Training Manual on Health Insurance

(with Facilitator's Guide)

Institute of Public Health
Bengaluru - India

In collaboration with
Ministry of Health & Family Welfare, Government of India
and
World Health Organisation - Country Office for India

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Institute of Public Health
250, 2nd C Main, Girinagar 1st Phase
Bengaluru – 560085.
Tel: +91 80 2279 7532
Fax: +91 80 2642 1929
Website: www.iphindia.org
Email: mail@iphindia.org

Contributors

(In alphabetical order)

Name of author	Organisation, City, Country
Mr. Anindo Banerjee	PRAXIS, Patna, India
Prof. Bart Criel	Institute of Tropical Medicine, Antwerp, Belgium
Dr. N. Devadasan	Institute of Public Health, Bengaluru, India
Mrs. Srilakshmi Guru	Hunger Project, Bangalore, India
Mrs. Gangamurthy	Ministry of Health and Family Welfare, Government of India, New Delhi, India
Mrs. R. N. Gautam	United Health Care India (P) Ltd., New Delhi, India
Prof. I. Gupta	Institute of Economic Growth, New Delhi, India
Dr. Gopal Iyengar	KIAM, Bangalore, India
Dr. Nishant Jain	GTZ, New Delhi, India
Dr. Sylvia S. Karpagam	Mysore, India
Mrs. S. Lakshmikutty	Freelance consultant
Mr. S. Manoharan	ACCORD, Gudalur, Nilgiris, Tamil Nadu, India
Dr. S. Nagpal	IRDA, Hyderabad, India
Mr. S. Nandraj	WHO Country office, New Delhi, India
Dr. S. Peppin	Xavier Institute of Management, Bhubaneswar, India
Mr. K. Ramachandran	JB Boda insurance Brokers, Mumbai, India
Prof. P. Singh	College of Insurance and Risk Management Studies, New Delhi, India
Dr. S. Srikantiah	Baroda, India
Mr. S. Thekaekara	Just Change, Gudalur, Nilgiris, Tamil Nadu, India
Mrs. Pushpa Thumsi	Public Health Management Institute, Hyderabad, India

Foreword

The notion of 'Health Insurance' is of a relatively recent origin in the country. A large number of Health Insurance Schemes have been launched both in the public and private sectors, since the economic reforms process began in the early 1990s. Yet, there is very little clarity about issues relating to health insurance, even among the economists as well as health professionals, not to mention the general public. The expansion of health insurance in India has also brought with it greater degrees of complexities in the subject, that need to be explained to the professionals well as general public in simple terms.

The Training Manual on Health Insurance prepared by Institute of Public Health, Bengalure is an attempt in this direction. It tries to explain in simple terms, the issues involved in "Health Insurance". The manual is expected to not only help the trainers who conduct training programmes on health issuance but also the policy maker who could take more informed decisions.

The Institute of Public Health, and in particular, Dr. N. Devadasan, along with other contributors, deserves to be complimented for bringing out such a useful document.

Arvinder. S. Sachdeva
Economic Adviser
Ministry of Health and Family Welfare

Preface

There is a lot of interest in health insurance in our country. All the stakeholders, especially the governments and the insurance industry have been encouraging people to use health insurance as a mechanism to finance their health needs. Various schemes have been introduced, both for the rich as well as the poor.

However, health insurance is a new concept and it has its own theories and principles. We note that there is a singular lack of awareness about this, both among the planners as well as the implementers of the schemes. Moreover, health insurance is usually seen from the perspective of the insurance industry, rather than from the population or health perspective. In an attempt to rectify this gap in knowledge and skills, the Institute of Public Health had organised a series of training courses with the support of the WHO India office and the Ministry of Health and Family Welfare, Government of India. This programme was principally aimed at the middle- and senior-level officers within the state and national governments.

The success of these training programmes has moved the Ministry of Health and Family Welfare to scale up the programme so that more states and officers can be trained. The original training manual was revised to incorporate the learning from the previous training programmes. A section on teaching methods and the steps in teaching the sessions have also been introduced for the benefit of the trainer.

This document takes the reader through the basics of health insurance, especially within the Indian context. Its strength is the set of exercises that have been systematically developed and help the participant to apply the theory.

This manual would not have been possible without the financial assistance of WHO India office and specifically the technical and conceptual support of Mr. Sunil Nandraj. We would also like to thank all the experts who gave their precious time for this activity. We would like to express our gratitude to Mrs. Ritu Singh who helped us to edit this manual. And last but not the least; we would like to thank Mrs. Gangamurthy from the Ministry of Health and Family Welfare, Government of India, who took an active interest in this publication and supported us through all the stages of its gestation.

Dr. N. Devadasan
Institute of Public Health
Bengaluru
1/6/09
mail@iphindia.org

Why this book?

Is there a need for a book on health insurance in India? Considering that there is such a low penetration of health insurance in India, why should anybody want to read about it?

One of the main reasons for this book is the fact that there has been a burgeoning of health insurance schemes in the country in the last five years. Both the government and non-governmental sectors have been initiating various schemes to meet the needs of different communities. Today, there are more than 100 schemes launched by the non-governmental organisations (NGOs). The government has also launched more than 15 schemes. On the other hand, the private health insurance sector has also been proactive, especially after the amendment of the Insurance Act in 1999. The number of insurance companies has more than quadrupled from four to 18. They are introducing innovative products in order to attract customers. And finally, because of the rising healthcare costs, families are recognising the importance of insurance and the need to insure themselves against medical expenses.

In such a complex and changing scenario, we find that many governments and NGOs are introducing schemes that are poorly designed and badly administered. This has two consequences – one is that such schemes do not benefit the community and the money is wasted. More important, it makes the community cynical about health insurance and resistant to re-introducing it.

From our analysis, we feel that the main reason for the failure of many schemes is because the organisers have a poor understanding of health insurance. Most of them have not understood basic issues like the linkages between premiums and benefit packages, the importance of insurance awareness and the need to regulate the providers.

So this book and the associated training programmes are an effort to build the capacity of key policy makers and practitioners. Through this endeavour, we hope to increase their understanding of health insurance so that they are able to design and implement good schemes for their target community. And this will hopefully make healthcare more accessible, affordable and equitable for the people, especially the poor.

Having said all this, we would like to introduce a caveat. We the authors are not blind advocates of health insurance. We realise that a well-funded and efficiently managed health system funded by tax-based revenue is still the best option for Indians, especially the poor. However, given the context, where 72 per cent of healthcare is financed by individual families, this is a long-term dream. Till then, health insurance can be an interim measure to protect the families from catastrophic health expenditure and impoverishment.

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How to use this manual

This manual has two audiences. It is primarily meant for participants of the health insurance training programme. This handbook gives them the theoretical basis for their learning and should be used as a reference material in case they have some doubts. On the other hand, it can also be used by the policy maker who wants to be more informed about health insurance. Both these people need to just use the first section titled 'A training manual on Health Insurance'. The next audience is the trainer. These may be participants of the training course or other trainers who will want to take sessions on health insurance for their students. These would need to go through the first section, as well as the second section on 'Health Insurance Training'. This second section gives details on training adults, and also on the steps to take to teach each one of the chapters of the handbook.

As this handbook will accompany the training on health insurance, the next piece of advice is meant for them. If you are a participant who has just come to learn about health insurance, then all you have to do is listen to the teachers and read the relevant chapters in the first section. On the other hand, if you are expected to both learn about health insurance as well as return to your state and teach about health insurance, then things are a little more complicated for you. We request you to listen to the teachers – but concentrate not just on the content, but also on the teaching processes. Identify the way the teachers teach, the way they make it participatory, the way they use group work to emphasise certain points, etc. You also need to read the relevant chapters in the first section to thoroughly understand the theory. This is a must so that you know as much about health insurance as possible. And finally, you are expected to read the relevant chapters in the second section, to understand how the teacher took the class, what were the answers to the exercises, what were the points that s/he emphasised, etc. Also, please read the articles in the list of 'additional readings' at the end of each chapter. Soft copies of these are available on the CD. All this will help you master not just the topic, but also the ability to teach at a later stage.

The second section is meant for the facilitator who will be taking the sessions on health insurance for the managers of health insurance programmes. The emphasis right through the training programme will be on 'how to' rather than on theory. The facilitators should be clear on this and it cannot be overemphasized.

It would be desirable that there are different facilitators for different sessions, so that the participants get a varied presentation. However, the organiser of the training programme should ensure that there is continuity between the training sessions, so that the participants get a comprehensive picture of implementing a health insurance programme.

An important feature of this training programme is the thread of exercise that will run through the entire four days. This exercise will be developed using the participants' data. The participants should be requested to submit details of their health insurance programme with special emphasis on health status of the community, design of the HI programme and some indicators. In the case of participants who do not have an HI programme (but are planning to start one), they should be requested to bring along data about their community (demographic profile, morbidity details, health status details, cost of treatment for specific conditions and the socio-economic status of the community, etc.). These details should be submitted to the organisers before the training programme commences. Using these details, the organisers should develop three anonymous case studies. Anonymity will ensure that people are not caught up in the trap of specificities. These case studies should be developed over the four days, so that at the end of training programme, each participant will take home a 'model' programme that can then be modified to suit their local purposes.

We hope that this manual will be useful for those who are spreading the knowledge about health insurance. We would like to hear from you about your experiences regarding this manual, so that it can be improved.

A Training Manual On Health Insurance

Theory and Principles of Health Insurance

Learning objectives

Understand the concepts of health insurance
List the elements of a health insurance scheme
List the advantages and disadvantages of health insurance
Differentiate amongst the three types of health insurance
Define some of the common terms used in health insurance

Materials required

- ☐ Power point presentation on Health Insurance

Time Requirements

Presentation: 120 minutes

Note to Faculty

Please take this session as slow as possible. Remember that there are many new concepts and terms that they need to internalise. Try and make sure that they understand the concepts of insurance, risk pooling, adverse selection and moral hazard and also emphasise the measures needed to minimise negative consequences of health insurance. You can also help them internalise the elements of a health insurance programme and explain to them that this framework is important when they are designing a programme, or evaluating one.

SUMMARY

HEALTH INSURANCE

Pre-payment of small amount by many individuals into a common fund pool that can finance healthcare costs of enrolled members later if required. It minimises the uncertainty of both the timing of treatment and the cost of treatment.

VALUES IN HEALTH INSURANCE

Solidarity, risk pooling, equity and participation.

TYPES OF HEALTH INSURANCE

Four broad categories with some overlap.

- Social health insurance (SHI)
- Private health insurance (PHI)
- Community health insurance (CHI)
- Government initiated health insurance (GHI)

ADVANTAGES OF HEALTH INSURANCE

- Can remove financial barriers to healthcare
- Can protect families from impoverishment
- Is more equitable than out-of-pocket payments
- Can empower the patient to seek healthcare as a right

PROBLEMS WITH HEALTH INSURANCE

These are adverse selection, moral hazard, cost escalation, fraud and administrative costs.

Functions of a health financing system

Health financing systems also have three basic functions – revenue collection, pooling of revenue, and purchasing of healthcare. Revenue collection is the way the health system receives money from households, enterprises and donors. It can be through taxes, contributions to health insurance or direct out-of-pocket payments. Pooling is accumulation and management of revenues in such a way as to ensure that the risk of having to pay for healthcare is borne by all members of the pool and not by any individual contributor. In tax-based systems, pooling is done by the ministry, while in insurance schemes, pooling is done by the insurer. There is no pooling in direct out-of-pocket payments. Purchasing is the process by which pooled funds are paid to providers in order to deliver a specified set of health interventions. Purchasing can be performed passively or strategically.

There are various ways of financing the health system:

- Through revenues raised from general taxation, e.g. United Kingdom, Denmark
- Through direct payments by patients, e.g. Myanmar
- Through health insurance, e.g. Germany (social health insurance) and USA (private health insurance)
- Mixed – a mixture of the above three mechanisms, e.g. India

What is health insurance?

The reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member (ILO-1996). Insurance reduces a person's uncertainty concerning the timing and amount of possible future expenses that may be incurred. It relies on the fact that what is unpredictable for an individual is highly predictable for a large number of individuals.

Consider a women's group with 100 members. The members are about the same age, and they have similar lifestyles. From their experience, they know that one of the members gets sick and incurs health costs of about Rs 5,000 every year. While they are not able to predict who will fall sick, they do know that one member at least will fall sick every year. The women, worried about potential losses due to illness, decide to collect Rs 50 from each member. They put the Rs 5,000 so collected into a bank account at the beginning of the year. When a member falls sick, this amount is withdrawn to pay for the treatment. This in a nutshell, is insurance. The women have paid Rs 50 to avoid the risk or uncertainty of having to pay Rs 5,000.

Modified from The Economics of Health and Health Care. S. Folland et al. 2004

To put it simply, in insurance, there are three elements - pre-payment, pooling and guarantee of service. So people pay a small amount when they are healthy. This contribution is shared among many people and is used to meet the healthcare costs of the enrolled members, when they need it. Health insurance operates in circumstances where people are risk averse, i.e. they prefer the certainty of insurance to the uncertainty of illness. They are then willing to pay a premium to cover the costs of a medical event. The main advantage of health insurance over tax-based financing of healthcare is the guarantee of services.

Health insurance –

- Pre-payment (one pays a small amount when healthy)

+

- Pooling of funds (funds from many individuals are put into a single fund)

+

- Guarantee of services

Once an individual has enrolled in a health insurance scheme, then it is legally binding on the organisers to provide the service promised. Health insurance is a tool to minimise uncertainty –

- The uncertainty of timing of illness
- The uncertainty of the cost of treatment

History of health insurance

Most societies have coping mechanisms to take care of medical emergencies. These could be in the form of mutual aid societies or semi-formal organisations like tontines in West Africa. These associations collected money and supported a patient who required expensive healthcare. It was based on the principle of solidarity and reciprocity. However, the main limitations of this form of financing were the arbitrary nature of the arrangement and the limited funds it could generate.

Health insurance as we know it now developed first in the 17th century with the solidarity-based relief funds of the medieval guilds in Germany. Workers in factories would contribute every week to a sickness fund that was then used for meeting medical or funeral expenses. Bismarck passed the first insurance law in 1883, bringing all these voluntary funds into a single social health insurance scheme. Subsequently there has been gradually increasing coverage. Today, this form of health financing covers about 90 per cent of the German population. Similar developments took place in Belgium, France and other European countries.

From its social roots of solidarity, health insurance was commercialised into a profit-making tool, leading to the entry of private health insurance. However, in many parts of Africa and Asia, the variants of the sickness funds still exist. These funds are for the local communities and managed by the communities. This community health insurance is growing in leaps and bounds both in Africa and in India and provides protection against medical expenses, especially for the informal sector.

FIGURE 1: Coverage of the German citizens by social health insurance over time (1885–1995)

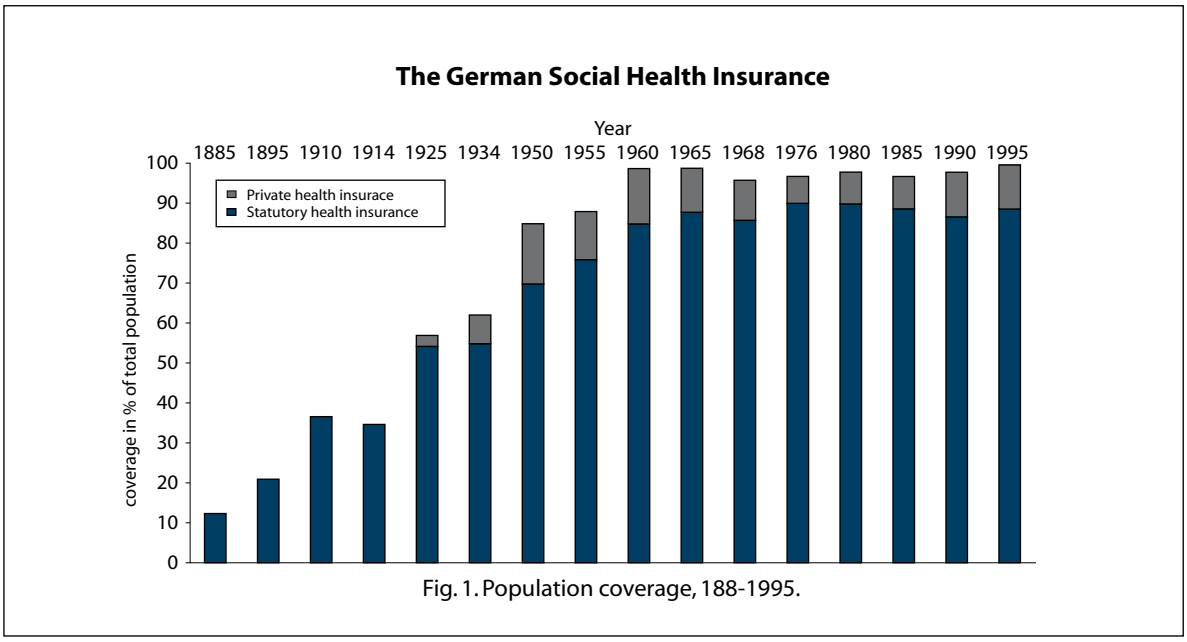


Fig. 1. Population coverage, 188-1995.

Values in health insurance

Solidarity

This is one of the fundamental bases of a health insurance programme, especially social health insurance and community health insurance programmes. It operates less in private health insurance schemes. It is

defined as "the awareness of unity and a willingness to bear its consequences". It means that people accept that the size of the return may not match the resources they have put in the system.

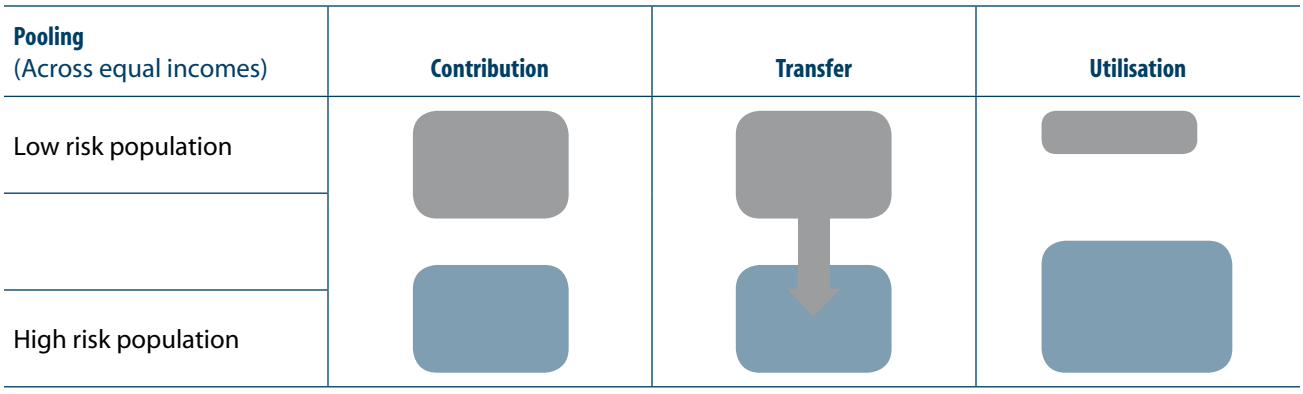
Risk pooling/sharing

Related to solidarity is risk pooling. It implies that there is sharing of risks between the high-risk and the low-risk populations. This is traditionally shown as risk sharing between the healthy and the sick, between the rich and the poor, and between the economically active and economically inactive. Risk sharing builds on the concept of solidarity, where people are willing to contribute for the sake of others. It can be graphically depicted as below:

Equity

This is a very important value of health insurance and is one of the reasons for introducing health insurance

FIGURE 2: Graphic depiction of risk pooling



in countries. Under optimal conditions, health insurance is more equitable than direct out-of-pocket payments and can be as progressive as tax-based financing. There is horizontal equity when for a particular income level; equal contributions by members are used to meet the unequal needs of these members. And vertical equity when across income levels, unequal contributions are used equally to meet the needs of the members.

Participation/empowerment

Health insurance, by its contributory nature, can allow people to express their concerns to the health services. Unlike user fees, where the interaction between the patient and the health services is on an individual basis, in health insurance there can be collective negotiation. This is emphasised in community health insurance, as the distance between the insurer and the health services is usually small. Thus health insurance can be a tool for empowerment of the patient community in relation to health services. This is especially so since there is a guarantee of service in health insurance.

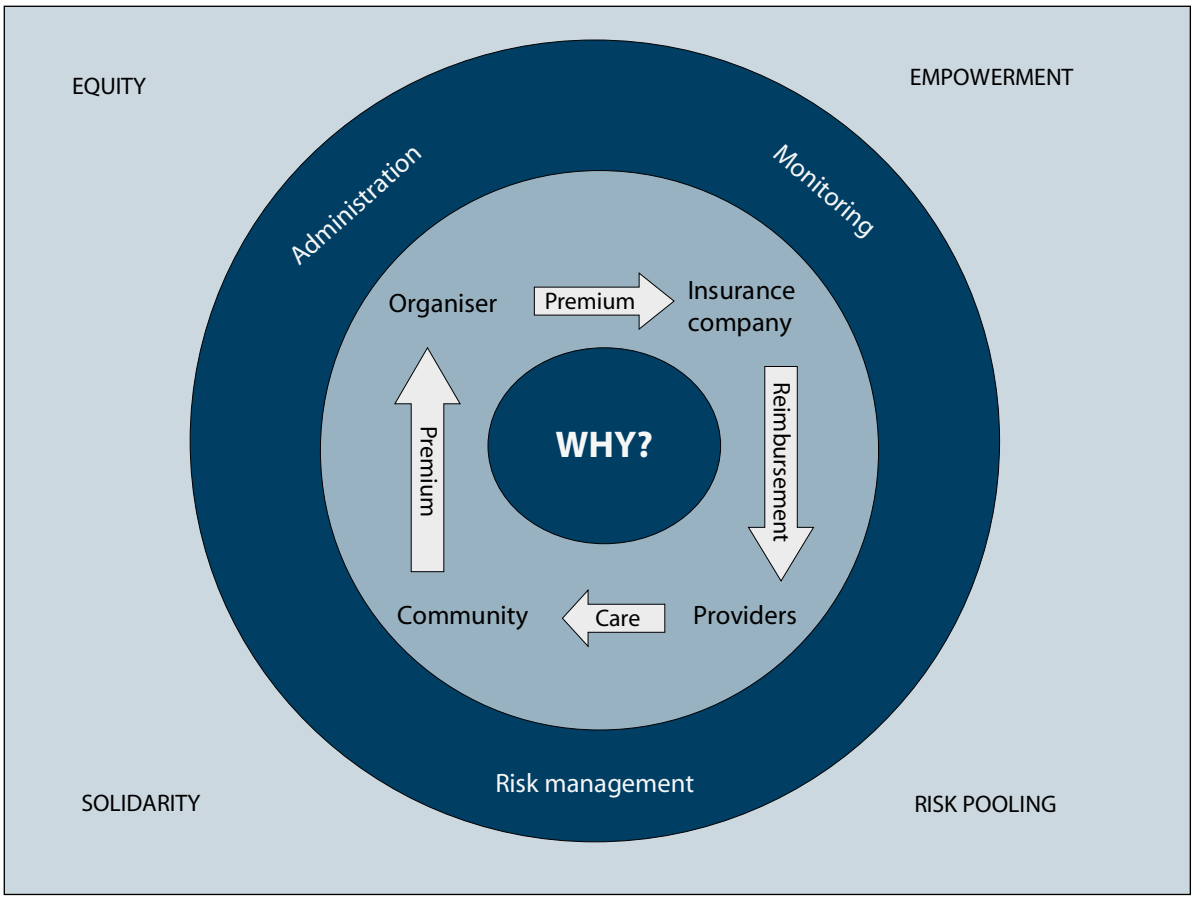
The health insurance framework

The various elements that make up a health insurance scheme are given in Figure 3. These are called the design features of health insurance and vary from situation to situation. Here we describe a generic design. It is useful to use this framework when designing a scheme or assessing a programme.

Community

Every health insurance scheme requires people to contribute towards the health insurance fund. This may be in the form of groups, e.g. civil servants in a country, employees in the formal sector

FIGURE 3: The health insurance framework



or villagers from a particular village. Or it may be random individuals as in a private health insurance scheme.

Providers

These may be public or private providers, e.g. in Belgium, the insurance companies contract with both public and private providers. In India, social health insurance for industrial workers contracts mostly with the public providers. On the other hand, most of the private health insurance schemes empanel private hospitals.

