developing insurance benefits for positive people. Both parties see the urgent need for an appropriate insurance package and decided to make use of their respective strengths. A study on this topic will be conducted as soon as funding permits.

Useful Weblinks

www.munichre-foundation.org

Munich Reinsurance Company has established the Munich Re Foundation earlier this year. One of the first activities of this Foundation will be hosting a conference on microinsurance (Munich, October 2005).

www.haiweb.org/medicineprices/

Health Action International conducts surveys on availability and prices of medicines in various countries. Such a study was also conducted for parts of India and results are available online.

www.bimtech.ac.in

The Birla Institute for Management Technology is our partner in capacity building. We will start our educational component in November.

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For more information please visit www.microhealthinsurance-india.org or write an email to link-up@microhealthinsurance-india.org.