Organiser

The organiser is the institution that manages the scheme. It could be an entity within the government, e.g. the state nodal body in Rashtriya Swasthya Bima Yojana (RSBY). Or it could be a para-statal body, e.g. the Employees' State Insurance Corporation (ESIC). Or it could be an NGO, e.g. the ACCORD community health insurance scheme. Even a community-based organisation could be the organiser, as in KKVS. In some cases, the organiser is not relevant. For example, in private health insurance, the individual members enrol without an intermediate organiser. The main role of the organiser is to orchestrate the various stakeholders and take responsibility for the operations. This would include creating awareness, collecting and pooling the revenue, purchasing healthcare, reimbursing claims and monitoring the entire programme. It plays a dual role of governance and administrator.

Insurer

The insurer is the entity that manages the fund and takes the risk. Many times, the insurer and the organiser are a single institution, e.g. with the ESIC. The insurer develops the product and manages the risk, so that

the insured get their benefit. In India, to be an insurer, one has to be registered with the IRDA (Insurance Regulatory and Development Authority) and have a paid-up capital of Rs 100 crore. There are more than 14 general insurance companies and three life insurance companies today that provide health insurance packages.

Premium

Premium is the amount collected from the insured. It may be collected annually or monthly (as in payroll deductions). The premium is determined by the size of the benefit package. It can be calculated as follows:

- Risk-rated premium – Here the insurer calculates the premium by the risk covered. So a person with a chronic illness and a high probability of falling sick will have a higher premium compared to a young and healthy adult who has a low probability of falling sick. This means that different individuals pay different amounts for the same level of insurance coverage. Thus the elderly or those with poor health generally pay more. There are equity issues in risk-rated premiums, as those who need healthcare more (and probably cannot afford it) are asked to pay more. Private insurers usually use this type of premium for insuring individuals.
- Community-rated premium – Here the insurer pools the risks of both high-risk and low-risk group of people and charges a premium that reflects the average risk of illness. This is more equitable than the risk-rated premium as everybody shares the cost of illness equally. This is usually used in community health insurance schemes.
- Income-rated premiums – This is usually prevalent in social health insurance programmes. Here the premium is calculated according to the income levels. Thus, those who have higher income pay a higher premium and vice versa. The total premium collected is expected to cover the cost of the insurance programme. This is the most equitable type of premium among the three categories.

Premiums can also be voluntary or mandatory. Most private health insurance schemes are based on voluntary contributions. On the other hand, in social health insurance all potential members have to join the scheme and compulsorily contribute to the insurance fund. This has the advantage of increasing the size of the pool and also of ensuring a mix of low and high-risk individuals.

Benefit package

The benefit package is the return for the contribution. Usually a benefit package contains events that are of low probability but high cost, e.g. hospitalisation. However, there are many schemes that provide for just the opposite, events that are of high probability and low cost, e.g. outpatient visits. And of course a mixture of both is possible. Note that as the benefit package increases, the premium also rises proportionately. Also most private health insurance schemes usually exclude some conditions from the cover. For example, many insurers do not cover treatment of HIV-AIDS. Similarly, treatment of chronic conditions or very expensive procedures is excluded.

Payments

There are basically two ways of settling insurance claims. One is the third party payment mechanism, where the organiser pays directly to the provider. This form of reimbursement has the least burden for the patient. On the other hand, many private health insurance schemes have an indemnity mechanism, where the patient pays the bills upfront and is reimbursed by the insurer after submitting the bills and documents. The disadvantage is that the patient has to make arrangements for paying the bill. This can have repercussions, both on access to healthcare and financial protection.

The reimbursement to the provider can be either a fee for service or a case-based payment or a capitation payment. The fee for service in an insurance scheme is dangerous as it can lead to irrational therapy and cost escalation.

Administration

The insurer usually has to perform many administrative functions apart from the onerous task of managing the funds. These include:

- Creating and maintaining insurance awareness among the insured
- Fixing premiums and benefit packages
- Processing claims
- Negotiating with providers
- Redressing grievances
- Providing feedback to the insured

In India, the IRDA has given permission to insurance companies to employ Third Party Administrators (TPA) to administer the policies. The main role of a TPA in the Indian context is to process the claims and reimbursements. All TPAs have to be registered with the IRDA. As in March 2009, there were 27 registered TPAs.

Risk management

Health insurance has many risks to manage, e.g. moral hazard, adverse selection, fraud and cost escalation. An effective programme will introduce measures to minimise these risks.

Monitoring the programme

Health insurance programmes need to be closely monitored. There are many indicators that are specific to health insurance, e.g. claims ratio, liquidity ratio, etc. More details are given in the chapter on 'Monitoring'.

Types of health insurance

Most health insurance schemes can be classified into three broad categories, social health insurance, private health insurance and community (or micro) health insurance. In India, we have a fourth category called government initiated health insurance schemes that do not fit into any of the above three categories. Each has its own specificities. However, there are some features that overlap among the three.

Four types of health insurance

1. Social health insurance
2. Private health insurance
3. Community health insurance
4. Government health insurance

Social health insurance (SHI)

Social health insurance schemes are statutory programmes financed mainly through wage-based contributions and related to level of income. SHI schemes are mandatory for defined categories of workers and their employers. It is based on a combination of insurance and solidarity. The classical example of an SHI is the German or Belgian health insurance system. Here, employees and employers contribute to a 'mutual fund(s)' that is then used to finance the healthcare for the entire population. Citizens have to enrol compulsorily in one of these mutual funds. The government also provides significant funding to cover those who are not able to contribute.

In many low-income countries, SHI has been implemented mainly for the civil servants and the formal sector. This can lead to gross inequities. For instance in India, 18 per cent of the central government budget is used to finance an SHI for the civil servants who constitute only 0.4 per cent of the population.

In India, there are three well-known SHI schemes - the Employees' State insurance Scheme (ESIS), the Central Government Health Scheme (CGHS) and the ECHS (Ex-Servicemen's Contributory Health Scheme).

There are many advantages of SHI:

- A healthier workforce as they are covered, and so have easy access to health care.
- SHI produces a stable source of income for healthcare and which is independent of the Ministry of Finance and not subject to budget fluctuations.
- It provides additional source of funds to the health sector, as there are contributions from the employees and the employers.
- The funds of the scheme are earmarked for healthcare. It cannot be diverted for any other purpose.
- A mandatory scheme saves money in marketing the product. Also, a mandatory scheme ensures that there is significant enrolment, minimising some of the inherent problems of health insurance, like adverse selection. SHIs with a large pool can negotiate with providers for better quality of services
- There is considerable pooling between the rich and the poor, between the sick and the healthy and between the young and the old. Being a compulsory enrolment, both the healthy and sick enrol. Similarly, the current employees and the retired employees are also part of the scheme. And finally, since the family members are also enrolled, both children and elderly are covered under this scheme. This means that there is substantial cross subsidy – from the healthy to the sick, from the young adult to the children and elderly and also from the rich to the poor.
- Many SHI schemes receive grants from the governments. This further stabilises the fund and makes it financially sustainable.
- There is more equity, because of the income-rated premiums – the premiums are collected in terms of ability to pay, rather than the need for health services

But there are also some disadvantages:

- Since these schemes only target the formal sector, the large majority of population in low-income countries are not covered. For example, in India, only 10 per cent of the adult population is employed in the formal sector.
- If the scheme is not managed properly, there is scope for abuse as is seen in the CGHS.
- Quality of care can be low, especially if the scheme has its own facilities and employs doctors as salaried professionals. This is the common complaint with the ESIS.

Favourable conditions for a successful SHI programme:

- Political will
- A reasonably large formal sector that can contribute
- A legal framework to manage the funds
- The country should have the administrative capacity to manage the scheme
- A high population density with considerable urbanisation
- Reasonable per capita income, with a high economic growth

However, recent experiences suggest that these are desirable but not essential conditions. Vietnam, which is a low-income country, has introduced SHI and successfully covered most of its population. The same goes for the Philippines, which has managed to cover more than 50 per cent of its population in a short time. Kenya and Tanzania are also embarking on ambitious plans of SHI to cover their population.

Private health insurance (PHI)

Private health insurance refers to insurance schemes that are financed through individual private health premiums, which are often voluntary, and risk rated. 'For-profit' insurance companies manage the funds.

ESIS

Community – Employees in factories who earn less than Rs 10,000 per month.

Organiser – The ESI corporation, which is a para-statal body.

Insurer – The ESI corporation.

Providers – ESI network of hospitals and clinics as well as some empanelled clinics and hospitals.

Premium – Joint contribution by employee (1.75% of pay) and employer (4.75% of pay). State governments also contribute.

Benefit package – A comprehensive cover ranging from health care benefits, loss of wages, maternity benefits, disability benefits, life insurance and funeral expenses.

Payment – The providers are salaried employees. Health care is provided as a cashless system

Enrolled – Currently more than 1 crore families have been enrolled in this scheme

In low-income countries like India, they provide primary insurance cover, i.e. they insure hospitalisations. On the other hand, in high-income countries, they usually provide supplementary secondary insurance cover. In Belgium, private health insurance is used to cover services not provided by the SHI, e.g. a private room, or dental services. In the USA and in some countries in Latin America, the private health insurance is the main actor in financing healthcare.

Being a voluntary health insurance, it has the potential for adverse selection. People who have a pre-existing illness may enrol in larger numbers, thus endangering the financial viability. Most PHIs use risk-rated premiums as a measure to overcome this.

Community health insurance (CHI)

Community health insurance is "any not-for-profit insurance scheme aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management".

The important point to note is that in CHI, the local community takes the initiative in establishing a health insurance scheme, usually to improve access to healthcare as well as protect against high medical expenses. The solidarity element is strongest in CHIs as most of the members know each other.

Community health insurance as a movement is quite active in sub-Saharan Africa. Even in Asia, we have examples from India, the Philippines, Indonesia, Cambodia, Bangladesh, etc. Their main strengths are:

- Their closeness to the people. This allows people to have a say in the design and management of the health insurance scheme and thereby in the delivery of their healthcare.
- Their ability to cover the informal sector – the farmers, the peasants, the self-employed and the landless workers. These sections of society are usually not covered by other forms of health insurance.
- Their ability to design schemes that meet the people's felt needs, keeping the premiums affordable and the benefit package acceptable.
- However, some of their weaknesses are:
- Their size. Most CHIs are small and do not have significant risk pooling. It is limited to risk sharing between the healthy and the sick.
- This small size and the fact that the insured are poor means that the benefit package is limited in scope and may not cover the entire needs of the community.

Government-initiated health insurance schemes (GHI)

As stated earlier, India has a fourth category that is not usually seen in other countries. This is the 'GHI'. The specificity of this is that the government introduces a health insurance programme, usually for the poorest and vulnerable sections of the community. In many of the schemes, the premium is totally subsidised by the government (from tax-based revenues) and is paid directly to the insurance company. Rarely, the community may be expected to pay a token amount. The insurance company or an independent body is the organiser of the scheme. These schemes last for a couple of years, depending on the political will and longevity of the government. These are seen more as populist welfare schemes rather than a long-lasting intervention.

Differences in the four categories

While we have presented the four types of health insurance as separate entities, there is considerable overlap amongst the four in many aspects.

Source of funds – While SHI raises its funds from pay roll deductions, both CHI and PHI are dependent on voluntary contributions from individuals/groups. On the other hand, the GHI is funded from tax-based revenues.

Pooling – SHI uses state/para-statal bodies to pool the money, e.g. the ESI Corporation. Switzerland is an exception, where private 'for profit' insurance companies pool the payroll deductions. In the case of CHI, this role is played by NGOs/CBOs. Private 'for profit' companies pool the money in the case of PHI. In GHI, the health insurance company plays this role.

Community – SHIs usually target the formal sector, especially in low-income countries. In the European system, there is normally universal coverage, but this has taken many decades to achieve. On the other hand, CHI is probably the only category that has been successful in reaching out to the informal sector in low-income countries. The GHI schemes of course cover the poorest and the vulnerable, the BPL (below poverty level) populations.

Nature of health insurance – SHI schemes are usually mandatory and supported by legal provisions. Thus those covered have to contribute regularly towards the fund. On the other hand, both CHI and PHI are usually voluntary in nature and it is up to the individual to decide whether to join or not. GHI schemes depend on the whims and fancies of the government departments.

Premiums – There are usually distinct differences in the three categories in the way premiums are calculated. SHI is the most equitable and calculates an income-rated premium, while the CHI has a community-rated premium. PHIs usually use risk-rated premium and are the most inequitable. The GHI subsidises the premium and so there is hardly any contribution from the community. Wherever they do contribute, it is on a voluntary basis.

Risk management – SHI, with its third party payment, is a fertile ground for moral hazard. Patients are not aware about their bills and so have a tendency to overuse the health services. Providers also are not under any restrictions to contain costs and tend to over-prescribe. On the other hand, both CHI and PHI have the problem of adverse selection, i.e. those who need more healthcare tend to join. This limits risk pooling and can put the financial viability of the scheme in jeopardy. GHI on the other hand is prone to fraud and underutilisation. Insured patients may not even be aware that they are insured. And worse, the better-off may use the benefits on behalf of the poor.

Advantages of health insurance

Today many countries are shifting over to health insurance as a mechanism of financing their healthcare programme. In India, we need to shift from the current predominance of out-of-pocket payments to a health insurance programme. The reasons are very clear:

- Direct out-of-pocket payments are a financial barrier to accessing health services. On the other hand, an insured patient can walk into a health facility without the fear of financial burden.
- Direct out-of-pocket payments can push families into indebtedness or poverty. Health insurance protects the patient from the burden of raising funds at the time of illness.
- Direct out-of-pocket payments are inequitable as they place the burden on the vulnerable. Insurance through its risk pooling mechanism is more equitable.
- Direct out-of-pocket payments do not permit patient's participation in his/her treatment. On the other hand, by its collective nature, a health insurance programme can negotiate for better quality care.

Problems with health insurance

While there are many advantages of health insurance, there are some characteristic problems with health insurance that one needs to be aware of.

Adverse selection

Adverse selection occurs when those who anticipate needing healthcare choose to buy insurance more often than others. This happens when insurers lack full information about the risk of individual insured persons and there is an asymmetry of information. This will mean that an insurance scheme with adverse selection will be full of people with high risk of illness. This in turn results in a financial drain on the scheme and may challenge the viability of the scheme (Figure 4). However, in terms of public health logic, high-risk individuals are people who have a higher requirement of health services. So, through health insurance, these people are protected from high medical costs, because this is cross-subsidised by the healthy.

SOME COMMON PROBLEMS WITH HI

- Adverse selection
- Moral hazard
- Cost escalation
- Administrative costs

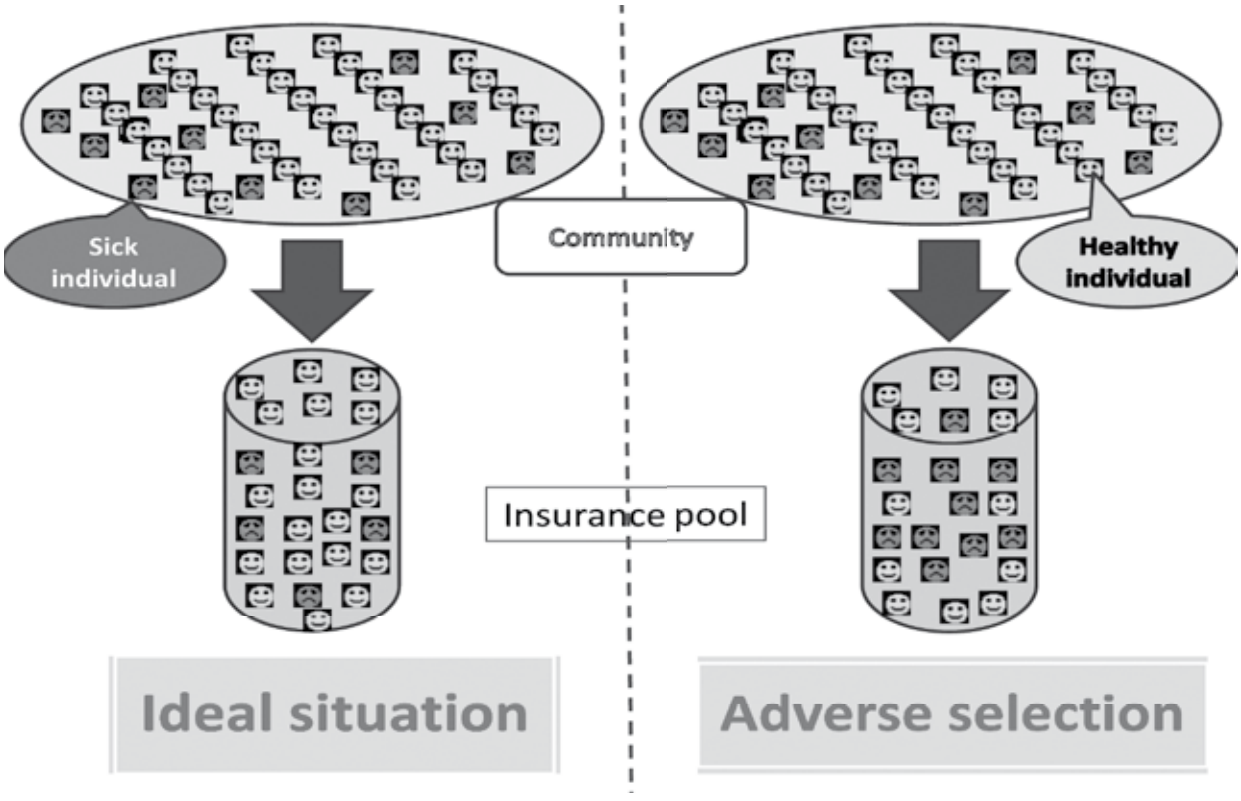
Ways of countering adverse selection are by having a large enrolment unit, e.g. a family instead of individuals, setting specific collection and waiting periods, and making the insurance scheme compulsory. This means that those with low risk cannot opt out of the scheme and will subsidise the high risk.

The opposite of adverse selection is 'risk selection' or cream skimming. This happens when insurers (usually private) only select people with low risks and avoid enrolling people with high risks. While this will be a profitable venture for the insurer, it is a burden on society. Invariably, public services will be expected to provide services for the high-risk population who have not been covered by the health insurance scheme. This places a strain on public health services as well as individual households.

Moral hazard

Moral hazard refers to the way in which insurance changes people's perspectives. It is defined as "the tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have insured". For example, knowing that he/she is insured, a person may indulge in more risky behaviour (e.g. smoking, fatty diet) or may use more health services. This is called consumer moral hazard or demand side moral hazard. On

FIGURE 4: Diagrammatic depiction of adverse selection



the other hand, knowing that a third party is paying the medical bills, providers may alter their treatment patterns for insured patients. This is called supplier moral hazard. This is especially so if the provider is paid on a fee-for-service basis. Moral hazard is a problem both for financial viability and for public health logic, as it results in cost escalation, excessive medical treatments and even iatrogenesis.

Consumer moral hazard can be countered by introducing co-payments, so that the patient shares some of the medical costs. This puts a barrier on unrestrained use of health services. However, co-payments, if sizable, can act as a barrier to utilisation of health services and defeat the objective of health insurance. Yet another way of countering consumer moral hazard is to introduce a referral system or pre-authorisation, so that patients have to contact a first-line health service before arriving at a hospital. This will restrict unnecessary utilisation of expensive hospital services and make the system more efficient.

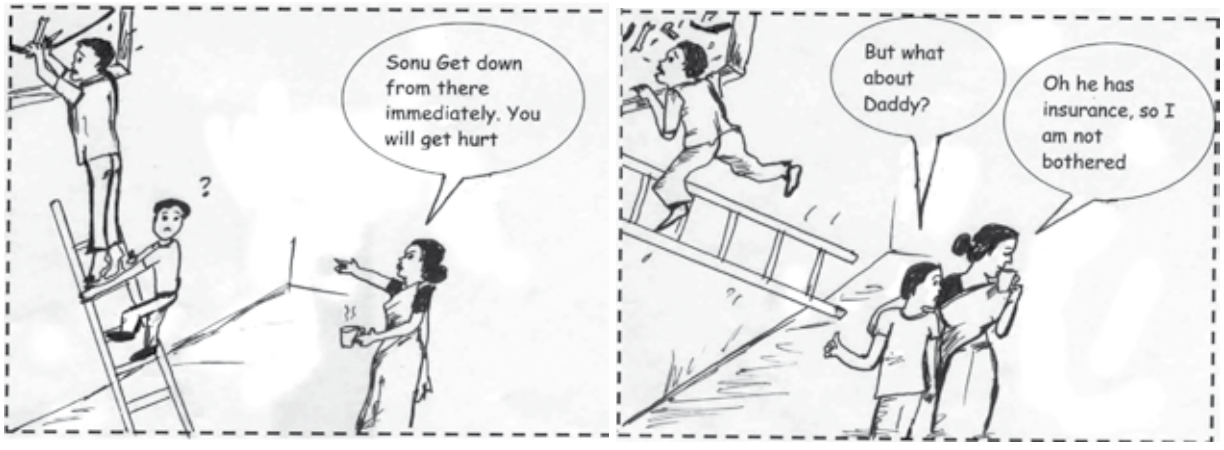


TABLE 1: Types of co-payments

Co-insurance	Insured pays a percentage of the cost of any treatment.
Deductible	Insured pays a fixed amount of the cost. If costs are more than this amount, the insurer pays the rest.
Pay – out limit	Insurance company pays no more than an established amount.

Source: Health economics for developing countries 2000.

Supplier moral hazard can be countered by modifying the way the providers are paid. Payments on a capitation basis or a case basis will remove incentives for the provider to over-treat. Medical audits/reviews also help in limiting moral hazard.

Cost escalation

Health insurance, with its third party payment is an incentive for cost escalation. This is especially so, if the market is unregulated and the providers are paid on a fee-for-service basis. This is now recognised as a major problem in most OECD countries, and checks and balances are being introduced to manage the costs. So it is imperative that when one introduces health insurance, there is strong government stewardship to protect the rights of the patient and prevent abuse of the system.

Administrative costs

There are substantial administrative costs associated with marketing, processing claims and countering frauds. These are known as loading costs. If these costs are high, insurance coverage can become expensive. This can be reduced through economies of scale, e.g. if the health insurance policy covers a large number of people, then the administrative cost is distributed among them and so there is a lower cost per capita.

Fraud

Fraud is a big problem with health insurance, especially in India where the provider is totally unregulated. There are two types of fraud. The first is that committed by the insured. This may be in the form of producing false or inflated bills and claiming for treatment that never occurred or cost much less. However, the most important fraud is usually committed by the hospitals. They may do unnecessary investigations or provide irrelevant treatment or inflate the bill in case of an insured patient. This needs to controlled by the insurer, else it affects the sustainability of the scheme.

Conclusions

It is common for policy makers to consider health insurance as a panacea for all the ills in their health system. Policy makers think that introducing health insurance will solve most problems. One must guard against such simplistic reasoning. While health insurance can improve access to healthcare, can protect against catastrophic health expenditure, can improve quality of services and has the potential of allowing the people to have a say in the way healthcare is delivered, there are many conditions to be met for these to be realised. Without this, health insurance is reduced to a mere financing tool that may not benefit the most needy.

Health Financing in India

Learning objectives

- To list the sources of financing healthcare
- To understand the various mechanisms by which healthcare is financed in India
- To understand the financial and other implications of out-of-pocket expenditure

Materials required

- ☐ PowerPoint presentation on Health Financing in India
- ☐ Handout of the exercise data 'Association between health expenditure and health status' – hard copy and soft copy (on a pen drive)

Time Requirements

Presentation: 45 minutes
Exercise: 45 minutes

Note to Faculty

Adults have expectations, and it is critical to take time early on to clarify and articulate all expectations before getting into content. Keep the session as interactive as possible, try to get the participants to answer and build on it as much as possible. Provide your answers only when they don't raise it. Supervise the exercise. The initial issue would be drawing the graph. Encourage them to use MS Excel (or any other spreadsheet). Make sure that they sort the concerned variable (e.g. Total health expenditure or Total government health expenditure) in ascending/descending order before plotting the graph. And also plot a graph with two different Y axes. Thus the IMR is on one axis and the variable is on Y1 axis (or vice versa).

SUMMARY

SOURCES OF FINANCING HEALTHCARE

- Taxes
- Private firms
- Individual households
- External aid

In India, the most common source is from individual households.

Mechanisms of financing healthcare

- Financing from taxes
- Through insurance
- Direct out-of-pocket (OOP) payments

In India, the most common mechanism is the OOP payments.

Health services anywhere in the world have to be financed by somebody. There are 'no free lunches'. What varies is the amount of money that is spent on healthcare. Table 2 gives us an idea of the variations that countries spend on healthcare.

TABLE 2: Health expenditure by different countries

Country	Proportion of GDP spent on health	Per capita expenditure on health (US$)
USA	15.3%	6714
UK	8.4%	3361
Brazil	7.5%	426
China	4.5%	90
India	4.9%	39
Bangladesh	3.1%	13

Source: WHO Statistical Information Systems.

From this table, it is clear that though India spends nearly 5 per cent of its GDP on healthcare, it is really a small amount, just Rs 1600 per person per year. This amount may be slightly more today, given the extra allocation from the NRHM. However, it is nowhere near the United Kingdom, which spends 100 times this amount on its citizens.

While all the money ultimately comes from the individual/community, we divide the sources into four broad categories. These are from:

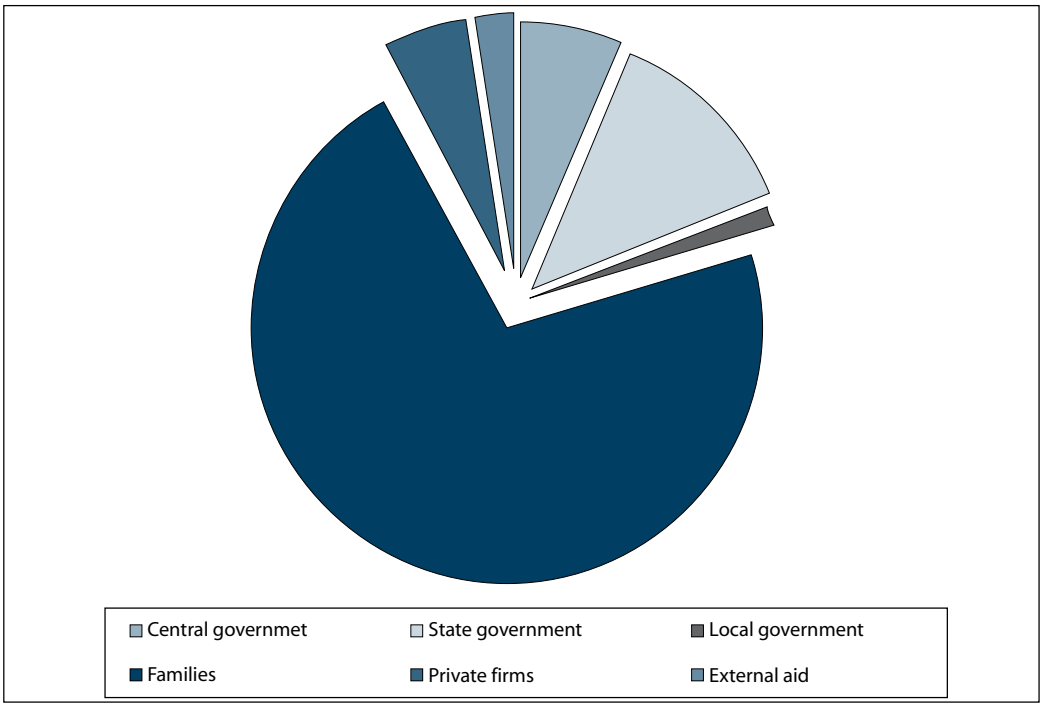
- Government taxes. This could either be the Central government, or the State government or even the Local government. In India, health services are the responsibility of the state governments. So they contribute the higher share of the government funding.
- Private firms. Private firms use their profits to ensure that their employees get adequate health and medical care. This may be in the form of dedicated medical services for their employees or purchasing healthcare from private or public sector providers or insuring their employees against medical expenses.
- Individual households. This is the most common source for financing healthcare in many low-income countries. Here, individual families pay fees for medical or health services at the point of use.
- External aid. Some countries depend a lot on external aid. For example, in Uganda, 43 per cent of funds for the health sector are provided by external donors. In India, this is much lower.

Figure 5 gives the details of the sources of funds for the health sector in India.

In 2001-02, India spent about Rs 1 billion on healthcare. Of this, only 20 per cent was raised by the governments. The majority (72 per cent) was spent by individual households while accessing healthcare, especially for outpatient services. Donors (including bilateral and multilateral agencies) contribute just 2.4 per cent of the total expenditure.

Most of this money was spent on the private sector – 70 per cent; while only 23 per cent of the total health expenditure was spent by the public sector (including ESI and CGHS facilities). Of the total health expenditure, 74 per cent was spent on curative care (36 per cent at primary level, 21 per cent at secondary level and 15 per cent at tertiary level).

FIGURE 5: Sources of funds for healthcare in India



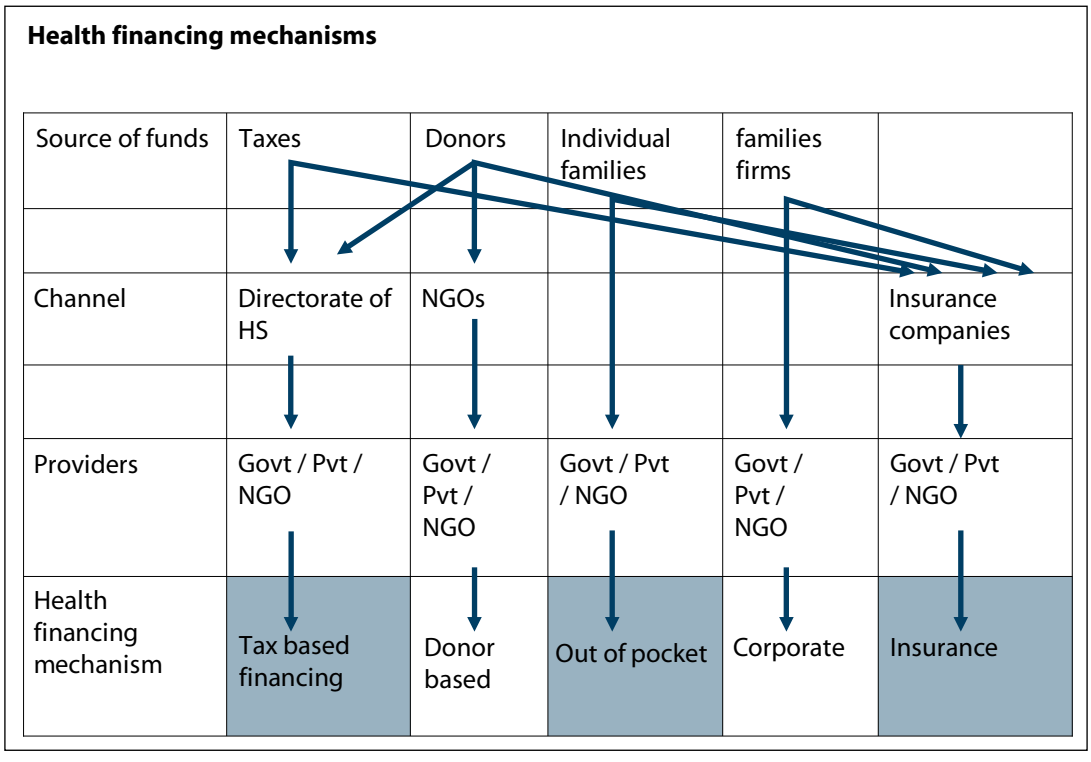
Source: National Health Accounts India: 2001-02.

While there are usually only four sources for financing healthcare, it can be spent through different channels resulting in many mechanisms of healthcare financing. Figure 6 shows these various mechanisms. However, the most common health financing mechanisms especially in India are:

- Direct financing by individual households
- Tax-based financing
- Insurance-based financing

The proportions vary from country to country. In high-income countries like the UK and Australia, the main mechanism is tax-based mechanism. On the other hand, some high-income countries like Germany and the USA are dependent on insurance-based financing mechanism. Most citizens from low-income countries pay their health providers directly through out-of-pocket payments. This is one of the highest in India. Many African countries are dependent on donors also; sometimes a fifth of their total health budget is from external donors. Some mechanisms of health financing in different countries are given in Figure 7.

FIGURE 6: Various mechanisms to finance healthcare



Public money is usually spent directly on the government services. For example, the money from the taxes as well as large donors like the World Bank goes straight into the government treasury and is used to finance the government health services. They then provide health services. In this case, the government is both the financer as well as provider of health services.

Some of the government money is also used to pay the contribution for health insurance, e.g. in the ESIS, the CGHS and some subsidised government health insurance schemes. However, usually most of the health insurance schemes, especially the private and community health insurance schemes are financed by individual households.

As one can see, individual Indian households pay a large amount of money from their pockets towards healthcare. Most of this is used for curative care, especially at the primary and secondary level. This out-of-pocket expenditure is one of the highest in the world and has three obvious consequences:

1. It may cause patients to avoid treatment. According to the NSSO report of 2007, more than 5 per cent of the patients did not utilise health services because they did not have money. Compare this with a citizen in the UK, who can approach her GP without any fear as she does not have to pay any money at the time of treatment. The government pays her costs by reimbursing the GP.
2. It may cause impoverishment. Studies show that 17–34 per cent of Indian patients are impoverished because of hospitalisation expenses. Compare this with patients in Germany (health insurance) or Australia (tax-based revenues) who can get free care up to any level. They are not affected by the double burden of the disease and the fear of high bills at the time of illness.
3. Out-of-pocket payment at the time of illness is inequitable. The most vulnerable has to also bear the economic burden of illness. In other systems, e.g. tax-based or insurance based, this burden is distributed among the rich, the able and the healthy.

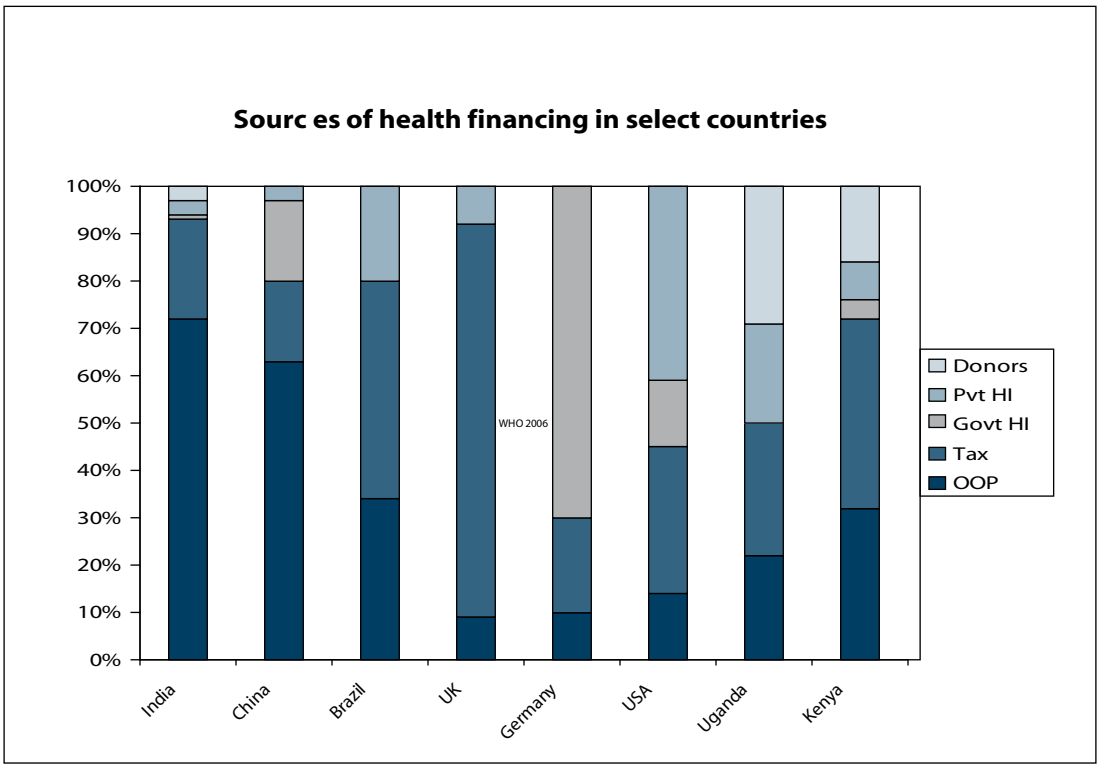
Mrs S pointed tearfully at a neighbouring three-storeyed house. "We had a house like that. Our shop was on the ground floor and we used to stay on the upper two floors. Then my husband had an accident. A car hit him while he was cycling. He was admitted in a hospital and had to spend many months there as he had fractures as well as injuries in his lungs and liver. Finally he had a heart attack and died in the hospital itself.

But by then we had spent lakhs for his treatment. My son had to sell our building and we had to shift to this shack. My daughter-in-law's gold has been sold also – look at her, with no ornaments.

Today my sons work in a shop to feed our stomachs. Just imagine, they were owners at one time and now we are workers in somebody else's shop." She wipes away her tears with her saree.

Source: From an interview conducted by Dr. N. Devadasan in Gujarat.

FIGURE 7: Financing mechanisms in different countries: a comparison



One possible solution is to increase the government allocation for healthcare. This is one of the objectives of the NRHM. However, in spite of increased budgetary allocations, the outputs leave much to be desired. One of the main reasons for this low performance is the inability of the health system to absorb the extra funds. Many states are able to spend only 50 per cent of the extra funds. Second, while additional resources are necessary, it is not sufficient to improve the health system. One needs to also tackle the problem from other aspects, like improved management, leadership and motivation.

Another solution to improve access to affordable and quality healthcare is to introduce health insurance. So what is health insurance? There are many definitions. The ILO definition of it is "the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in common fund that makes good the loss caused to any one member (ILO - 1996)". This has been explained in detail in the previous chapter.

To summarise, there are usually four sources of financing healthcare. In India, we have a mixed form of financing healthcare. The government is supposed to provide 'free' healthcare for all the citizens by raising funds from taxes. Unfortunately, because of the small tax base, the government's revenue is low, resulting in a small proportion being allocated for healthcare. Because of this chronic under-funding, most government facilities are not able to provide healthcare to all its citizens. So, many patients go to the private sector institutions and pay for their healthcare. Health insurance plays a very small part in financing health services in India. Thus the Indian health service is mainly financed by out-of-pocket payments (OOP). The individual household bears the brunt of the total health expenditure. This is not desirable as it reduces access to health services, has the potential to impoverish and is inequitable. To protect these families, one can increase the budget allocation for healthcare. The other possibility is to introduce health insurance as an interim measure.

Exercise: Association between health expenditure and health status

30 minutes: for group work 15 minutes: for presentation and discussion

Is there any association between low spending on healthcare and the health status of the population? In the next page, there is a table with data from 30 countries. The data consists of the total health expenditure of each of these countries, the expenditure by the government on healthcare, the expenditure by the private sector on healthcare and the infant mortality rates of these countries.

Please go through this table and do the following:

Group A to make a graph with the total health expenditure and the IMR

Group B to make a graph with the total government health expenditure and IMR

Group C to make a graph with the total private health expenditure and IMR

Comment on each of these graphs. What are your conclusions?

Country	Per capita government expenditure on health at average exchange rate (US$)	Total expenditure on health as percentage of GDP	Private expenditure as a % of THE	IMR (per 1000 live births)
Argentina	251	10.1	55%	14
Australia	2227	8.7	35%	5
Bangladesh	5	3.1	63%	52
Belgium	2536	9.5	30%	4
Brazil	204	7.5	51%	19
Burkina Faso	15	6.4	48%	122
Cambodia	8	6	75%	65
Canada	2754	10	30%	5
Chile	249	5.3	50%	8
China	38	4.5	60%	20
DCR	2	4.3	64%	129
Denmark	4054	9.5	18%	3
Egypt	38	6.3	61%	29
Finland	2350	7.6	23%	3
Germany	2809	10.4	26%	4
Ghana	13	6.2	65%	76
India	8	4.9	82%	57
Indonesia	17	2.2	?	26
Kenya	14	4.6	53%	79
Malaysia	115	4.3	56%	10
Mexico	217	6.2	58%	29
Nigeria	10	4.1	69%	99
South Africa	191	8.6	59%	56
Sri Lanka	30	4.2	50%	11
Sweden	3143	8.9	20%	3
Thailand	73	3.5	34%	7
Uganda	7	7.2	74%	78
UK	2939	8.4	12%	5
Zambia	23	5.2	53%	102

Health Insurance in India

Learning objectives

- To understand the four broad types of health insurance in India
- To critically evaluate the four broad types of health insurance in India

Materials required

- ☐ Power point presentation on Health Insurance in India
- ☐ Exercise on 'Health Insurance models' as hard copy (handout and soft copy (on a pen drive)

Time Requirements

Presentation: 30 minutes
Exercise: 45 minutes

Note to Faculty

The facilitator has to explain health insurance in India in the cultural and economic context of India. Some of these schemes have been specially designed for India and may not function in other countries or contexts. The facilitator discusses the broad outline of schemes, but also focuses on avoidable flaws. Understanding this chapter should help participants evaluate schemes independently and draw resources from the best. This helps in dissemination of positive factors and also reduces flaws that have occurred with other ventures. Try and describe each of the schemes keeping the framework in mind.

SUMMARY

Health insurance in India has low penetration < 10 per cent of the total population have any sort of assured health security.

India has all the four broad types of health insurance programmes:

- Social health insurance – ESIS, CGHS
- Private health insurance – Mediclaim, others
- Community health insurance – more than 100 schemes
- Government-initiated health insurance – Aarogyashree, RSBY, etc.

Health insurance has already covered about 20 per cent of the population through the above schemes. While some ignore health insurance on ideological grounds, one needs to understand that it is an equitable form of financing healthcare and is here to stay.

Health insurance in India

Indians have the following options when they fall sick:

1. Approach a government health facility. These facilities range from primary to tertiary institutions that provide both preventive and curative care. While public facilities are expected to be free (some charge a token user fee), in reality, patients pay considerable amounts to access even ambulatory care. Patients have to pay to purchase medicines and investigations (that are not available in the government pharmacy or laboratory). They also may have to pay informal fees to staff to get services. Usually these expenditures in public facilities are met by out-of-pocket payments.
2. Approach private (including NGO) facilities – again a range from primary general practitioners to super speciality, quaternary institutions. All services are charged and most patients end up paying out-of-pocket at the time of illness. Those who are insured can either get it reimbursed by the insurance company, or can walk out at discharge with the knowledge that their insurance company will directly reimburse the hospital.
3. Employees in large industries can go to their company facilities. Healthcare in these facilities is totally free and patient usually gets comprehensive care for primary, secondary and tertiary medical conditions.

4. Patients can opt not to seek care. This is usually the option for the indigent who cannot afford healthcare.

In this section, we concentrate on the health insurance mechanism of paying for health care. There are four broad types of health insurance in India:

Mandatory social health insurance schemes

- CGHS, ESIS and ECHS

Voluntary insurance by private insurance companies

- Mediclaim

Voluntary community health insurance schemes

- ACCORD, KKVS, SEWA, etc.

Government-initiated health insurance schemes

- RSBY, Aarogyashree, etc.

Each of these is discussed in detail below.

Social Health insurance

Employees' State insurance Scheme (ESIS)

The Employees' State insurance Act, launched in 1948 envisioned an integrated need-based social insurance scheme that would protect the interest of workers and their families in emergencies such as sickness, maternity, temporary or permanent physical handicap, death due to employment and injury resulting in loss of wages or earning capacity. Following the promulgation of the ESI Act, the central government set up the ESI Corporation to administer the Scheme.

All non-seasonal factories using power and employing ten or more persons or non-seasonal factories and establishments not using power, but employing twenty or more persons have to enrol compulsorily with the ESIC. 'Appropriate Governments' are empowered to extend the provisions of the Act to other classes of establishments – industrial, commercial, agricultural or otherwise. Under these provisions, most of the state governments have extended the ESI Act to certain specific classes of establishments such as shops, hotels, restaurants, cinemas, etc. employing 20 or more persons (Ministry of Labour 1999).

Employees in these factories or establishments who earn less than Rs 10,000 per month have to join the scheme. All others are exempt from joining. The employers and employees contribute 4.75 per cent and 1.75 per cent respectively of the enrolled employees' wages. This is pooled with the ESIC who then provides care through its own facilities. Where the ESIC facilities are inadequate, the ESIC purchases care from public and private providers.

The benefits under the ESIC are as follows:

- Free, comprehensive healthcare at ESIS facilities
- Cash compensation for loss of wages due to illness
- Maternity benefits
- Disability benefits
- Survivorship and funeral expenses in the event of death of the worker.

[1] Source: ESIC website

Number of employees and family members enrolled as of 31/3/2006[1]	91,48,605
Number of institutions	3,00,718
Total contribution	Rs 24,10,61,77,00,000
Number of beneficiaries	3,54,96,589
Total expenditure	Rs 12,78,96,16,00,000
Claims ratio	53%

Central Government Health Scheme (CGHS)

The CGHS was started in 1954 in Delhi with the objective of providing comprehensive medical care facilities to central government employees (including pensioners) and their family members. Besides Central Government employees, the scheme also provides services to (i) Members and Ex-Members of Parliament, (ii) Judges of the Supreme Court and High Courts (both sitting and retired), (iii) freedom fighters, (iv) Central Government pensioners, employees of semi-autonomous bodies/semi-government organizations, (v) accredited journalists and (vi) Ex-Governors and Ex-Vice Presidents of India. In addition, employees of the Accountant General of India are being provided these services in a few cities.

Contributions range from Rs 5 to Rs 150 per month by the cardholder. The number of cardholders currently is about 10 lakh with the total number of beneficiaries being around 43 lakh.

The services are provided to the beneficiaries through dispensaries, polyclinics and government/empanelled private hospitals and cover out-patients facilities under all systems of medicine, emergency services in the allopathic system, free supply of necessary drugs, laboratory and radiological investigations, domiciliary visits to seriously ill patients, and specialist consultations both at the dispensary and hospital level. It also includes secondary and tertiary care.

The scheme was initially started in Delhi, but was then extended to 23 cities. It has all except three of the important features of SHI. The exceptions are that individuals can opt out of the scheme, though in reality such attrition is low. But more important, the contributions are low and not proportionate to earnings. Also, the management of CHGS is not done by an autonomous body as in the case of ESIS.

Voluntary (commercial) health insurance

Private health insurance is different from social health insurance in that it is voluntary and for profit. The insurer is usually a for-profit insurance company that collects the premium from the individuals who can afford to pay. It then invests this to supplement the insurance fund. It may or may not empanel hospitals to provide healthcare for the insured. It may either reimburse the hospital directly or may reimburse the insured when she/he produces all the bills and documents after treatment.

Private health insurance can be a standalone primary health insurance product that provides health security for the individual or a family or a group[2] or it can also be used as a supplementary health insurance for those with social health insurance or some other form of health cover. In this latter form, it covers medical care that is not covered by the original scheme.

In India, private health insurance is relatively a new phenomenon. The first 'Mediclaim' product was introduced in 1986. It was offered by the four public sector general insurance companies[3] and was not very popular because of poor design features. However, people purchased it as it provided tax benefits. In 2000, the insurance market was liberalised and foreign players were allowed to enter the market in partnership with Indian companies. Since then 14 new insurance companies have sprung up, some of them like Star Health and DKV Apollo are dedicated health insurance companies. Brokers, third party administrators (TPA) and insurance agents have also been authorised

[2] E.g. employees working in a company.

[3] National insurance Company, New India Assurance Company, Oriental insurance Company and United India Insurance Company.

by this new act. To regulate this surge of private insurance companies, the government of India has created a regulator – the Insurance Regulatory and Development Authority (IRDA) that protects the interest of the customer. One of the requirements under the IRDA Act is that insurance companies have to serve the rural areas and also the social sector; 5–10 per cent of their business has to come from these. This is why many insurance companies are willing to enter the rural market and provide health insurance. Today, the premium collected from health insurance by private insurance companies has tripled from Rs 944 crore in 2003 to Rs 2,758 crore in 2007. 2.4 Crore Indians were insured by private health insurance products in 2007.

Today there are three broad categories of health insurance products in the Indian market. The first is the old 'Mediclaim' or hospitalisation product. Hospital expenses incurred by the insured are covered under this scheme. While initially the product was expensive, had plenty of exclusions and was an indemnity model, today the premiums are more affordable, exclusions are limited and a cashless system has been introduced. The next product is the 'Daily charge' product. In this product, the insured is paid a fixed amount for each day hospitalised. This is advantageous as the patient has to only prove that s/he has been admitted for x number of days. The insurance company then pays the insured the sum assured for the x number of days. The patient can spend it according to the need, e.g. on medicines or on transport. There are no restrictions from the insurance company. And finally, there is a 'Critical care' product, wherein the patient is given a one-time payment of a fixed amount if diagnosed to have a specified illness, e.g. cancer, renal failure, stroke.

Some of the criticisms of private health insurance are that:

- They often cover wealthier populations.
- Being a voluntary scheme, they are open to adverse selection; i.e. only the sick or potentially sick may join. To combat this, they usually resort to 'cream skimming', i.e. enrol only those individuals who are healthy and have little risk of falling ill.
- The premiums are risk rated, i.e. those who have a higher risk have to pay more. This goes against the principle of equity.
- Usually there are a lot of problems in getting reimbursements from the insurance company. Both hospitals and individuals face this problem in India.

MEDICLAIM – AN EXAMPLE FROM NEW INDIA ASSURANCE COMPANY[4]

This is a typical Mediclaim policy providing hospitalisation benefits for individuals. The premium is risk rated and varies with age. For a sum assured of Rs 2,00,000, the premium is Rs 2,469 for a person aged less than 35 years. The corresponding premium for a person aged 55 is Rs 3,900. It also offers pre- and post-hospitalisation expenses. It excludes a list of standard conditions like cosmetic surgery, spectacles, contact lenses, dentures, artificial limbs, external medical equipment, treatment for HIV, ailments arising from self injury/criminal activities/ substance abuse/ war/nuclear irradiation/pregnancy and child birth. Most important, it will not reimburse the expenses for treating pre-existing ailments, e.g. hernia, diabetes, hypertension. Also, only those less than 70 years are eligible to enrol. Thus senior citizens are not eligible and have to take a different policy.

Mediclaim is also now available as a family product. Here the enrolment unit is the family, i.e. two adults and two dependent children. The advantage of a family floater is that the premium is lower compared to insuring four individuals.

DAILY HOSPITALISATION EXPENSES – ROYAL SUNDARAM'S HOSPITAL CASH

Individuals are eligible to take this product. The benefit is a daily cash of Rs 1000 per day hospitalised, up to a maximum of Rs 1,80,000. The premium is Rs 1500 for an individual aged 45 years. If the patient is hospitalised for more than 21 consecutive days, convalescence benefit of Rs 15,000 is also given as a lump sum. The standard exclusions of Mediclaim plus exclusion of pre-existing diseases apply for this product also. The main advantage of this product is that it is easily administered. There is no need to produce bills and receipts, etc. All one needs is a discharge summary from the hospital declaring the date of admission and discharge, the diagnosis and the treatment given.

[4] Note that the details of these policies are valid as of January 2009. The company may change the policy details subsequently.

CRITICAL ILLNESS COVER – ICICI PRUDENTIAL'S CRISIS COVER

Individuals between 18 and 60 years are eligible for enrolling. On paying an annual premium of Rs 9804 (for an individual of 45 years), the insured gets a lump sum amount of Rs 5,00,000 if diagnosed with any one of the following 35 conditions

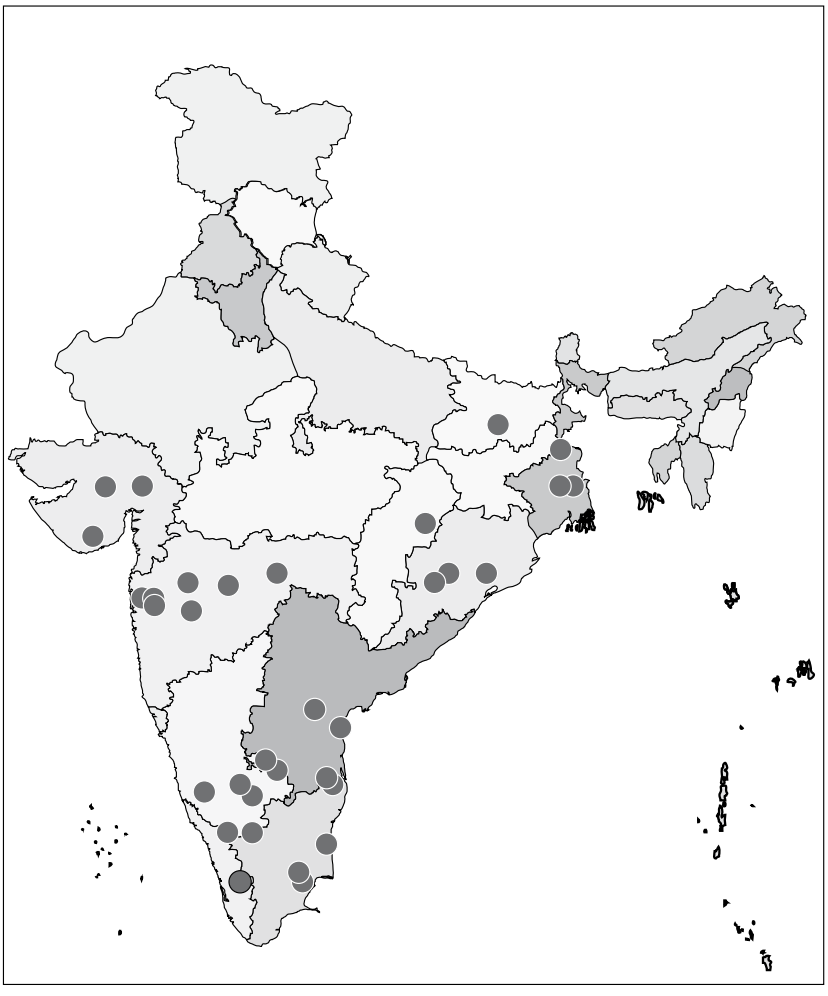
(Aphallic syndrome, Benign brain tumour, blindness, brain surgery, cancer, chronic lung disease, coma, CABG, end stage liver disease, MI, heart valve surgery, CRF, loss of independent existence, loss of limbs, major burns, major head trauma, organ transplantation, paralysis, stroke, surgery on aorta, terminal illness, angioplasty, Alzheimer's disease, aplastic anaemia, cardiomyopathy, deafness, loss of speech, medullary cystic disease, motor neurone disease, multiple sclerosis, muscular dystrophy, Parkinson's diseases, polio, primary pulmonary hypertension, SLE with nephritis).

There is a waiting period of 6 months. The main disadvantage of this product is that it covers rare diseases. And since pre-existing ailments are not included, the probability of getting such a disease is very low.

An analysis of the voluntary commercial insurance sector, and in particular the penetration of Mediclaim (Gupta and Trivedi, 2005) indicated that while health insurance is growing significantly, it is still much below the potential market it can capture, and there is still no spontaneous demand for the product. There are hardly any incentives built into the current product that will make it attractive to younger people, the elderly or to women. It is clear that individual householders do not see much merit in buying health insurance and do so only when they perceive tangible health risks. Other research and results indicate that:

- Those with lower ability to pay have a significant willingness to buy insurance.
- Those with some coverage through employment – middle class – have the least interest in purchasing additional insurance.
- Individual insurance is relatively small compared to group insurance (corporate coverage).
- Current products are not very flexible and customer-friendly.
- Marketing and distribution of such products is poor.
- Some innovative partnerships exist that have been able to use the voluntary insurance sector, but such coverage is very low.

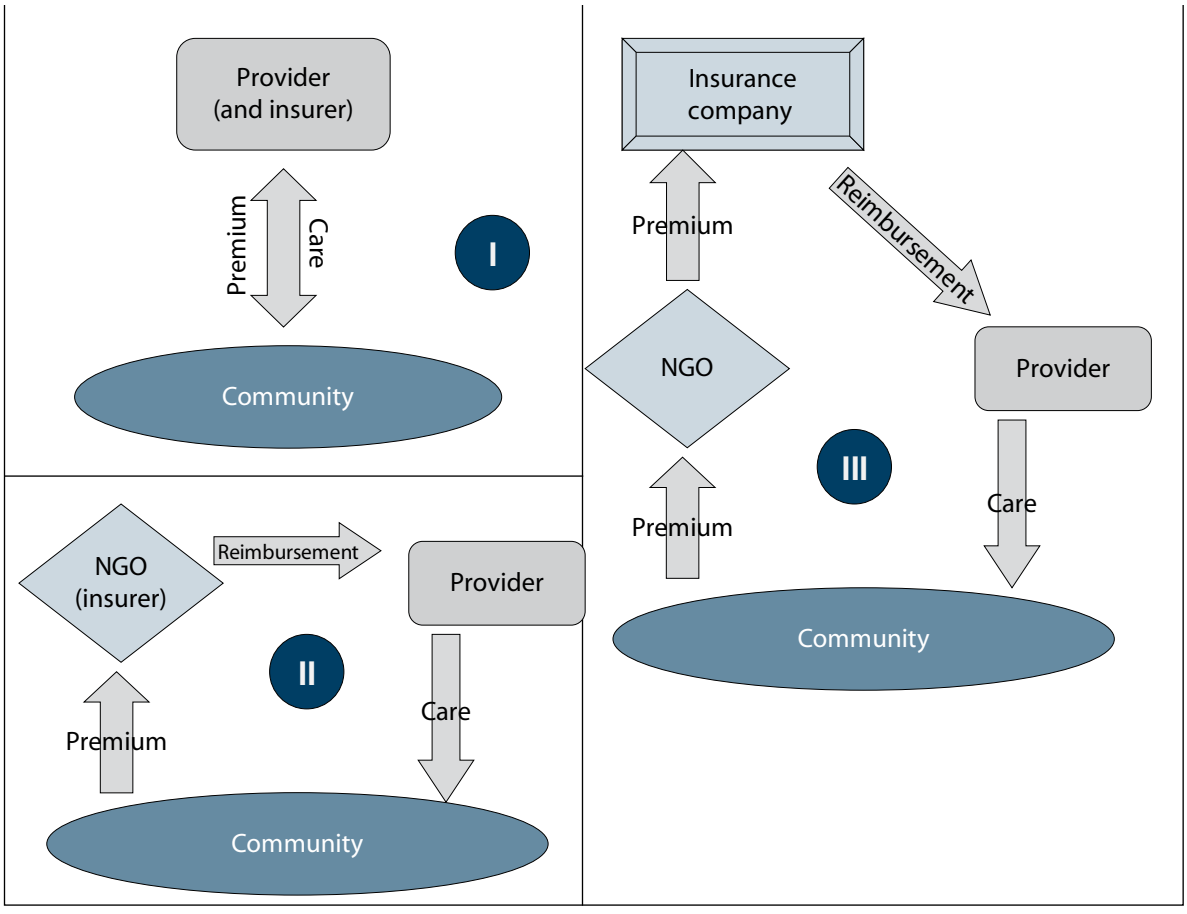
FIGURE 8: Locations of some CHI schemes in the country



Community health insurance (CHI)

Since the SHI is usually for the formal sector and the Private health insurance is for the well-to-do, many NGOs initiated community health insurance to provide health security for the people working in the informal sector, e.g. farmers, labourers, vendors.

FIGURE 9: Types of community health insurance in India



Source: Overview of community health insurance in India, 2004.

Community health insurance (CHI) is defined as 'any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks. The community has a role in the management of the programme'. This definition includes mutual health organisations (MHOs), local health insurances and micro health insurances (MHI). While the CHI movement is vibrant in Africa, it is slowly picking up momentum in India. Currently there are about 100+ CHIs in the country, many of which have begun operations in the past two to four years (Figure 8). ILO estimates that more than 1 crore individuals are members of CHI schemes in India.

As stated in the definition, the main characteristics of CHI are that they are not-for-profit and the community is involved in the scheme to varying degrees. For example, at ACCORD, the community is responsible for collecting the premium; at SEWA the community representatives manage the claims while at KKVS, the community manages the entire scheme from premium setting to managing the funds.

CHI schemes in India can be broadly grouped into three types (Figure 9).

- Type I or Provider model
- Type II or Mutual model
- Type III or Linked model

Type I is the provider model where the hospital is both the provider of care as well as the insurer for the scheme. The classical example is the Medical Aid Programme by the Voluntary Health Services (VHS), Chennai. Here the VHS has organised the programme and its field workers collect an annual income-rated premium ranging from Rs 75 – to Rs 400. The insured is given a card which they can use in the VHS hospital only. When they fall sick, they go to the VHS hospital and get both outpatient and inpatient care. They have to pay a nominal amount; the rest is reimbursed from the insurance fund.

In Type II or the mutual model, the NGO acts as the insurer and manages the risk. A good example of this is the RAHA Medical insurance Scheme. Here an NGO called RAHA operating in three districts of Chhattisgarh collects an annual premium of Rs 20 per person from the rural communities in these districts. The insured is given a card with which he/she can receive outpatient and inpatient care at select rural health centres and three referral hospitals. If the bill crosses Rs 2500, then the patient has to pay the extra amount. RAHA reimburses the health centres and the hospitals on a monthly basis.

In the Type III or partner agent model, the NGO is mainly the facilitator. SEWA collects a premium of Rs 250/ family/year from members of the SEWA Union. This is handed over to an insurance company that covers the insured against the following risks – illness requiring hospitalisation, loss of assets and loss of life. The claims are processed by community representatives and the insurance company reimburses the patient.

In order to include CHI within the regulatory framework, the IRDA has passed the Micro insurance regulations 2005. It recognises the role of the NGO in reaching out to the informal sectors and providing micro insurance (health, life, assets, etc.) to those who are not reached by the formal insurance companies. It requests the NGOs to link up with the insurance companies and act as their agent. The NGO's role is then to create awareness about insurance and enrol those interested with the insurance company.

There are some advantages of CHI.

- First because they are developed in close dialogue with the community, the product is usually affordable and acceptable by them.
- Again because the community and the NGO share the administrative burden, the costs are low.
- Usual problems like fraud are minimised because of social control.

However, there are some problems also with CHI. Many of the NGOs do not have adequate technical skills. So there are basic design flaws in many schemes. Second, being a voluntary scheme, the chances of adverse selection are higher compared to an SHI. And finally because the schemes cover small number of people usually (in thousands only), the scheme is susceptible to bankruptcy in case there are any outbreaks etc.

Government-initiated health insurance schemes

Other than the three classical types of health insurance, India has a fourth type – called the government-initiated health insurance scheme (GHI). The main characteristics of these are that they are launched by the government for a specific constituency, usually the poor, the premiums are heavily subsidised and the benefits are varied. While the insurer is invariably a private insurance company, the organiser varies from nobody to independent bodies. Some of the classic examples of GHI schemes are the Universal Health insurance Scheme (UHIS), the Rashtriya Swasthya Bima Yojana (RSBY), the Yeshasvini Farmers' cooperative health scheme, the Aarogyashree Community health insurance scheme, etc.

Universal Health Insurance Scheme (UHIS)

The Finance Department of the Government of India launched the Universal Health Insurance Scheme (UHIS) in 2003. It was a standard Mediclaim product with a cover of Rs 30,000 for a family (or Rs 15,000 for an episode of illness). The premium was Rs 365 per individual, Rs 548 for a family of five and Rs 730 for a family of seven. The scheme was to be marketed by the public sector insurance companies and was targeted at the poorer sections of society.

It was felt that the original UHIS was skewed in favour of the non-poor. As a result, only a very small number of poor families (9,252) were covered. In 2004, the new UPA government restricted it to BPL families only and increased the subsidies on the premium. A BPL individual/family needed to only pay Rs 165, Rs 248 or Rs 330. The central government subsidised to the tune of Rs 200, Rs 300 and Rs 400 respectively. In spite of this generous subsidy, BPL families did not avail of this scheme. This was because the scheme had many restrictive features. In 2008, the scheme was further revised. The premiums were reduced to Rs 100 per individual, Rs 150 for a family of five and Rs 200 for a family of seven. The age limit was increased from 68

to 70 years and coverage of pre-existing ailments (including maternity) was incorporated into the benefit package. The scheme has also been converted from a reimbursement model to a cashless model. In March 2009, the Uttaranchal government insured 30 lakh BPL families under the UHIS with the Oriental Insurance Company. The government paid the premium amount directly to the company.

However, the basic problem with this scheme is the absence of an organiser of the scheme. It is left to the insurance companies to create awareness, market the scheme, and administer it. As this is a small fraction of their larger business, naturally it is neglected.

The Rashtriya Swasthya Bima Yojana (RSBY)

The Ministry of Labour, Government of India launched the RSBY in October 2007. Aimed to cover the informal sector, all BPL families (as per Government of India guidelines) were eligible to enrol in this scheme. On payment of Rs 30 per family of five, the insured would receive a smart card with family details on a microchip. They could avail of hospitalisation benefits at empanelled hospitals (private and public) up to a maximum of Rs 30,000 per family per year. There were minimal exclusions. The smart card helped in making the scheme cashless and the hospitals were reimbursed directly by the insurance companies. Insurance companies bid for this scheme in each state and agreed to competitive premiums ranging from Rs 500 to Rs 700 per family per year. While the Government of India paid 75 per cent of the premium to the selected insurance company, the state government paid up the balance 25 per cent. The entire scheme was administered by the insurance company but was monitored by a state nodal agency comprising representatives from the departments of labour, health, finance, rural development and also the insurance company.

Only 16 of the 28 states have taken up the programme so far. Some states like Gujarat, UP and Haryana have taken up many districts, while in others, the scheme has been introduced only in a couple of districts. Of the 120 lakh BPL families targeted for the first year, 37 per cent have been enrolled. The main reason for this under performance is the problems that the scheme faced with technology. There were problems with sourcing adequate smart card printers and readers, fitting the BPL lists with the smart card software and synchronizing the entire operations across many software programmes. This along with the discrepancies between the state and central BPL lists were the main cause for delay in enrolment. Hopefully this will catch up in the subsequent years.

As of date, (5/3/09) the following states have enrolled a total of 44,37,153 families.

TABLE 3: Enrolment status for the RSBY

Name of state	Districts in the 1st phase	Number of families enrolled
Bihar	5	5,75,141
Delhi	9	41,990
Goa	2	1,679
Gujarat	10	6,79,198
Haryana	20	5,52,781
Himachal Pradesh	2	80,242
Jharkhand	5	1,64,585
Kerala	14	8,21,932
Maharashtra	5	2,38,262
Nagaland	1	7,645
Punjab	7	87,387
Rajasthan	4	1,20,123
Tamil Nadu	2	57,925
Uttar Pradesh	15	8,34,871
Uttaranchal	2	53,940
West Bengal	2	1,19,452
TOTAL	**105**	**44,37,153**

Rajiv Aarogyashree community health insurance scheme (RAS)

The RAS was launched in 2007 in Andhra Pradesh to provide catastrophic cover for BPL families against high-end medical and surgical expenses. It is managed by the Aarogya Sri Healthcare trust, an independent body (Figure 10).

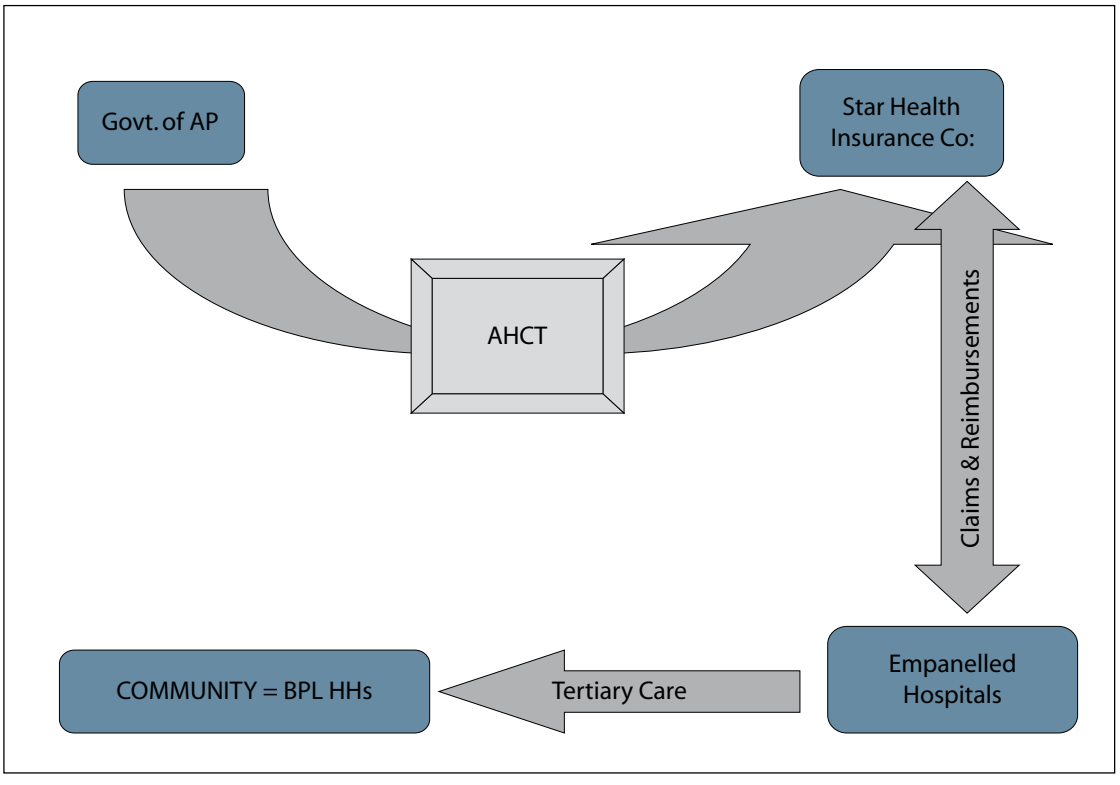
This is a true example of a government-initiated health insurance scheme, where the government pays the premium (Rs 68 per person per year) directly to an insurance company. The company then provides insurance cards to the community (in this case, the BPL families in Andhra Pradesh). The insured BPL families can then access care from empanelled hospitals. The benefits covered are 719 surgical and 144 medical conditions like by-pass surgeries, kidney transplants, care of strokes, etc. Even exotic treatments like cochlear implants are covered under this insurance programme. Some important exclusions are joint replacements and assisted devices for cardiac failure.

Patients are made aware of their insurance status and their medical condition through village health camps organised by the hospitals. Patients are screened and those found to have a condition that requires tertiary care are referred to the concerned hospital for treatment. Patient gets partially subsidised outpatient and fully free inpatient care.

In one year, 6.5 crore BPL individuals were covered through this scheme (100%). As of May 2009, more than 2,75,000 patients have been hospitalised and treated. Most of the patients are from rural areas, and the top three conditions for admission are cardiac, cancer and neurological. One of the main strengths of this programme is the use of technology to closely monitor this programme. Most of the data is available, real-time and online at their website – www.aarogyasri.org

One of the main criticisms of this scheme is that it covers only rare conditions like ischemic heart disease, etc. On the other hand, patients are dying of diarrhoea, respiratory infections, obstetric emergencies, tuberculosis, etc. However, the government's assumption is that these common conditions are being taken care of by the

FIGURE 10: The Aarogyashree community health insurance scheme



existing public health services. So there is no need for any insurance cover for this. Yet another criticism is the sustainability of the scheme in the long term. Currently there is a lot of political will and hence the scheme is well funded. Critics wonder whether the government will be able to sustain this level of funding, and more important, is it equitable?

Some of the key features of the four types of health insurance programme are summarised in Table 4.

TABLE 4: Key features of the four types of health insurance in India

	SHI	PHI	CHI	GHI
Covers	The formal sector CGHS – civil servants ESIC - low income factory workers	The well-to-do – either as individuals or as groups in private companies	The informal sector	The poor - BPL families
Enrolment	Compulsory	Voluntary	Voluntary	Usually automatic
Enrolment unit	Family	Usually the individual	Individual or family	Family
Premium	Income rated	Risk rated	Community rated	Community rated, but heavily subsidised
Affordability	Very affordable	Costly	Affordable	Very affordable
Benefits	Comprehensive	Selective	Selective to Comprehensive	Comprehensive to selective
Management	An independent body	Insurance company	Community + NGO	Autonomous bodies
Risk pooling	From healthy to sick From rich to poor From workers to retired and children	From healthy to sick	From healthy to sick From workers to retired and children	From healthy to sick only

Conclusions

Today in India, about 19–20 crore people are covered by some form of health security, amounting to about 20 per cent of the population (Table 5).

TABLE 5: Health security coverage in India

Health insurance scheme	Approximate number of individuals covered
ESIC	3.5 crore
CGHS	0.4 crore
Railways	0.8 crore
Defence	0.7 crore
Private health insurance	2.5 crore
Community health insurance	1.1 crore
Government health insurance	10.6 crore
Total	**~ 19.6 crore**

However, there are still 80 per cent of the population who is not covered under any form of health security. They are dependent either on the dysfunctional government health services or at the mercy of the private health sector. As a policy maker, if one wants to cover more of the population, then one needs to keep in mind the different risk pools and plan accordingly (Table 6).

TABLE 6: Proposed coverage plan for India

	High income	Middle income	Low income	Poor
Formal sector	Mandatory Social Health insurance + top up with Private HI			
Self employed	Mandatory Social Health insurance + top up with Private HI		Community health insurance	Social assistance or GHI
Informal sector	Private health insurance	Private health insurance	Community health insurance	Social assistance or GHI
Unemployed			Community health insurance	Social assistance or GHI

Some may question the reason to introduce health insurance in the country, usually on ideological reasons. They usually associate health insurance with the private for-profit health insurance in the United States of America. However, it is important for these and others to realise that there are many countries that use health insurance as a mechanism to finance healthcare. Some of the western European nations (Germany, Belgium, and France) are good examples. Other than this, Canada, Thailand, Taiwan, the Philippines, Latin American countries, China also use health insurance as an effective mechanism to protect their citizens from medical expenses. Forty per cent of all health expenditure in the world was through a health insurance mechanism, be it social health insurance (24 per cent) or private health insurance (16 per cent). Financing through taxes contributed to only 31 per cent of this expenditure; while out-of-pocket payments were 24 per cent. One can see that the predominant mechanism of financing healthcare in the world is the insurance mechanism.

Exercise – Health insurance models

Divide the participants into three groups and give them one case study each. The group goes through their case study together and have to formulate answers to the following questions:

1. Identify the key elements in this health insurance programme.
2. In this community identify which group plays the role of the organiser, insurer and provider.
3. What are the elements of risk sharing in this model?
4. What are the strengths of this health insurance programme?
5. What are the weaknesses of this health insurance programme?
6. Give suggestions on how to improve the programme.

Each group chooses one person to present the case studies and the answers at the plenary session. The trainer has to keep the discussion in control ensuring that all the questions are answered and one person speaks at any given time. Once all the groups have made their presentation, then the trainer sums up the key learning lessons and corrects any errors in the participants understanding

CASE STUDY 1

The Yeshasvini Farmers' Cooperative Health Fund was established in 2004 to provide financial protection against high surgical costs. The Yeshasvini trust was formed as a public-private partnership between the Cooperative Dept of Karnataka Government and the private hospitals. All farmers in Karnataka who are members of the Cooperative Societies are eligible to join this scheme. They have to be members for at least 6 months before they can join.

Farmers and their family members (between 1 and 75 years) can pay a premium of Rs 150 per person per year and join the scheme. This premium is collected by the Cooperative department staff and handed over to the Yeshasvini trust once a year (June).

In return, if any insured in the family gets sick, they can go to an empanelled hospital for treatment. The OP care is subsidised and if the patient needs a surgery, then the entire cost of the surgery up to a maximum of Rs 100,000 is borne by the Yeshasvini trust. The Yeshasvini trust has empanelled > 350 hospitals and has fixed the prices for > 600 surgical procedures. There are no exclusions, like pre-existing ailments.

Hospitals need to get prior permission from a third party administrator (TPA) to admit the patient and provide the treatment. After discharge, the hospital sends the claim to the TPA who then reimburses the hospital. The TPA's fund is replenished regularly by the Yeshasvini trust. The TPA also manages other administrative functions like distributing insurance cards, managing a help desk at each hospital, verifying claims and managing a 24x7 call centre.

While in the first year, the Yeshasvini trust had a surplus amount, in the subsequent years, there was a loss. The government of Karnataka met this loss through a one-time subsidy every year.

In the first year 25 lakh members (out of a total of 1.8 crore) joined. Subsequently, the numbers have been in the range of 15–20 lakh. In the first year there were 9,039 patients who benefited from the scheme.

http://www.yeshasvini.org/

CASE STUDY 2

The Medical Assistance Programme (MAP) was introduced by the Voluntary Health Services (VHS), an NGO in Chennai. VHS is a famous NGO started by the eminent physician – Dr Sanjivini. It provides comprehensive healthcare for the people living in the semi-urban slums of Chennai. The care includes primary care through mini health centres and a referral hospital to take care of hospitalisation. The MHCs are decentralised and as near as possible to the community. Each MHC has 2 multipurpose workers and covers about 10,000 people. A medical officer visits each MHC once a week.

The MAP was introduced to improve access to health services. The main target community is the people living in the semi-urban slums around Adayar. Unfortunately, there is no clear idea about the population in these slums. Most of them are not poor as they have employment in the offices and shops in Chennai. They belong to the low-income group of our society.

To enrol in the MAP, a patient has to pay a premium. The premium amount depends on the reported monthly income of the patient. The premium ranges from Rs 75 to Rs 450 for a family of four. However, individuals can also join by paying pro-rata premiums. The premium collection is done either at the village level by the MPWs at the MHCs. Or a patient can come to the hospital and pay the premium and get treatment. MHC staffs are given an incentive to collect the premium.

The insured get the following benefits:

- Free consultation and medicines at the MHC
- Subsidised outpatient consultation at the hospital
- Subsidised hospitalisation care (if admitted in the general ward)
- It is not clear how much subsidy the patient gets as there is a very confusing list of co-payments for every procedure.

The provider is the MHCs and hospital of VHS. Patients cannot get this insurance benefit from any other hospital. The hospital staffs administer the programme, issuing cards to the insured, transferring funds from MAP to the VHS hospital for reimbursing the claims.

In 2001, the hospitalisation rate per 100 insured members was 24, while among the uninsured, it was only 5 / 100 people.

Case study 3

The Universal Health Insurance Scheme (UHIS) was launched in 2003 by the Government of India. It was initially launched to provide an affordable health insurance cover for all, especially the underprivileged. Designed by the Ministry of Finance, Govt. of India, the four public sector insurance companies, i.e. NIC, NIAC, UIIC and OIC were expected to service the scheme.

Those who joined the scheme could avail of the following benefits:

- Hospitalisation benefit up to Rs 15,000 per admission or Rs 30,000 per family per year. Standard exclusions like pre-existing ailments, injuries, cataract, BPH, HIV, etc.
- Death benefit up to Rs 25,000 if Head of household dies due to an accident.
- Disability compensation @ Rs 50 per day if head of household is admitted. Maximum for 15 days only.

The premium is Rs 365 per person per year. For a family of 5, it is Rs 548 and for a family of 7, it is 730. BPL families however have to only pay Rs 165 for an individual, Rs 248 for a family of 5 and Rs 330 for a family of 7. Premiums have to be paid directly to an insurance company. Subsidies will be collected by the insurance company from the Ministry of Finance, Government of India. There is a waiting period of 30 days before benefits can be availed.

Patients can get hospitalised in any hospital with > 15 beds. They have to pay t e bill upfront and get it reimbursed by the insurance company after submitting all the necessary documents.

The government had expected that at least 1 million individuals would join. But the enrolment never crossed more than 1 lakh at any point in time. There is no data available about the claims ratio and the utilisation by the insured.

Prerequisites for starting a Health Insurance Programme

Learning objectives

- To identify essential and desirable prerequisites for a health insurance programme
- To list basic data required prior to designing a health insurance scheme

Materials required

- ☐ Power point presentation on Data requirements

Time Requirements

Presentation: 30 minutes

Note to Faculty

The facilitator emphasises that many requirements may be desirable but not essential and the choice has to be made because of limited funds and time available.

Analysing and understanding other experiences of health insurance is vital for the success of any similar undertaking. It is said that those who do not learn from mistakes of the past are bound to repeat it.

Participants must be encouraged to read about other attempts at providing health insurance, especially at the regional or national level.

These lessons should be incorporated into any plan.

Summary

Essential prerequisites

- There must be a need for health insurance.
- There must be an organiser of the health insurance programme.
- There must be a network of providers of healthcare.
- Some basic data about the community and the region should be available.

Desirable prerequisites

- The benefit package must be acceptable to the people.
- The community must be organised.

Health insurance is a mechanism for financing healthcare. Unlike tax-based revenues or direct out-of-pocket payments, it is a complex mechanism and requires some basic inputs both before starting the programme and also during the programme.

Essential prerequisites

- There must be a need for health insurance. Either there must be problems of accessing healthcare because of financial barriers or there must be problems of high medical expenses leading to impoverishment. These are essential requirements and without this health insurance may be a non-starter. For example, if there is a region where the government services are functioning well, and people do have access to affordable and quality healthcare, there is absolutely no sense in introducing health insurance into that region. On the other hand, if in a region, the government services are ineffective, and the people have to depend either on less than qualified practitioners or expensive private practitioners, then it is important to introduce health insurance so that patients can access the private sector at least.

In Tanzania, health insurance was introduced by the government health department into a milieu of 'free government health care'. The community already had access to free government health services that were of reasonably good quality. So when health insurance was introduced, the people preferred to continue with the free government health services. This meant that even after many years, the enrolment to the health insurance programme was low. On the other hand, in Ghana, where high user fees were the norm of the day, introduction of health insurance was well received as it meant that people had to pay a low amount and received substantial benefits.

- There must be an organiser of the health insurance programme. This is essential, for people are putting their money upfront. They would do so, only if there is a credible and trustworthy organisation that not only markets the scheme, but also services it regularly. This means that the organisers must be known, seen and heard by the community. The organisers must have both character and competence to run the programme. This was one of the major problems with the UHIS. It was introduced and serviced by insurance companies that did not have much of a rural presence. So people were not confident of enrolling as they were worried about reimbursements in the event of an admission.
- There must be a network of providers of healthcare. Many health insurance schemes have started without keeping this in mind. This has resulted in people paying premiums but not receiving satisfactory benefits. This in turn leads to disillusionment and thereby health insurance earns a bad name purely due to bad planning and design. This network of providers need not necessarily be only private providers. Public providers can be part of the scheme, provided the quality of care is improved substantially and they are able to compete with the private health sector.
- There should be some data to design the scheme. A basic list of this is as follows:
- The target population –
  - how many individuals/families;
  - their demographic profile – age and gender distribution;
  - their socio-economic profile – occupation, annual incomes, literacy rates;
  - their morbidity profile – incidence rate of common minor and major ailments, prevalence rate of chronic ailments like diabetes, hypertension, etc.;
  - their health-seeking behaviour – where do they go to seek health care for minor ailments, major ailments, chronic ailments;
  - Their health expenditure – how much do they spend in a year on healthcare, how do they cope with this expenditure, etc.
- The providers – mapping of both public and private providers and the services that are available in these facilities.
- Existing insurance schemes – a list of existing health insurance schemes in the area with the details
- Existing social capital in the region – number of NGOs, CBOs, microfinance institutions, unions/ associations, cooperative societies, etc.

While some of this data may be available from secondary sources,[5] some others need to be collected through primary data collection.

Desirable prerequisites

While the above-mentioned conditions are essential for initiating a health insurance programme, the under-mentioned elements are required for it being implemented successfully.

- The benefit package must be acceptable to the people. Without this, people will usually reject the entire programme after the first or second year as they realise that it does not meet their needs. This was the example of the UHIS, wherein the extensive exclusions, the reimbursement model and the rigidity in terms of definition of family made most people drop out in the second year.

[5] NSSO 60th round – gives morbidity rates, health-seeking behaviour and health expenditure.
NSSO – consumption expenditure round gives details about average per capita expenditure.
NCAER studies – gives ideas on per capita expenditure as well as health expenditure.
FLHS surveys, DLHS surveys – gives idea about utilization of some health services
Rural Health Statistics Bulletin – gives details about public facilities in the region
Health information of India – gives details about health practitioners
IRDA – gives details of cost of claims from private insurance companies (urban bias)

Some examples of benefit packages in community health insurance programmes

ACCORD – in the initial years (1992–1994), the benefit package contained the classical exclusions of a 'Mediclaim policy' – pre-existing diseases, chronic illnesses, deliveries, etc. The people expressed their dissatisfaction with this, especially with the exclusion of deliveries. Rightly they pointed out that while the ACCORD health programme was promoting institutional deliveries, the ACCORD health insurance programme was not covering it. We negotiated with the insurance company and managed to get it included. A few years later, as the incidence of HT, DM and strokes increased, the people requested us to include chronic illnesses in the insurance cover. They were willing to pay the extra premium for this. Thus over the years, exclusions were minimized to psychiatric illnesses only.

Karuna Trust – They realised the negative effect of exclusions right from the beginning and negotiated a package that had no exclusions. Also, as their target population were the poorest sections of society, they recognised the importance of indirect costs for these families. Hence they negotiated for a 'loss of wages' component in the benefit package, so that the patient gets some cash assistance at the time of hospitalization.

Prem Plan – Most of the insured in this region live in remote corners of the district. For them, accessing healthcare is a double burden of both direct costs as well as indirect costs, especially transportation costs. Prem designed the scheme to include transport costs, especially for deliveries. This means that any pregnant woman who needs to go to the hospital can do so now, as both the direct and indirect costs are met.

- The community must be 'organised'. This is a great asset as it helps in creating awareness, in collecting premiums and in administering claims and reimbursements. In the average Indian society, such organisations exist even in the informal sector, e.g. in rural areas, the cooperative societies are one possibility. The others are – caste-based organisations, self-help groups, traders associations, trade unions, students, etc.

Various mechanisms for collecting premiums

DHAN foundation – In this remote corner of Tamil Nadu, women meet every month to put aside some money into a micro saving scheme. Once a year, they supplement this with the insurance premium (Rs 100 per person per year). This is collected by the SHG leaders and they pass it on to the block level and then to the district-level federation. Thus with minimum fuss and administrative costs, the premium is collected from thousands of women.

Tribhuvandas Foundation – The dairy cooperative movement is very strong in Gujarat. Every day, lakhs of farmers pour milk into the collection vessels of the cooperative societies. Once a week, the accounts are settled and they receive payment for the milk supplied. A certain percentage of this money is deducted and paid to the foundation, so that the latter can organise healthcare for the dairy farmers. Thus without any pain, lakhs of rupees are collected for a health care programme that covers primary, secondary and tertiary care.

ESIS – Workers in the industries toil to make our country develop. They are protected by the ESIS which is a social security measure for the low-paid formal sector employee. In this scheme, the contribution from the employee and the employer are deducted at source and sent to the ESIS every month. This money is then used to provide the benefits under the ESIS.

Conclusions

While everybody is keen to start health insurance programmes, it is important to check whether it is feasible or not. The above points are just an indication; there are many more elements that need to be in place for a successful health insurance programme. However, we have chosen to highlight some of the important ones.

Strategies for covering uninsured communities

Learning objectives

- To understand the different dimensions of Universal Health coverage
- To analyse the factors that influence the measures taken for health insurance
- To identify needs of different income groups to introduce appropriate health insurance packages.

Materials required:

- ☐ Power point presentation on 'Choosing a Community'
- ☐ Handouts for the exercise 'Choosing a Community' as hard copy and soft copy (on a pen drive)

Time Requirements

Presentation:	30 minutes
Exercise:	60 minutes

Note to Faculty

It is important to emphasise that International and National experience has shown that it is important to choose the right kind of community for a health insurance programme. This can decide whether a programme is successful or not. Just choosing only poor will result in limited risk pooling.

Poor may need other mechanisms for financial protection, e.g. social assistance. Health insurance may not be the best mechanism.

The time taken initially to identify the community will have many benefits in the long run and should be done carefully. Knowing the community and its needs will also help to decide the best insurance package for this community.

Summary

UNIVERSAL COVERAGE

Universal coverage can be measured in terms of proportion of population covered, the amount of benefits provided and the extent to which out-of-pocket payments are made. In this chapter, we concentrate on the first aspect.

MULTIPLE RISK POOLS

Given the diversity of the population, India will need multiple risk pools. For example, a government-initiated health insurance programme for the BPL, multiple CHI schemes for the organised poor and low-income groups and a mandatory SHI/PHI for the middle- and upper-income groups.

Introduction

Today everybody is talking about universal coverage of communities. There are three dimensions to universal coverage:

- Breadth of coverage – who is insured, who is uninsured?
- Depth of coverage – which benefits are covered?
- Height of coverage – what proportion of the costs is covered?

In this chapter, we shall deal only with the 'breadth of coverage' i.e. how do we increase the health security of Indians.

Currently, only about 20 per cent of Indians have some form of health security. The rest 80 per cent have to rely on dysfunctional public health services or expensive private health services. It is desirable that this gap is reduced so that more come under the umbrella of health security. But how does one do it? As a policy maker or a practitioner, one is usually confronted with this question. There is no single answer. One size definitely does not fit all. A lot depends on the situation. The politics of the land may require that the policy

maker cover only the poorest – the BPL. Or the NGO may be working only with the poor. So it becomes imperative that these are covered. However, if one takes a long-term perspective, then it is essential that one starts with this group, but slowly tries to cover the entire population. This has many advantages:

- The first is that there will be a single system for the entire population – not multiple systems. Worse, a poor system for the poor and a good system for the rich.
- Second, this universal coverage through a single system will enable cross-subsidisation between the rich and the poor, the haves and the have-nots.
- And finally, it will be more equitable.

HEALTH EQUITY FUNDS

This has been used extensively in Cambodia. Poor families (determined by an external agency) are provided with an HEF card. A patient with this card can then approach a hospital for inpatient treatment. At the time of discharge, the patient goes home without paying any money. The NGO who is in charge of the HEF picks up the bill and reimburses the provider. The NGO gets this money from a donor. The main advantage is that this programme is easy to administer and is efficient.

In the next sections the author suggests some mechanisms to cover various sections of the population. These are suggestions and need to be moulded to the local situation.

Covering BPL populations

These are the poorest in the country, people who live on less than Rs 327/person/ month. For them, food security takes precedence over health security. However, it is these people who are most affected by health shocks like hospitalisation expenses and drug costs for chronic ailments. They need to be protected at all costs and cannot be left to the mercy of market forces. In this context, the RSBY is an excellent solution. Highly subsidised and providing basic cover for hospitalisation expenses, it has the potential to provide universal coverage at least to the BPL population. Its only drawback is the effort of enrolling and renewing the BPL families. This appears to take time and may be a hindrance to achieving the final goal.

The other possibilities are to use some form of social assistance mechanism. The Cambodian example of a health equity fund is a good example. Here the BPL patient can go to an empanelled hospital and get admitted. At the time of discharge, a local NGO (who has been appointed as a fund holder) pays the bill and gets it reimbursed from the government. Thus there is no need for enrolling the BPL, etc.; all they have to do is come with their BPL cards. This has been used successfully for institutional deliveries in Gujarat, but needs to be expanded to other disease conditions also.

The main disadvantage of this approach is that in many instances, the community is not aware of its insurance status. This is because most of the management and financing of the scheme has been done at a central level and the scheme managers have not invested adequately on creating insurance awareness.

Of course, ideally the government health services should be so strengthened that they are able to attract the patients back to the public health facilities, where the poor are provided with 'free' healthcare.

Covering the poor and the low-income groups

Unfortunately, there are still poor who may fall through the above safety net. And then there are others who are near poor, or low-income groups but cannot avail of the subsidies because they are not 'poor' enough. Such families also need to be protected by some form of health security. For them, and especially those who are organised in some manner or the other, community health insurance could be the answer. For example, a cooperative society could introduce a CHI scheme for its members. This would benefit all, especially the small farmers. The classic example in our country of this is the Yeshasvini Farmers' Cooperative Health Scheme.

Of course, there will be dropouts, especially people who do not belong to these social groups. They should be encouraged to join the scheme through incentives.

Covering the middle and higher income groups

While these are not a priority for a government, they should be covered, lest they drain the exchequer of vital resources that could be used for the poor. To give an example, it is these sections of the community who use the tertiary services of our medical colleges and super speciality hospitals. Thus public resources are used for subsidising the upper class. An NCAER study clearly showed that the rich 10 per cent of Indians are using 30 per cent of public funds. Naturally there are equity concerns.

More important, covering this section of society would permit some extent of cross-subsidy. Money raised from them could be used (through an equalisation fund) to reinsure the CHI schemes.

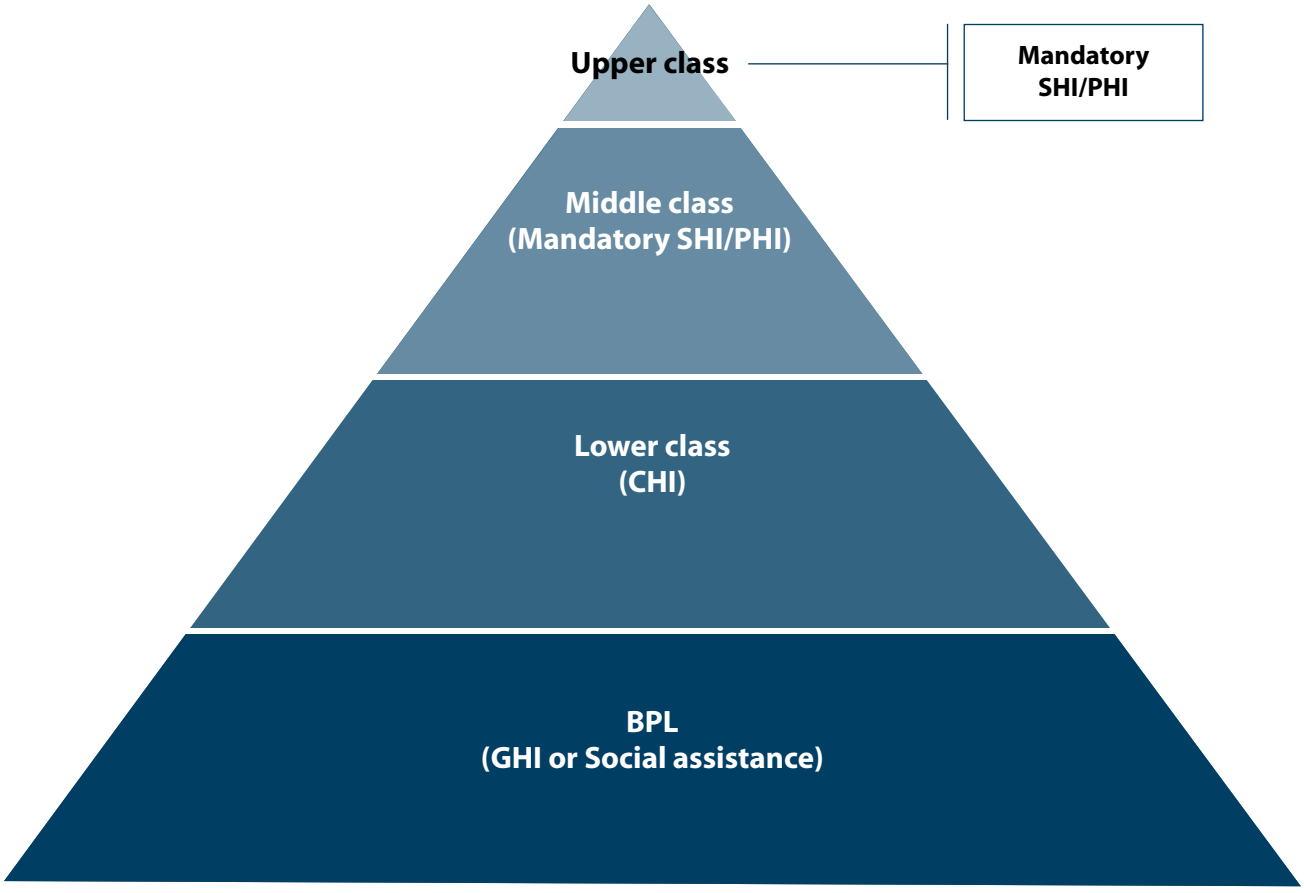
Those who are in the formal sector should be mandatorily insured so that they (and their employers) contribute towards their own healthcare costs. Those who are self-employed or in the informal sector should be made to purchase private health insurance as a mandatory measure, so that their healthcare needs are taken care of by the insurance fund. This has advantages in that one can achieve high coverage rates (100 per cent) with minimum effort. This is an advanced method of covering the population. We have the example of the Employees' State insurance Scheme (ESIS). This is the mechanism in many European countries also, wherein anybody who is employed has to join a health insurance programme and contribute towards it.

While this measure looks easy to implement, there are certain pre-conditions that need to be met. First, one needs a very strong sense of solidarity. People must be willing to contribute for a large group. Where this solidarity does not exist, legislation may need to be introduced to ensure that all contribute. This is the case with the ESIS.

This entire suggestion can be graphically portrayed as follows (Figure 11).

What measure to choose?

FIGURE 11: The suggested risk pools for universal coverage in India



The measure to choose depends entirely on certain factors:

- The organisation of the target population
- Their level of solidarity
- The relationship that the organisers of the insurance scheme have with the community
- The administrative capacity of the organisers
- The legislative framework within the region.

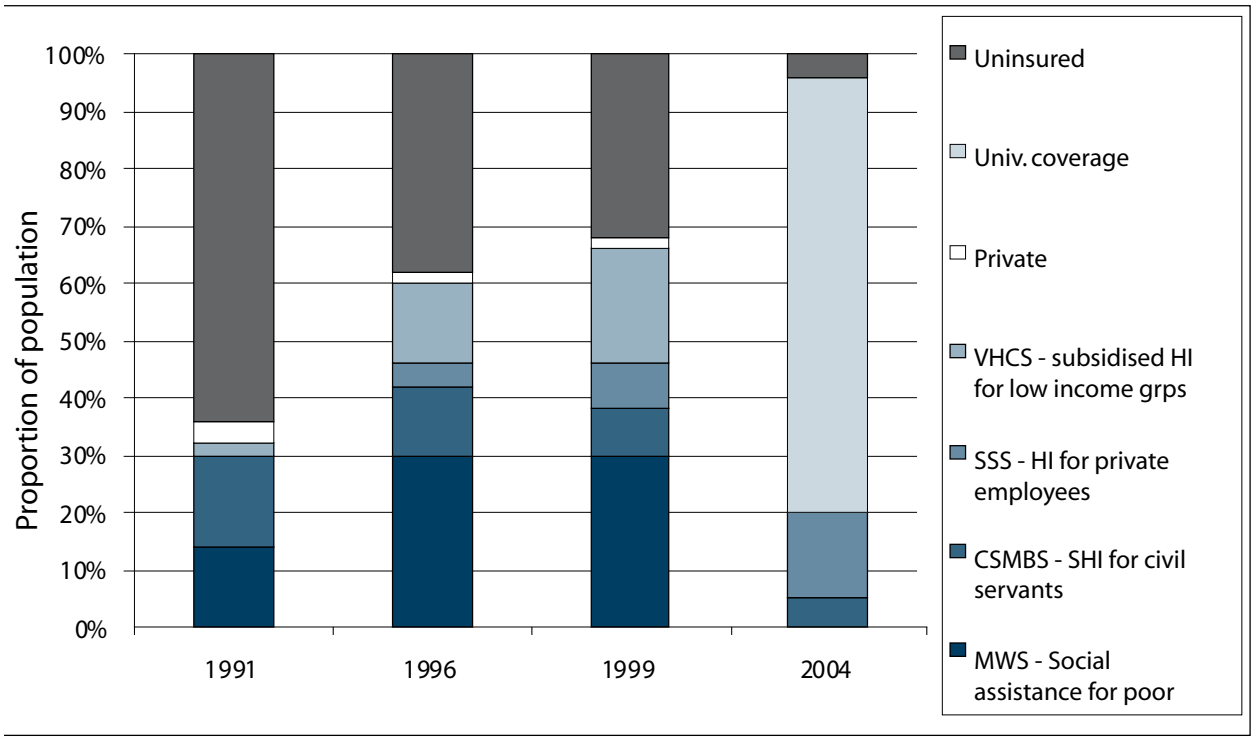
Depending on these factors, one can chose an appropriate measure.

Organised communities with high solidarity or with legal support, e.g. employees in an enterprise, members of micro finance institutions, members of trade unions	Mandatory coverage can be tried.
Organised communities with average to low solidarity, but with good administrative capacity and good relationship with the insurer	Community health insurance or voluntary private health insurance can be tried
Unorganised communities with no solidarity and no administrative capacity within the community	Voluntary – unorganised or automatic can be tried
The BPL sections of society	Automatic mechanisms

Conclusions

In our country with numerous population sub-groups, it is not advisable to have a single health insurance product, especially in the beginning when knowledge about health insurance is low and people are not comfortable with pre-payment and risk pooling. One way out is to cover different pools with different measures. For example, the formal sector can be covered by mandatory measures, the informal organised can be covered with voluntary – organised measures and the informal unorganised sector can be covered with automatic measures. This can be the precursor for moving towards a single system that covers the entire population. The Thai example is worthy of emulating, where over a period of five years, the government was able to provide near universal health security coverage (Figure 12).

FIGURE 12: Progress towards universal coverage in Thailand



Exercise – Choosing the community

Time: 60 Minutes

Activities

Divide the participants into 3 groups, preferably NGO participants into one group and Government participants into two groups.

To the Government participants – distribute the following slip

"Following your presentation with the CM, she asks you to design a health insurance programme and pilot it in one district. No more details are provided. Which community would you choose and why?"

To the NGO participants – distribute the following slip

"You make the presentation to the donor and he is very happy. He says that he is willing to fund a health insurance programme for 3 years. Your director accepts the offer and asks you to design a health insurance programme. Your NGO has been working with the underprivileged for many years. Your NGO runs schools, few health centres, a mobile clinic and also many SHGs. Which community would you choose for this health insurance scheme and why?"

Defining the benefit package

Learning objectives

- To gain an in-depth understanding of key elements of the benefit package with their associated benefits and risks
- To identify different elements for a comprehensive benefit package based on community needs
- To understand the relationship between the benefit package, the premium, administrative load and moral hazard

Materials required:

- ☐ Printouts of Exercise – 'Choosing the benefit package' as hard copy and as soft copy (on the pen drive)

Time Requirements

No presentation
Exercise: 90 minutes

Note to Faculty

This exercise allows the participants to identify all the benefits that they would like to put into a health insurance package. It brings in the idea that there are many areas that interventions can take place and the participants are allowed to freely explore all possible areas of intervention that would benefit the community.

Summary

Some possible benefit packages are:

- OP expenses
- Hospitalisation expenses
- Ambulance costs
- Loss of wages (in the case of poor patients)
- Pre-hospitalisation expenses
- Post-hospitalisation expenses
- Preventive services
- Medical camps
- Medical check-ups
- Catastrophic cover

For each benefit checks and balances must be instituted to ensure there is no misuse of the system, either by the providers or the consumers.

An ideal package is a balance of community demand, technical needs, administrative burden and affordability of the package.

What should the benefit package contain?

This is the crucial part of a health insurance programme. However well designed it may be and however affordable the premium may be, unless the benefit package suits the needs of the community, there will be minimum response from the people.

So what do the people need? We have listed many possibilities below. Depending on the needs and the ability of the community to pay for the packages, one can finalise the most appropriate one.

- OP expenses – everything or only part, e.g. only medicines, or only consultation
- Hospitalisation expenses – everything or only part, e.g. only medicines, etc.
- Ancillary expenses – ambulance costs, food expenses, etc.

- Loss of wages (in the case of poor patients)
- Medical appliances – callipers, pacemakers, stents, IOC, dentures, hearing aid, spectacles, etc.
- Pre-hospitalisation expenses – up to 7 days
- Post-hospitalisation expenses – up to 30 days
- Preventive services
- Medical camps
- Medical check-ups

THE BAIF BENEFIT PACKAGE

The BAIF CHI package initially only had hospitalisation as the benefit package. But people were not satisfied. So they added an annual medical check-up as part of the benefit package. Thus all insured would get a free medical check-up at the end of the year. This meant that those who have not used the money at all felt happy that they got 'something' in return for their contribution.

In the next few sections we take each one of them and review the same in detail.

OP Expenses

This is one of the most common requests of the community. They feel that as they pay some money they would like to have some concrete returns. Hospitalisation is a rare event, but on the other hand, minor ailments and corresponding OP care is more common. In an ideal situation where there are no barriers, the utilisation rate for OP is about 1 contact per person per year. Thus everybody is benefited by covering OP care.

However, administering OP care is difficult for the organiser of the health insurance programme. Processing claims and reimbursements for each OP contact is a nightmare as the insurer will be flooded with such claims. This is one of the reasons why insurance companies do not include OP as part of the benefit package. Yet another reason is the danger of demand side moral hazard. Every single headache will result in an OP contact. This is also not desirable as many conditions that could be managed at the home level would now be shifted to the dispensary level.

Yet another drawback of covering OP is the loading on the premium. This low cost can increase the premium by 40–50 per cent simply because the number of contacts can be high.

In case the community feels a strong need to cover OP, some of the possible ways to reduce administrative load and moral hazard are:

- Give the insured a fixed number of vouchers. They can use one voucher for every OP contact. Once the vouchers are over, then the insured will have to pay for OP contacts. The dispensary sends all the vouchers once a month to the insurer and is reimbursed.
- Introduce co-payments – e.g. the first Rs 100 of the OP bill should be paid by the insured, only the balance will be reimbursed by the insurance company.
- Use a capitation method for OP, i.e. give the providers a fixed amount per insured for providing OP care to the insured patients. This reduces administrative costs considerably. However, calculating the capitation fee per insured may require some expertise and good data. And of course the providers should be willing to accept capitation as the method of payment.
- Negotiate with the providers so that they provide subsidised OP care, e.g. consultation is subsidised and the patient has to pay only the cost of medicines and laboratory. The Yeshasvini scheme has used this successfully. Though there is always a danger that such patients may then be hospitalised (even for 24 hours) so that the provider can recover the consultation fees.

Hospitalisation expenses

This is the most common benefit package offered not only in our country but in most other countries where health insurance is prevalent. It also fits within the principles of insurance – covering low-risk but high-

cost events. The assumption being that hospitalisation is a rare event, but when it happens, it is a major shock for the household. So by covering this event, the household is protected from this shock.

In India, unfortunately this cover is inadequate. Not all hospitalisations are covered. There are many exclusions so that a patient is never sure whether she will be covered for the event. Second, insurance schemes cover only up to a certain limit. This means that anything above that limit has to be paid by the patient. This again puts an element of stress in the patient who approaches the hospital with fear and uncertainty – "Do I have to pay from my pocket at the end of the hospitalisation?" And finally of course, most of the insurance schemes in our country have a reimbursement model, making the patient pay and then get reimbursed at a later date.

In an ideal scenario, all medical conditions needing hospitalisation should be covered under the scheme. Generally the insurers say that pre-existing conditions, chronic illnesses and deliveries should be excluded. They use an economic logic, because patients with these conditions have a higher chance of being hospitalised and claiming money. But health insurance is about risk pooling. That is, the low risks pay for the high risk. So when insurers exclude the high risk, they indulge in cream skimming, that is, keeping only the low risk in order to minimise claims. Third, if one uses public health logic, then those with chronic illnesses and pre-existing diseases are the vulnerable populations. And they should be protected by insurance, not excluded. And finally, when one insures in groups, e.g. members of a self-help group, or a cooperative society, etc. the intensity of adverse selection is diluted. Hence such exclusions should be removed.

SOME INCOMPLETE HOSPITALISATION PACKAGES IN INDIA.

Mediclaim – Hospitalisation expenses for up to Rs 1,00,000 but excludes certain diseases like diabetes, etc.

RSBY – Hospitalisation expenses for all conditions but only for up to Rs 30,000.

Yeshasvini – Hospitalisation expenses up to Rs 100,000 but only for surgical conditions.

KKVS – Hospitalisation expenses up to Rs 10,000; but only for the first 75% of the bill.

Thus most of these schemes cover only a limited part of the expenses and require that patients have to pay out of pocket at the time of illness

Yet another point is that there should not be any upper limits. On the other hand, the prices for treating the disease conditions should be fixed, so that the insurance company can estimate maximum outflow from the morbidity rates and the unit costs. And of course it should be a cashless system, i.e. the insurance company should pay the hospitals and the patient should be allowed to return home without paying from her pocket.

Yet another problem with the current hospitalisation cover in India is the extent of fraud, both by the patient and by the hospitals. Fraudulent bills are supplied to the insurance company for reimbursements, non-existent patients are billed, etc. Health insurance companies and TPAs should ensure that this does not happen. There are simple ways for preventing this.

- All insured should have some identity card, which must be produced at the time of hospitalisation. It may range from a simple card to photo identity card to smart cards.
- In community health insurance schemes, the community can be given the responsibility of detecting frauds, e.g. claims have to be routed through local community representatives. They have to verify whether the claim is genuine or not.
- The TPA can conduct medical audits to ensure that the patient was admitted and treated as per the claims. Appropriate evaluation protocols can be used to check whether the patient received the correct treatment or not.
- Prices should be fixed for common disease conditions, e.g. normal delivery, acute paediatric admissions, acute GI surgeries, etc. This means that the insurance company will reimburse only a

fixed amount to the hospitals. Thus this removes the incentive for the doctors to prescribe more investigations and medicines. However, there is evidence that in such cases, the doctors make the patient purchase medicines from outside and still charge the fixed cost from the insurance company. This needs to be monitored.

- Insist on standard treatment guidelines for managing diseases.

To summarise, covering hospitalisation expenses is in accordance with insurance logic and is necessary for the community. However, the current system needs to be improved upon. One danger of having a pure hospitalisation cover is that cases that can be treated at the OP level may be hospitalised to get reimbursed.

Transport expenses

This is a popular demand, especially in remote areas. There is evidence to show that in such areas, the transport expenses are as high as the medical expenses. So, although health insurance may reduce the financial barrier, it will not remove it. So, to enhance the impact of health insurance in such areas, transport costs need to be included also.

The question is – how does one reimburse transport costs? It is also open to abuse. One possibility is to pay a fixed rate to the patient when she is admitted. The hospital pays this amount to the taxi/jeep driver and includes it in the claims. This minimises administration.

Loss of wages

In rural areas and especially among poor households, admission in a hospital is considered a luxury, as not only do they have to spend on care; they also have to forego income. This has a tremendous impact on the household and studies show that at least 40 per cent of hospitalised patients have to borrow or sell their assets. To prevent this effect, some health insurance schemes have included 'loss of wages' in the benefit package. This means that patients not only get treated, but also are able to meet the costs of indirect expenditure, e.g. food, miscellaneous travel and their loss of wages. Again, to minimise administration, the hospital can pay the patient this amount, e.g. Rs 50 per day hospitalised, and get it reimbursed from the insurance company.

There are some criticisms of including this in the benefit package. People feel that this will be an incentive for people to get admitted unnecessarily and claim the 'wages' component. However, given the major psychological barriers that our hospitals pose to the poor, it is unlikely that this measure will be abused.

Medical appliances

Most insurance schemes do not reimburse medical appliances. This is because the price range is so varied that it is open to abuse. However, if there is a demand from the population for covering this item under the benefit package, then it may be considered as actually in many cases it is part of the treatment, e.g. a person needs spectacles to effectively function, a calliper to walk after a fracture, etc. To minimise abuse, one may consider putting a limit on the amount reimbursed.

Pre- and post-hospitalisation expenses

Currently our Mediclaim policy does not cover pre- or post-hospitalisation expenses. Thus OP expenses leading up to a hospitalisation are not covered. Or expenses for check-ups after discharge are not covered.

This has problems in that patients may get admitted for investigations leading to a surgery. This increases the cost of the claim unnecessarily. On the other hand, patient's discharge may be delayed by a few days, so that the doctor can do repeat investigations, etc. under the cover of hospitalisation. To prevent such eventualities, we recommend that insurance companies should reimburse pre-hospitalisation expenses up to 7 days and post-hospitalisation expenses up to 15 days.

Preventive services

Some schemes are requesting that preventive and promotive care be also covered by health insurance. Thus expenses for immunisation services or medical check-ups should be reimbursed. However, these are not uncertain events. All children need immunisation, etc. So we suggest that these expenditures be met from other sources and not insurance. This would be a more efficient way of financing them.

Catastrophic cover

Usually most insurance schemes cover common medical, surgical and obstetrical conditions. However, in rare events a patient may experience a catastrophic event like a major road traffic accident, or a severe cancer. Such events require large sums of money for treatment. Can the health insurance company cover such events? If the insurance policy does not have an upper limit, then there is no problem. But in case there is an upper limit, then obviously the cover will not be enough for such events. In such cases, the benefit package could also include a 'catastrophic cover' – which will reimburse a few patients much higher amounts to take care of these rarest of rare events.

Medical camps

This is a useful ploy to convince the community that they have received something in return for their premium. Experience from CHI schemes shows that an annual medical camp satisfies the community to a certain extent. To make the camp useful, it could be converted into a screening camp, which detects hypertensives and diabetics at an early stage. This will not only help the patient, but also reduce the subsequent hospitalisation costs for the insurance scheme.

Conclusions

Does that mean that an ideal package should include all the above elements? It all depends on the community that is going to be covered. What are their needs? How much can they pay? Ultimately it is a balance of community demand, technical needs and affordability of the package. The 'Premium software' in the CD gives a rough guide to arrive at a premium after defining the benefit package. This could be used along with discussions held with the community to finally define a benefit package.

Exercise – Choosing a benefit package

Below is a list of possible elements that can be included in a benefit package. As a group, please go through this list and choose elements that you feel are relevant for your community. Please ensure that you have a reason for choosing these elements and discarding the other elements.

After choosing the elements, please write this down on the chart paper provided and then present it to the rest of the class at the plenary. Important is not what you have chosen, but also why you have chosen.

☐ Hospitalisation Expenses for all Illnesses	☐ Hospitalisation Expenses for expensive illnesses only
☐ Hospitalisation expenses with standard exclusions	☐ Medicines only if hospitalised
☐ A flat rate of Rs 1000 (can be changed) per day hospitalized	☐ Medicines + Laboratory if hospitalised
☐ Out-patient care (Consultation + medicines + laboratory)	☐ Free OP consultation
☐ Free OP medicines	☐ Laboratory tests for all illnesses
☐ Free Specialist consultation	☐ High-end dental treatment
☐ All ophthalmic treatment	☐ All ophthalmic treatment excluding glasses
☐ Transport costs	☐ Loss of wages for patient
☐ Loss of wages for patient + attendant	☐ Food expenses for patient + attendant
☐ Medical appliances like calipers, nebulizer, insulin pump,	☐ Organ replacements like joint replacement, valve replacements, kidney transplants
☐ Immunisation	☐ Maternity care (ANC, Delivery, PNC)
☐ Medical check-up	☐ Mobile clinics
☐ Accidental disability	☐ Funeral expenses
☐ Cost of treatment with AYUSH	☐ Nursing charges while at home
☐ Cosmetic surgeries	☐ ART for HIV
☐ Anti TB treatment	☐ Treatment of opportunistic infections in patients with HIV
☐ Hearing appliances	☐ Physiotherapy
☐ Food supplements	☐ Diabetic care only
☐ Cancer care only	☐ Any other…

Premium

Learning objectives

To list out the constituents of a premium and how to calculate each constituent. To list out the types of premiums

- To enlist different rating methods
- To understand strategies for collecting premium and their relative advantages and disadvantages
- To understand and accept that one has to balance the acceptability of the benefit package (community needs) with the affordability of the premium (ability to pay)
- To create a realistic benefit package balancing community need with budget

Materials required:

- ☐ Presentation of 'Premium'
- ☐ Handouts of Exercises 1 and 2 'Calculating the premium' and 'Revisiting the benefit package' to be distributed to the participants - soft copy and hard copy

Time Requirements

Presentation:	90 minutes
Exercise 1:	90 minutes
Exercise 2:	90 minutes

Note to Faculty

Here the group will begin to realise that the wish list may sound good but in reality may be difficult to implement. This is the transition point for the participants from theory to practical implementation and can decide the success or failure of the programme. Participants may begin to laugh when they realise that some elements may shoot up the cost of the programme and the trainer should highlight this.

When the participants re-prioritise the benefit package they will be able to have a more practical understanding of the limitations in the delivery of a health insurance programme. This will help them avoid mistakes in the field and help them to develop more successful and realistic programmes. The trainer has to emphasise the importance of this exercise as a precursor to their real field implementation.

Summary

Factors influencing health insurance premiums

Size of the benefit package
Claim costs
Administrative costs
Marketing costs
Contingency margins
Profit margins
Reinsurance

Different Rating Methods used by Health Insurers

Community Rating
Risk Rating
Income Rating
Experience Rating

Strategies for collecting premium

Payroll deductions – easiest in formal sector
Deductions at source – convenient in cooperatives or self help groups
Membership payments – e.g. from members of a trade union group
Voluntary payment – the most common method adopted in India

Introduction

Premium is the consideration paid to the insurer by the insured for the health insurance coverage. Different health insurance models and schemes use varying methods to calculate and charge for the benefit package offered by them. In this module, we will discuss some of the important rating methods used by health insurers, and also understand the factors on which the premia are dependent, the modes of collection of these premia, and funding alternatives for health insurance schemes.

Factors influencing health insurance premium

Various factors affect the amount of premium that needs to be charged from the beneficiaries of health insurance. The size of the benefit package and the associated claim costs are usually the predominant determinant of the cost of a health insurance premium. Factors affecting claim costs are important in determining the amount of premium that is necessary to be charged under a health insurance plan. These include, for example, the morbidity rates in the community, the risks insured and the conditions covered by insurance, i.e. the benefit package, costs of healthcare in the community (including any specific provider payment arrangements or bulk purchase arrangements which bring down the costs of purchasing healthcare), whether and to what extent dependents are covered by the insurance policy, etc.

However, there also exist factors other than the claim costs, which play an important role in the setting of premia by health insurers. These include administrative costs, marketing costs and profit margins of the insurer. These are briefly discussed below, as these could be important in designing models where such costs can be minimised.

Administrative costs include the costs of collecting premium, costs of underwriting, costs of issuing policy documents and identification documents to the beneficiaries, costs of enrolling and accrediting/ monitoring providers of care, costs of processing and paying claims, government taxes and levies like stamp duty on policies, etc., and also the costs of planning, supervising and managing the health insurance scheme.

Marketing costs include not only the commissions and incentives paid out to agents, advisors, brokers and other sales functionaries, but also the costs of acquiring and maintaining a sales network, costs incurred on print and visual media, and also, especially in the case of community-based schemes, costs of advocacy and awareness generation in the community.

Insurers also need to provide contingency margins in their premium structure, as the claims experience could be greater than what was expected by them. Such contingency margins also help build reserves which could see the insurer tide over a 'bad' year when exceptional claim costs may arise. Finally, over and above all these costs, insurers may provide for a profit margin, if they are a for-profit organisation.

Insurers may also opt for reinsurance, wherein part of the premium they collect is given or 'ceded' to a reinsurance company, in return for various types of reinsurance covers, which reduce the exposure of the insurer.

Different Rating Methods used by Health Insurers

Community Rating

This is a system of determining uniform health insurance premia for all individuals in a community, based on the cost of providing medical services to all people in the community, without adjusting for individual risks and medical history. Under 'pure' community rating, insurers would be required to charge the same premium for every policyholder, regardless of age, sex or any other indicator of health risk. Under 'modified' community rating, the price differences could be based on age and sex, but other than that, sick people could buy health insurance for the same price as healthy people.[6]

[6] National Centre for Policy Analysis. Community Rating. State Briefing Book on Health Care. NCPA, 1994.

The community rating method recommends a uniform premia, which actually means higher premia being charged from the healthy and lower premia from the sick, than what they would pay in a risk-rated model. Thus, we can infer that community rating is more suitable for mandatory models of health insurance, or where no alternative voluntary models (e.g. risk-rated plans) are available. Otherwise, the sick would tend to opt for community-rated coverage more than the healthy would (adverse selection), and this would reduce risk pooling and progressively raise premia. Where community-rated premium works well, the equity is raised as the healthy tend to subsidise the sick. This is the usual type of premium used in community health insurance schemes and also in government health insurance schemes.

Risk Rating

This is a system of determining health insurance premium for each individual based on the risk perceived by the insurer, and involves consideration of the individual's medical history, occupation, lifestyle and other individual characteristics in the determination of his or her premium. Thus, the relatively healthy individuals pay a lesser premium than those perceived by the insurer to be sick or more likely to become sick.

RISK RATING IN PRIVATE HEALTH INSURANCE

Most private health insurance products are risk rated, e.g. in Mediclaim, the premium increases with the age. This is to compensate for the higher risk with older age groups.

Risk rating necessitates a variety of administrative procedures, verification strategies, and types of economic incentives or disincentives to be put in place by insurers[7] to address asymmetry of information and moral hazard. It is usually used in private health insurance schemes and is the most inequitable among the different types of rating.

Income Rating

This is a system of determining health insurance premium based on the income or wages of the individual. A defined proportion of the income is charged as premium, irrespective of the health status of the individual. This system is used most commonly in SHI schemes and is appropriate for a mandatory model or where alternative options are not available, for the reasons cited above in community rating. The ESIS in India is an example of income-rating where the employee contributes 1.75 per cent of his salary, while the employer contributes 4.75 per cent. Thus the higher income people contribute more and subsidise the contributions of the low-income people. This is the most equitable method of collecting premium but requires tremendous solidarity or legal frameworks.

Experience Rating

This is a system of determining health insurance premium based on the insured's past loss experience. Thus, the method is used for individuals and groups who have been covered for a sufficiently long length of time to enable the insurer to assess the loss experience or service utilization by the insured. The method is widely used in India for the Group Mediclaim covers sold by public sector health insurers, where premia are revised based on the claim experience in the recent past.

Strategies for collecting premium

As a planner of a health insurance scheme, one needs to consider various strategies to collect premia. Some illustrations are given below along with their relative advantages and disadvantages:

Payroll deductions– This could be the easiest method to collect premiums, especially if one is planning to cover people employed in the formal sector. However, such a scheme requires widespread consensus

[7] Kaelin MA, Barr JK, Golaszewski T, Warshaw L. J. Risk-rated health insurance programs: a review of designs and important issues. AJHP, 1992.

and consent of all the stakeholders, including the employees, the employers, the trade unions/ associations, etc.

Deductions at source – For example, while collecting premium from dairy farmers, one can collect the premium at the level of their dairy cooperative society. Thus, the cooperative can deduct an amount towards their monthly contribution from the dues of the member farmer, and collectively pass it on to the health insurance scheme. Similarly, a self-help group can collect contributions on behalf of its members and pass it on to the scheme. This is an efficient way of collecting, though one needs to convince all the members to be part of the scheme. Difficulty increases if only some members join the scheme, because then keeping track of the members and their contributions becomes more complicated.

Membership payments – For example, in a manner similar to the above deduction, but not linked with any simultaneous financial activity, members of a trade union can be asked to pay an annual contribution towards enrolment in a health insurance scheme.

Voluntary payment – This has been the most common method of premium collection in our country so far. Here the scheme is announced and the people are invited to come and join. Collection depends on the interest of the individual.

Each of the above strategies has its pluses and minuses. One should note that the mandatory nature of payment reduces as one comes down on the above list of strategies, and the cost of administration simultaneously goes up.

To summarise, in collection of contributions from members of the scheme, it is far more cost effective if the deduction is made from the wages/pay of the member by the employer and is collectively paid into the scheme, than collection from individual members. Alternatively, if the members of the scheme are already grouped together in some form or the other, and premium for the group as a whole is paid by the whole group as a body, the transaction costs are minimised. The premium could also be drawn from any payment normally due to the member (like a milk or poultry cooperative deducting premium from the payables to the member). Effective strategies to minimise collection costs of premia, could thus be reduction in the total number of transactions taking place (e.g. by grouping of members and collective payment of premium), increased automation (vis-à-vis manual procedures), bundling of insurance premium payment with other transactions (like payment of wages or periodic payments of other dues), etc.

Measures to reduce administrative costs

Other than the above mechanisms of premium collection, there are mechanisms to reduce the administrative costs of the premium. These are listed below.

Initial, non-recurring costs and Identification documents

An important component of the administrative costs are the initial, one-time costs including those of examining an insurance enrolment proposal and any pre-insurance examination required, costs of issuing the policy document and those of issuing identification documents, etc. The last mentioned is an important aspect, which needs due attention. The extent of security and foolproof technologies to be deployed in the identification document will depend on the size and nature of the scheme and the costs involved. A small, local insurance scheme with a limited number of providers who would normally recognise the beneficiaries will have different identification needs from a large insurance scheme offering a large, geographically spread-out network of providers. The options include the policy document itself, or the policy with another valid identification card (voter card, etc.) in which the insurer incurs no additional costs, or laminated photo-and-signature cards, and perhaps even smart cards which could include greater details about the beneficiary and the plan in the chip embedded in the card. The latest technique used is the smart card in the RSBY – a debit card with a micro chip that contains the insured's details including details of the family, the utilisation of medical benefits, the medical history

and the balance left for utilisation. This card can be used in any of the empanelled hospitals across states and cities.

Recurring Costs

The other set of costs, recurring costs, include the cost of collection of contributions/ premia. As is obvious, these costs must be minimised as they eat into the kitty of the insurer and serve no useful purpose. Automated collection at source, for example, from salaries/wages/payables, as discussed above, is a low-cost method of collection. However, when it is being planned to enrol the unorganised sector in a big way by the health plan, alternative mechanisms for collection will need to be evolved which are effective and cost-efficient. One option could be collection of contribution by community volunteers like Anganwadi workers, postmen, schoolteachers, etc. who are accountable, locally available, and who also travel in the course of their work to their supervisory offices for regular meetings (where collected premia could be handed over). Community health insurance schemes often use the voluntary effort of their community representatives to market the health insurance product, collect premium and to detect fraud. This minimises their administrative costs considerably while retaining the accountability of people involved in the process.

However, it must be remembered that the actual costs (including the cost of time devoted by the manpower involved) of collecting, compiling and processing small contributions could even be higher than the amount of the contribution itself, and so the effort should be that the size of each individual transaction in terms of rupee-value is increased through grouping of individuals, grouping of premia, etc. This would ensure that a larger share of the collected corpus is available for service provision, and is not lost in administrative costs.

Enrolment unit

The unit of enrolment in health insurance policies could be the individual, the family, or larger groups, for example, self-help groups, groups comprising all members of specific communities or all workers of an enterprise. Voluntary schemes are more likely to have the unit of enrolment as the individual member, while mandatory schemes are in a better position to take advantage of larger group sizes. As the size of the unit of enrolment increases, the pooling of risks improves and administrative costs to service the same number of persons also go down. However, in certain plans (for example, family floater plans), individuals covered within a single unit of enrolment may share the sum insured, whereby if one individual over-utilises health services, it affects the service available for the remaining individuals within the unit.

In India, we are accustomed to the individual being insured as the enrolment unit. However, this has many drawbacks, including increased risk of adverse selection - those who are sick will tend to enrol at a higher rate than those who are healthy. This will lead to the scheme becoming financially unsustainable. Adverse selection can be reduced with larger units of enrolment, e.g. the family, the organisation. Thus, if the plan insists that individuals cannot be enrolled and the entire family/self-help group/ organisation should be enrolled, this will ensure that both the healthy and the sick will be members of the scheme. This increases the risk pooling considerably, and hence there is cross-subsidy as also reduction in administrative costs, which reduces the premium.

Collection periods

The scheme could be planned such that it has an open-ended or a close-ended contribution period. In the close-ended form, there would be a definite collection period during which all the eligible members would be required to pay their premia. In the other option, which is open-ended, the members are free to enrol at any point of time, all through the year or at any point in the tenure of the scheme. Open-ended schemes could also increase the risk of adverse selection. For example, people will enrol when they perceive illness or other potential medical costs (e.g. pregnancy).

Administratively also, it could be harder to keep track of enrolment and renewal, and to remind the members about renewals on time. Thus, a close-ended plan allows people to join during a fixed period only and its follow-up and administration is much easier. However, this collection period should be planned in a manner which coincides with the period of high finances, e.g. in a predominantly agricultural community, it could be at the time the crop is ready, or in an industrial set-up, it could coincide with the period when annual bonuses are paid out. Hence, one has to weight the pros and cons of these options, too, before finalising a method.

Waiting periods

Waiting periods are usually introduced as a cost-containment mechanism to minimise adverse selection, as these discourage sick people from joining at the time of illness and encourage healthy individuals to join before they need medical care. For example, certain benefits could be denied for one month (or longer) after enrolling in the scheme. While this is indeed an effective tool to minimise adverse selection, it also can be a difficult concept to explain to the community. ("I have paid the money, so why can I not get the benefits".) Waiting periods are usually imposed at the time of first joining the plan and are not applied on renewals when renewals are being made on time.

Addressing Sustainability

The careful setting of the premium and assessing other sources of financing the plan, vis-à-vis the costs of the benefit package, are important considerations towards ensuring sustainability of the scheme. While undertaking this iteration between affordability and the benefit package that should be offered, care needs to be taken to put in place certain reserves to meet unexpected costs. This is all the more important where the costs are being estimated with limited data, as the actual experience of the plan could be far different from these estimates.

Moreover, a long-term plan for the scheme, especially where the plan is being initially rolled out with a substantial component of subsidies or donor funds, needs to be considered. Often, the subsidies and donor funds could be only for a limited duration, and the scheme may be expected to take on all or most of the costs of the scheme in due course. Planning for the long-term sources of funds for the scheme, and to determine the extent of costs that could be afforded by the beneficiaries to sustain the scheme could thus be important at the design stage itself.

To protect the scheme from catastrophic costs, opting for reinsurance could also be one of the mechanisms for protecting the scheme from sudden depletion. Also, an operating reserve to meet fluctuations in cash flows and unexpected scheme costs, as mentioned above, is also an important tool to ensure liquidity, though building up a technical reserve, as is maintained by pension funds to meet higher future costs, may not be required for a health insurance plan. Finally, maintaining a constant eye on cost data, and not delaying inevitable (but sometimes quite difficult) financing decisions based on this data, in terms of adjusting premia or benefits under the scheme, will also play an important role in maintaining the viability of the scheme and its continued availability to the beneficiaries.

Balancing Benefit Packages and Financial Resources

The available financial resources are a major determinant of the range of benefits that can be offered under a health insurance plan. Such financial resources could be the contributions or premia paid by the members of the scheme, any subsidies provided by government or donor funds available to the scheme and any gains or returns on these preceding funds. In certain designs of the schemes, co-payments and user charges could also be designed in a way that these are not just cost-containment mechanisms but also important sources of finance for the scheme.

The benefit package on offer by a health insurance programme could be chosen from a range of possible services which could be offered to its intended beneficiaries. To illustrate a few, the choice ranges from

primary care and preventive care services, to specialist consultations, varying levels of inpatient care, maternity benefits, day surgery, medicines, laboratory and radiological examinations, dental care, ocular care, ambulance services, physician home visits, financial support for incidental expenses during illness in the form of a per diem or otherwise, and even support for loss of pay during periods of illness. Obviously, the planners of the scheme will need to choose the best fit and decide their own benefit package.

This best fit, of course, will depend on a multitude of factors other than the financing angle, including the perceived need of the community, the available health infrastructure, the alternative sources of healthcare for the community, available technology, available array of provider payment mechanisms, healthcare costs, rates of morbidity and utilisation of services, availability and costs of reinsurance and so on. However, the bottom-line will be what health priorities the scheme can afford to provide within the resources it can muster. This would require an iterative process of balancing desired benefits within affordable costs, the outcome of which should yield the best fit the planners had sought out to achieve. Again, the best fit is a dynamic process, and can again be moved in either direction depending on scheme experience, changed aspirations and needs of the beneficiaries and changes in availability of finances, among others.

Conclusions

This chapter has covered the important topic of premium. How premiums are calculated, what are the determinants and finally, strategies to collect premium and reduce costs. Setting the premium could well be one of the most important steps that the health insurance planner will be taking. This will, of course, depend on how much the target community can afford and what they need from the benefit package. There are no clear-cut answers – and one has to manage a balance between these two conflicting demands.

Exercise 1 – Calculating the premium

Reassemble in the groups from the previous exercise on 'Choosing elements for the Health Insurance programme'. Please go through the list of conditions below and tick the ones that you had selected in the previous exercise. Now look at the right-hand column. This is the cost that this element brings to the premium. Thus if you have hospitalisation and OP consultation only, then the premium will be Rs 100 + 50, i.e. Rs 150 per person per year. Similarly, add up the cost of all the elements that you have ticked and now come up with the total premium.

Element	Prob.	Cost	Prob. X Cost
Hospitalisation Expenses for all illnesses	.02	5000	100
Hospitalisation Expenses for expensive illnesses only	.001	50,000	50
Medical consultation for all illnesses	.5	100	50
Specialist's consultation for all illnesses requiring specialist consultation	.05	200	10
Medical and specialist consultation for selected illnesses only	.01	200	2
Medicines for all illnesses	.5	100	50
Medicines related to hospitalisation cases only	.02	500	10
Medicines for specific rare and high cost diseases (like cancer)	.0001	1,00,000	10
Diagnostic tests for all illnesses	.5	100	50
Diagnostic tests related to hospitalisation cases only	.02	500	10
Dental treatment of all types	.25	200	50
Dental treatment - only surgical, high cost	.01	1000	10
Eye care-related expenditure - all types, including glasses	.25	200	50
Eye care-related expenditure - all, excluding glasses	.05	200	10
Eye care-related expenditure - only expensive, surgical treatment	.001	3000	3
Ancillary expenses during hospitalisation, like travel cost and food expenses for attendant, etc.	.02	500	10

Element	Prob.	Cost	Prob. X Cost
Cover for loss of wages of the patient	.02	3000	60
Cover for external Medical Appliances – callipers, etc.	.0001	1000	1
Preventive Services - Immunisation	.25	80	20
Preventive Services - Medical Check-ups	.5	200	100
Periodical Medical Camps	.5	100	50
Cover for maternity and related expenses	.1	2000	200
Cover for ambulance and patient transport costs	.02	500	10
Cover for accidental disability	.0001	25000	2.5
Cover for funeral expenses	.007	1000	7
Cover for treatment under alternative and indigenous systems	.25	100	25
Cover for rehabilitation-related costs	.0001	10,000	1
Cover for costs of mental illnesses	.05	500	25
Cost of health education for community	1	10	10

Premium per person per year = Rs

Add 20% administrative costs = Rs

Total premium per person per year = Rs

IS THIS PREMIUM AFFORDABLE FOR YOUR COMMUNITY?

Exercise 2 - Redefining the benefit package

It appears that the benefit package designed by you is too costly for your community. Now, keeping the community needs and also the cost of the elements of the premium, can you reassemble in your groups and redesign the benefit package? Remember to maintain a balance between the community needs (acceptability) and premium amount (affordability).

Present your lists at a plenary

Providers

Learning objectives

- To understand the roles and responsibilities of a healthcare provider in an insurance programme
- To enumerate provider payment mechanisms
- To identify strategies for cost and quality control within a health insurance programme
- To understand the concept of standard treatment guidelines and essential drug lists

Materials required:

- ☐ Power point presentation on 'Provider'.
- ☐ Exercise on Providers as handout and soft copy (on a pen drive).

Time Requirements

Presentation:	45 minutes
Exercise:	60 minutes

Note to Faculty

Providers have a major influence on the costs and quality of the services and have to be subjected to appropriate guidelines. The trainer should read this session thoroughly and make sure all the key points are communicated to the participants. In the case of Government participants, the key provider may be the Government itself, but in the context of a Public-Private partnership, it will also be any private hospital. Therefore they should be aware of all the criteria to select a good provider organisation

SUMMARY

Empanelling providers is a must for managing costs and quality.

Some of the ways are to negotiate for:

- Standard treatment guidelines
- Essential medicines
- Cashless system
- Referral system / pre-authorisation
- Various provider payment mechanisms

Selecting Providers

The benefit package proposed to be offered by the scheme would be the key determinant to decide the types of providers that the scheme should negotiate and contract with. For example, a scheme only covering high-end catastrophic, inpatient care would need to negotiate with tertiary-level hospitals only. At the same time, a scheme contemplating provision of primary care would need to engage into dialogue with general practitioners and primary care providers, and perhaps also with diagnostic centres and pharmacies, depending on the scope and the design of the plan.

A major limitation in the rural and semi-urban setup could be the relative unavailability of many qualified providers. Under such circumstances, the scheme could consider if it would also like to select providers from systems of medicine other than the western medicine, i.e. qualified providers from Ayurvedic (BAMS), Homeopathic (BHMS), Unani (BUMS) systems, etc. Such providers could be utilised for a primary care function, subject to guidelines laid down by the insurer, and could also play the gatekeeper role in areas where other providers are not available. However, the contracts with alternative medicine providers may need to be inclusive of drugs/pharmacy costs for better access to the medicines prescribed by them.

Empanelment of Providers

The first question that we should address in this section is whether the scheme should employ providers, empanel them or leave it to its members to access care from whichever source they are comfortable with. Both cost and quality considerations are important in answering this question. Experience from around the world suggests that employing providers, i.e. direct provision of care by the insurance scheme itself normally leads to quality problems, while purchasing care from providers could have implications of cost control.[8] Thus, separation of funding and provision of services is desirable for the health insurance plan. At the same time, cost-containment mechanisms as discussed in the following sections, and provider payment mechanisms as also discussed later, will play an important role in controlling costs for provision of care, where the service provision is indirect. For such cost controls and provider payment mechanisms, therefore, empanelment, as also legally binding arrangements with providers, are called for.

For the patients, empanelled providers could also mean advantages like cashless facilities, where the provider does not bill the insured and directly receives its payment from the insurance scheme. However, empanelment could also mean reduced choice, as not all providers can be approached by the insured, and there could be disincentives for approaching providers outside the network. This is often resented by the insured, even though it is important to the insurer for its cost containment.

For the insurer, empanelment ensures that the provider meets the basic criteria for service provision as laid down by the insurer, is accountable to the insurer, and has also agreed to certain conditions imposed by the insurer (for example, in terms of credit, discounts or alternative payment mechanisms), which addresses the cost and quality considerations of the insurer to some extent. These cost and quality considerations are discussed at length in later sections of these modules.

Negotiating with Providers

While general principles of negotiating and contracting have been discussed in another module, this section will discuss the various aspects of the negotiation to be undertaken with providers, once they have been selected for empanelment based on the scheme design.

While some aspects of what could be negotiated in terms of costs and quality is discussed in more detail in ensuing sections, in the form of cost containment and alternative payment mechanisms which will need to be negotiated with them, there exist other aspects which could be negotiated with the providers. This could include special privileges to the insured persons like separate queues for the insured or any other mechanisms for priority attention to the insured clients, which could enhance the service experience of the insured.

At the stage of empanelment itself, it would also be good if the clauses to undertake medical audits at the discretion of the insurer, or to review billing records pertaining to the cases reimbursed by the insurer, are incorporated. These serve as a deterrent against inflated or fraudulent claims, and can also help the insurer gain greater confidence over the quality of services and processes of the provider.

For large insurers and with automated processing systems, where coding and standardization would be more helpful than for smaller, manual processing systems, it could also be negotiated to have billing in a standardised format, with codified procedures and standard rate schedules, especially in fee-for-service systems. For example, CGHS in our system has laid down such category codes and schedules, which providers adhere to. The requirements could also include a detailed discharge summary, a detailed bill, a list of medicines prescribed (and justifications for not adhering to essential drug lists, where applicable), a list of procedures performed (codified, if so required), list of laboratory investigations performed (this could be codified again) and list of appliances given (as provided by the insurance plan).

[8] Normand C, Weber A. Social Health insurance - A Guidebook for Planning. WHO and ILO, 1994. pp. 53-58.

Credit periods for settlement of payments, provision of cashless services to the insured, etc. will need to be incorporated in the legal document itself, after mutual agreement in this regard.

Some hospitals do not like the cashless system, because of previous bad experiences with TPAs who have been slow in reimbursing the hospitals. One way out is to provide them with an advance that is replenished regularly as it falls below a threshold value.

Where gatekeeper mechanisms are being put in place, specialised and inpatient providers may be required to accept referrals from authorised gatekeepers only. Thus, the various aspects of the referral system, like the higher level providers accepting referrals only and not direct walk-in patients, and the primary care providers passing the referrals on to higher levels will also need to be negotiated and built into the agreement.

Controlling costs, Ensuring Quality

For a health insurance plan, the importance of controlling costs and yet ensuring quality of services provided to the beneficiaries cannot be over-emphasised.

Strategies for cost containment are closely related to the design of the scheme, and so it is very important to be aware of the dangers and the measures to prevent them during the process of establishment of the scheme itself.[9] At the same time, ensuring quality is a vital factor in the eventual success of the scheme. A WHO study reports that in an evaluation of the Maliando scheme in Guinea-Conakry, when membership was discussed specifically, lack of quality of care was cited as the most important cause of non-enrolment.[10]

Various measures to control costs have been employed by health insurance organisations the world over. We shall discuss some of these in the sections that follow.

Referral Systems and Pre-Authorisation

Certain plans, especially in the managed care environment, employ a primary care provider or 'gatekeeper', who is responsible for authorising treatment by specialists or non-emergency hospitalisations. As the costs of accessing care at a specialist or tertiary facility are higher for the insurance plan, this system serves as an effective cost-control mechanism, and encourages utilisation of primary care facilities. However, care needs to be taken to avoid over-referral or indiscriminate referral by the primary care provider, instead of managing the case at his own level. Clear policies for referral therefore need to be in place.

The plan could also have a system for pre-authorisation or prior authorisation before a specialist service or a non-emergency indoor treatment is availed. The pre-authorisation is the insurer's approval of the hospitalisation or procedure being a covered service which will be reimbursed or borne by the insurer as per the policy provisions. In certain designs, the gatekeepers issue this pre-authorisation to the patients, while in others, the authorisation is provided to the serving hospital directly when a procedure or admission request is made.

The referral systems should also have clear provisions as to what constitutes an emergency, where these requirements of approaching through a gatekeeper or for prior authorisation are usually relaxed. If these provisions are not clear, misuse of services could occur, which could raise costs for the insurer.

[9] Normand C, Weber A. Social Health insurance- A Guidebook for Planning. WHO and ILO, 1994. pp. 82-83.

[10] Criel B., Noumou Barry A. & von Roenne F. (2002). Le Projet PRIMA en Guinée Conakry-une expérience d'organisation de mutuelles de santé en Afrique rurale. (Brussels: Medicus Mundi Belgium).

Standard Treatment Guidelines and Essential Drug Lists

The insurers may also lay down standard treatment guidelines for managing cases of specific conditions, particularly at the primary care level, where substantial scope for standardisation of diagnostic and treatment practices, as also referrals, could be perceived by the insurer. However, these practices have also borne their share of criticism in the managed care environment, where consumers believe that such guidelines encourage delay in ordering of expensive investigations and specialist consultations. Again, the cost-containment versus quality of service equation needs to be carefully balanced here too. The promotion of rational use of drugs is also often part of such guidelines, and even in India, such guidelines have been attempted even without the insurers being in the picture, e.g. by the Brihanmumbai Municipal Corporation.[11]

Reference price systems for pharmaceuticals is another, relatively new, cost-containment method wherein a cluster of similar drugs is associated with one specific price accepted by the insurer for reimbursement purposes.[12] Any prescribed drug, which is priced above this 'reference' price, if bought, results in the patient bearing the difference. This policy is meant to encourage patients to demand reference-priced drugs.

Another similar cost containment mechanism, which could be part of standard treatment guidelines also, is the use of an Essential Drug List, wherein the primary care level would be encouraged (or even compelled) to prescribe medicines from the Essential Drug list only, and any exclusions would need specific approvals or documentation. This, particularly when clubbed with a policy for prescription of Generic Drugs rather than branded medicines, can bring about substantial cost-containment. The essential drug strategy is supported by WHO, which states that careful selection of a limited range of essential medicines results in a higher quality of care, better management of medicines, including improved quality of prescribed medicines and a more cost-effective use of available health resources.[13] With scarce resources, insurers do need all the cost-effectiveness strategies they can gainfully employ.

Provider Payment Mechanisms

The manner in which healthcare providers are paid can significantly affect both the cost and quality of care, and in these ways helps in optimal use of resources.[14] Once a patient has taken the step of contacting the provider, it is thereafter the provider who determines, to a large extent, the demand for his or her own services, and the kind and quantity of treatment required.[15] Thus, the provider payment mechanisms determine the quantity of services consumed as well as their costs. They are an important component in the strategic purchasing of health services by insurers, with the other component being negotiating and contracting with providers so that they agree to provide health services according to the requirements and conditions of the insurer.[16] Negotiating and contracting have been discussed in another module.

It must be remembered that like any other provider of services, the health provider would also like to maximise his income. He could do this by attracting more patients, over-treating these patients, increasing the number of visits by the same patients, or by charging more for his services. The provider payment mechanisms chosen by the insurer must contain costs, but also give the provider an opportunity to earn

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[11] Express Healthcare Management. http://www.expresshealthcaremgmt.com/20021031/index.shtmlMCGM formulates Standard Treatment Guidelines for indoor patients. Oct 16-31, 2002. Mumbai, India.

[12] Carrin G, Hanvoravongchai P. 'Health care cost-containment policies in high-income countries: how successful are monetary incentives?' Discussion paper. WHO Geneva, 2002.

[13] WHO. http://www.who.int/medicines/areas/rational_use/en/index.html. Internet.

[14] Carrin G, James C. 'Reaching universal coverage via social health insurance: key design features in the transition period'. WHO, Geneva. Discussion Paper, 2004.

[15] Normand C, Weber A. Social Health insurance - A Guidebook for Planning. WHO and ILO, 1994.

[16] WHO, Geneva. 'Community based Health insurance Schemes in Developing Countries: facts, problems and perspectives'. Discussion paper, 2003.

a reasonable income to motivate them to provide quality services. Commonly used provider payment mechanisms are discussed below.

Fee-for-service

The providers are given a fee for each service, procedure or act provided to a patient. It provides an incentive to providers to provide health services, and this could be perceived as leading to better quality. However, this incentive effect could itself lead to overproduction of health services (supplier-induced demand), a tendency to reduce the time spent per activity and to encourage repeat visits as they generate fresh fee. It has been suggested that the overproduction can be counteracted by combining this mechanism with fixed fee schedules, ceiling budgets, or by co-payments for patients. By far, this is the predominant provider payment mechanism in our country, though it is also perhaps the most expensive, and has high administrative costs for processing claims and prevention of fraud.

Daily (per diem) payment

This is a simple and easy to administer method for inpatient treatment, but like the fee-for-service method, it has a weak capacity for cost-containment because there is a similar incentive to expand the length of stay of patients, and/or to increase the number of admissions. The hospitals also have an incentive to cut down on the inputs to limit their costs. Attempts have been made to provide a progressively reducing per diem payment, which could remove the incentives to prolong the inpatient stay. A ceiling budget for the hospital could also be used, like that in fee-for-service.

Case payment

This is based on managing the whole case, rather than a single act as in fee-for-service, and can be used for both ambulatory and inpatient care. The system is easy to administer, and could be a flat rate system where all types of cases are paid the same flat rate, or a system where the type of case determines the quantum of payment. An important example of the latter is the Diagnosis Related Group (DRG) payment method followed in many countries, where hospitals are paid an all-inclusive flat payment for a patient's treatment according to his/her diagnostic group. The system encourages efficient providers, but the effect could be offset by encouraging increased admissions and by the 'DRG creep', the tendency to record a more complicated diagnosis if that qualifies for a higher DRG slab. There could also be an incentive for providers to transfer the more complicated (and thus more expensive) cases towards other providers, particularly public providers, rather than managing them.

Capitation

Under the capitation system, providers receive payment according to the number of people served and cover services for each enrolled member for the entire enrolment period for a pre-specified sum. There is no incentive to provide excessive health services, but it could give rise to the opposite problem of potential underproduction. Further, referral of cases to higher levels of care could affect the potential of this method in containing costs. Competition amongst providers may also help lessen the problem of under-production, as providers' income is dependent on the number and type of people served and people, once given the choice to select their provider, are likely to enrol with the providers who provide due care. The administrative costs of this method are very low, and are especially suited in primary care settings.

Budgets

Budgets are the predominant method of funding the government health system in our country. As with capitation, there is no link between the quantity and mix of health services given to the individual patient and the total amount received by providers. However, if the budget is insufficient or utilised inefficiently, not enough services may be produced and this results in other providers having to provide the necessary care. Also, when budgets are not very strict, and as they are often based on historical costs, there is no incentive for providers to minimise costs, and there is even a perverse incentive to exceed the budget ceiling as it implies a higher provision in the next year. Underproduction and waiting lists are thus common where budgets are the sole mode of financing services.

Salaries

This is where the insurer employs personnel to provide health services and pays these personnel a salary, unlinked to workload handled. Here again, overproduction is unlikely but underproduction is, because fixed salaries may not provide sufficient motivation for sustained good performance. Administrative costs are low, but it may be difficult to encourage and retain good personnel. Ensuring variable, performance-related factors in the salary could be an important way of ensuring better quality.

Combinations of these payment mechanisms can also be attempted. For example, the NHS in the UK uses capitation for paying its general practitioners, but they are also paid fee-for-service for certain specified activities, bonus payments for certain performance targets etc. Different mechanisms can also be combined at different levels of care, to optimize the cost-quality balance.

Conclusions

The importance of providers in any health insurance system can never be over-estimated. Indeed, the very concept of health insurance is based on the availability of providers to meet the demand for care. As discussed above, providers have a major influence on costs as well as the quality of services, and so need to be carefully selected and subjected to appropriate guidelines and mutually negotiated terms and conditions, which could well be the foundation for a successful health insurance plan.

Exercise – empanelling providers

Now that you have decided on the benefit package and the premium, the next question is to identify the providers. In your region, there are government and private providers at the primary, secondary and tertiary level. Many of the government facilities have inadequate doctors, equipment and medicines. As an organiser of the insurance programme, please

1. Decide whether you will select public/private providers or both. And why?
2. Decide on the criteria for empanelling these facilities.
3. Decide on how you will pay the facilities.
4. Decide on measures to ensure quality.
5. Decide on measures to prevent cost escalation and fraud.
6. What are problems that you can anticipate when you try to introduce these measures?

Organising the Insurance scheme

Learning objectives

- To gain knowledge about the basic functions required to organise an insurance scheme
- To identify major activities involved in the administration of an insurance scheme
- To enumerate essential features of an insurance card
- To understand different techniques of claims processing
- To gain a working understanding of fund management
- Map out the design of the health insurance programme that s/he is developing
- Delineate the roles and responsibilities of each stakeholder in the programme

Materials required:

- ☐ Power point presentation on Administration
- ☐ Handout on Exercise 'Organising the Health Insurance programme'

Time Requirements

Presentation:	90 minutes
Exercise:	60 minutes

Note to Faculty

Most of the knowledge gained till now by the participants is primarily theoretical. If this chapter is well understood, the participants gain good knowledge on the practical aspects of health insurance. This helps them to implement the programme at the field level, which is one of the major objectives of this manual.

Care should be taken by the facilitator to address different issues even if it appears simple or obvious. Sometimes these factors can decide the success or failure of the health insurance programme.

This could be a boring session. The topic on administration is enough to put people to sleep. Try and make the class as interactive as possible.

Summary

Any insurance scheme needs an organiser who will ensure that there is an uninterrupted flow of resources between the various actors, e.g. from the community to the insurance company, from the insurance company to the provider and from the provider to the community.

Organising an insurance scheme is a complex task. To begin with, the organiser of the scheme needs to take the responsibility for the scheme. This is the entity that will finally be accountable for the success or failure of the scheme. To put it colloquially, "The buck stops here". Most successful health insurance schemes have a clear organiser, e.g. the ESI Corporation for the ESIS; the Yeshasvini trust for the Yeshasvini scheme, the State nodal agency for the RSBY scheme. Lack of an organiser has led to some schemes failing, e.g. the UHIS.

The organiser has many functions:

- Governance functions
- Management functions
- Administration functions
- Monitoring functions

A good example is the Yeshasvini trust that designed the Yeshasvini scheme. It convinced the cooperative department to insure its members and fixed the benefit package and the premium. It also negotiated with the government to subsidise the premium. It meets once a month and reviews the financial status of the scheme. It decides every year on the premium, depending on the previous year's experience. The day-to-day administration of the scheme is with the TPA.

Governance functions

The organiser has to have an oversight of the entire scheme. It should be able to engage all the stakeholders towards a common goal of providing affordable healthcare to the population. Thus it

should be able to balance the interests of the community, the providers, the insurance company, the local government and the donors (if any).

It is the organiser who will be deciding which community should be targeted, the overall design of the scheme and the extent of subsidies that will be made available. They also monitor the macro indicators like financial status of the scheme, the utilisation rates and any major grievances from the community or providers.

Management functions

There are some basic management functions that an organiser may do or may delegate it to another agency. These management functions can be broadly categorised as:

- **Creating awareness about the health insurance –** This is an important but oft-neglected function. The managers usually assume that the people are aware about health insurance and its complexities. But from our experience, even well educated people have basic doubts about health insurance. More details about this are given in the chapter on 'Creating awareness'.
- **Training the staff/community representatives –** Not only do staff need to be trained on the programme, they also need to be given detailed inputs about health insurance. This is necessary so that they are able to answer the questions posed to them by the community.
- **Negotiating with insurance companies –** Most insurance companies look at the scheme from their perspective, i.e. to make profits. So it is important that the community's needs and the organiser's requirements are also met. The organiser needs to read the fine print of the policy document very carefully before signing on the same. More details about this are given in the chapter on 'Negotiations'.
- **Negotiating with providers –** Here also, hospitals are usually only interested in increasing their bed occupancy and profits. Quality of care, access to healthcare and financial protection is secondary to them usually. Hence it is imperative that the organiser negotiates on behalf of the insured community to ensure that people get the benefits that they have contributed towards.
- **Fixing the benefit package and the premium –** This is an important part of the management function and should be negotiated between the community and the insurer. A balance has to be maintained between the community needs, technical requirements and affordability.
- **Marketing the product –** Marketing the product is different from creating awareness on health insurance. It is closely linked, but here the emphasis is on convincing the community to subscribe to the insurance programme.
- **Managing risks –** Any scheme needs to be self-sufficient. For this moral hazard and adverse selection need to be minimised. The organiser needs to introduce these measures so that the scheme is protected against bankruptcy.
- **Controlling costs –** Mechanisms to control costs need to be introduced into the programme right from the beginning. Different provider payment mechanisms like paying for DRGs, or capitation payments are useful in this matter.
- **Controlling fraud –** This is one of the banes of health insurance, especially in India. Measures to prevent fraud, especially by doctors and hospitals are required. For this the organiser needs to employ medical officers who will be able to see through the machinations of providers.
- **Redressing grievances –** This is yet another important function that is oft neglected. People need to air their grievances with the programme. This has two advantages – one, it makes the community feel in control of the scheme. And two, it gives the organiser insight into the performance of their scheme. Grievances can be useful in fine-tuning the programme over time.
- **Monitoring the programme –** Too many programmes in India are launched and then ignored. At the maximum, the organisers monitor the financial status of the scheme. However, it is important that the programme is monitored regularly – details are given in the chapter on 'Monitoring'.

Administrative functions

Administration is an important component in the smooth operation of the insurance programme. Once the insurance policy has been designed, it is the responsibility of a team of efficient administrators to implement the insurance scheme without any hurdles. Any insurance policy will typically involve a large number of people. Transactions take place at different places at different times. Documents need to flow smoothly between various stakeholders and financial details of each subscriber and of the entire policy need to be closely monitored. Hence, it is essential that a good administrative system is established and the various tasks involved at every stage are clearly articulated to the team members. Administration can take place with a team within the insurance company, or within the organiser. It can also be outsourced to third party administrators (TPAs). These are legal bodies that are registered with the IRDA and have the mandate to administer health insurance schemes.

In the next section, the word 'organiser' is applicable to the actual manager of the scheme or the insurance company or the TPA depending on the scheme and the context.

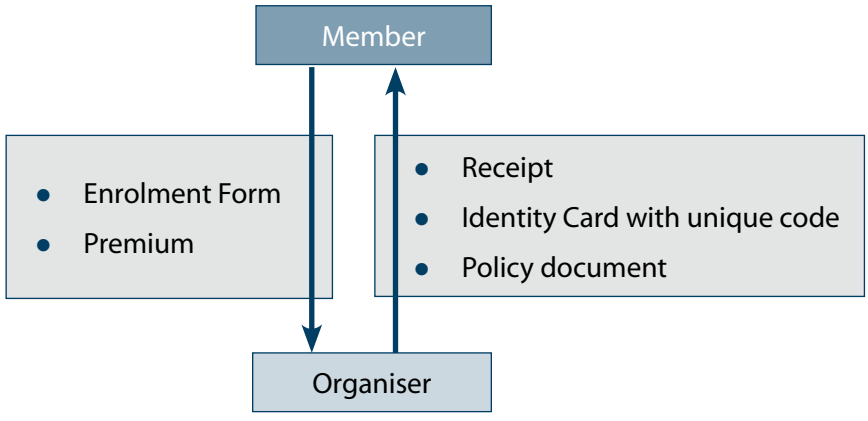
Broadly, the major activities involved in the administration of an insurance scheme can be listed as follows:

- Collecting premium
- Empanelling providers
- Authorisation of admissions
- Processing claims and reimbursements
- Managing Funds
- Personnel Management
- MIS Reports for Monitoring

Collecting Premium

Premiums are collected from individuals or from groups. Either way, there will be an Enrolment Form, which the potential insured person is required to fill. The organiser collects various details of the individual (and her/his family) through the process of filling the enrolment form. The profile of the members in terms of their age, sex, previous medical history, pre-existing illnesses, address, etc. are obtained in the enrolment form. However, in group memberships, there may be just one enrolment form for the entire group. Here just a list of the members has to be attached to this single form.

The enrolment form and the premium are paid to the organiser who in turn insures the individual/group. In the case of renewals, there is no need for a new enrolment form.



On receipt of the premium, the organiser is expected to issue a receipt indicating the amount of money received and the purpose for which received. A receipt is an important document because it is the primary document from which the subsequent transactions are triggered and the insurance coverage starts. The Receipt should clearly mention the name(s) of the individual(s), any identification code for the insured members and the date of the receipt of money. If intermediaries collect the premium from individuals and pay to the insurer, then the insurer while issuing a Receipt to the intermediary should attach the complete list of members on behalf of whom the premium has been collected.

Subsequently, the insured is given an insurance card with a unique identification code and other details, like address, age, gender, etc. The cards can vary from simple cards with just the names of the insured, to a photo id card, to a smart card. Remember that the more complex the card, the costlier it is and all this adds up in the premium. One has to balance the need for a card (to identify the patient and prevent fraud) with the cost of the card. The card should contain the following details:

- Name of the insured member (with photograph if required)
- Names of all the family members (in case of Family Units)
- Insurance identification code
- Name of the insurer and organiser (if they are different)
- Period of validity of the insurance policy
- Brief details of the policy – like claim limit, exemptions, etc.
- Signature of an authorised person (of the insurer or the organiser)

Finally the insurer should also issue a policy document that gives the details of the insurance scheme, the benefits, the validity period, the exclusions and any disclaimers.

The organiser should also maintain financial records of the amounts collected, and the number of individuals/families/groups insured as well as their details.

Empanelling Providers

The insurance team should negotiate with hospitals in the vicinity of the target population for treating patients under the insurance scheme. The team should ascertain the services and facilities available with the hospital in terms of qualified personnel (doctors, nurses, pharmacist, laboratory personnel, etc.), diagnostic tools/equipments and infrastructures like labour room, operation theatre, and separate wards for sick patients/infectious diseases, etc.

The insurance team should then negotiate the costs that the hospital will charge for the patients for various procedures and the treatment protocol for various diseases. Once the treatment procedures and the charges for the majority of the diseases are mutually agreed and standardised, then that hospital can be empanelled as a Provider under the insurance programme. The list of empanelled providers should accompany the policy document, so that the patient knows where to go when ill.

A small team in the hospital needs to be trained on the terms and administrative procedures involved in the insurance programme.

Authorising admissions

When the insured member becomes ill, s/he seeks medical treatment from an empanelled provider. In the case of a reimbursement mechanism, there is no need for pre-authorisation. The patient gets admitted, pays the bill and then gets reimbursed by the insurer. On the other hand, in the case of a cashless mechanism, if the provider feels that the insured patient requires admission, then it is expected to get a pre-authorisation from the organiser (be it the insurance company or the TPA).

The tasks involved in this activity are as follows:

a) Intimating the insurer or TPA: When the patient requires admissions, the provider is expected to immediately inform the insurer giving the following details:
   - Name of the insured patient with the Identification code
   - Preliminary diagnosis
   - Approximate admission costs.

b) Authorisation: The insurer/TPA has one of two options – it can authorise the admission or it can reject the request. The latter is done usually for the following reasons:
   - The disease for which admission is sought is excluded from the benefit package.
   - The patient has exceeded the upper limit available under the policy.

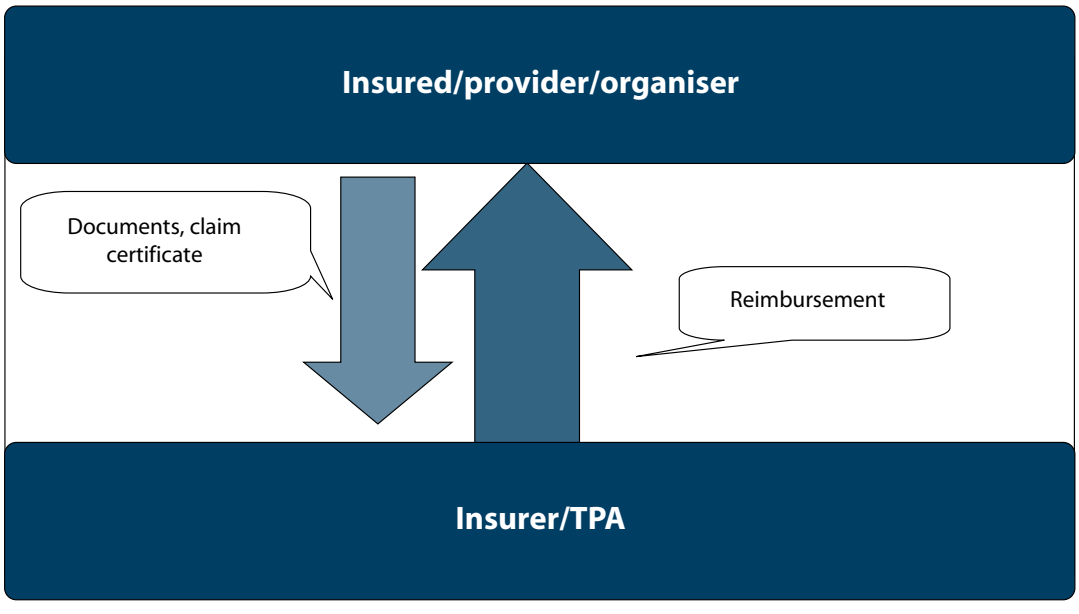
If the patient receives the authorisation, then s/he can get admitted and leave the hospital without paying any amount (provided that the final bill is less than the sum assured). On the other hand, if the authorisation is refused, then the patient can either opt out of the treatment or can get treated and pay the money from out-of-pocket. Usually the authorisation includes the permission for the provider to treat the patient and the maximum amount reimbursable by the insurer for this treatment.

Processing of claims

There are two common routes for receiving claims. One is from the provider (in a cashless system) and the other is from the individual insured patient. Sometimes (as in SEWA or ACCORD), the organiser submits the claim to the insurance company on behalf of the patient. In either case, the insurer/TPA will review the following:

- Confirm the identity of patient
- Confirm whether the patient had a pre-authorisation
- Confirm whether the patient was admitted during that period
- Assess the diagnosis and the appropriateness of the treatment
- Assess the cost of treatment

FIGURE 13: The processes for claims and reimbursements



The documents required will vary from scheme to scheme, but usually the minimum required are:

- The id number
- The discharge summary, hospital bill, prescriptions, laboratory reports, medical and laboratory bills – all original documents

If all are acceptable, then the insurer will reimburse the amount to the insured/provider/ organiser.

Managing the Funds

The insurer ideally should have the financial systems to manage the funds received as premium from the members and keep track of the claims and reimbursements made to individual members. To put it simply, the insurer receives funds from all the Members initially and then reimburses their expenses from this pool over a period of time as and when claims are received. In the case of a group policy, the role of the insurer is more or less like a bank, which receives funds initially and returns it back to the intermediary over a period of time. Hence, the insurer needs to have good systems for fund management. The following tasks are involved in the management of funds by the insurer:

a) Budgeting the administrative expenses: The insurer will be incurring administrative expenses in terms of salaries of personnel, overhead costs like telephone and other office expenses, etc. It is important that a budget is prepared for these expenses and they are monitored to see whether they are within the estimates.

b) Estimation of Cash flow: The insurer's main task will be to estimate the cash flow and estimate the possible outflow of funds. If the Members/providers/ intermediaries are expected to send the claims on a monthly basis, then the insurer should also try to make the cash flow projections on a monthly basis, taking into account the administrative expenses.

A format for the projected cash flow is suggested below.

Particulars	Jan	Feb	Mar	Apr
Opening Balance				
Add				
Premium Received				
Interest on investments				
Withdrawn from investments				
Total Funds				
Less				
Reimbursements expected				
Administrative expenses				
Investments made				
Closing Balance				

At least on a monthly basis, the actual figures need to be filled in this format and the cash flow projection needs to be reworked for the subsequent months.

c) Investing Funds: Depending on the cash flow projections, the unutilised funds available with the insurer should be invested in banks/other options. The interest earned from such investments will be a significant income for the insurer and should be aimed to meet a significant portion of the administrative expenses of the insurer.

Personnel Management

Composition of the team

As mentioned before, a multi-disciplinary team of people is required to administer the insurance programme efficiently. The services of the following personnel are required by the administrative team of the insurer:

- **Medical Professionals:** The terms of the insurance policy may involve details of diseases that are covered/exempted and hence inputs from a doctor are essential while processing the claims. Similarly, the treatment given for the members and the costs incurred need to be vetted by a qualified medical professional. The insurer may do well to have broad parameters for monitoring the claims in terms of the prevailing diseases, incidence of a particular kind of illnesses, average costs for different categories of procedures, etc.
- **Actuarial/insurance professional:** When the insurance policy is designed, the company is expected to do an analysis of the historical data with respect to prevalence of diseases among the insured population, historical data of charges prevailing in the various hospitals/providers, the expected rate of claims, etc. As the policy gets underway and the company starts receiving the claims, an analysis of the actual data compared to the earlier estimates shall be done by the Actuarial/insurance professional on a monthly basis to ensure that there is no malpractice or flaw in the programme. This close monitoring will help design the policy for subsequent years.
- **Finance/Programme Manager:** The profitability of the insurance programme depends on the fund management efficiency of the insurer as well. The company will have invested the unutilised funds in short-term/medium-term deposits and the interest income is crucial for the programme. So, the finance/ programme manager should keep tabs on the funds situation on a regular basis and make suitable investment decisions. The cash flow projections made at the beginning of the policy period shall be revisited at least on a monthly basis. The administrative expenses also will have a bearing on the cash flow of the programme and hence the finance manager will monitor these expenses as well.
- **Legal Professional:** The insurance policy issued at the beginning of the policy period is a legal document and hence needs to be drafted according to the existing laws that cover insurance. The inputs of a legal professional, particularly well-versed with medico-legal cases, will be useful. Similarly, if there are any disputes regarding claims and reimbursements between the insurer and the Members/Providers, one party may resort to courts to settle the disputes. Hence, it is important to keep a legal professional also as part of the team and get all the documents approved by her/ him.

Exercise – Organising the health insurance programme

Identify the organiser and then make a list of the roles and responsibilities of each of the actors in your health insurance programme.

Monitoring

Learning objectives

- To be able to understand key monitoring indicators
- To be aware of data required to calculate key monitoring indicators

Materials required:

- ☐ Power point presentation
- ☐ Exercise on 'Monitoring' as a handout (hard copy and soft copy (on a pen drive)

Time Requirements

Presentation:	45	minutes
Exercise:	45	minutes

Note to Faculty

For any programme to be successful it is important to develop monitoring indicators during the planning stage itself. Many implementers introduce monitoring retrospectively but the knowledge gained is not adequate. Monitoring helps to avoid systematic flaws and facilitates sustainability as well as upscaling of the project. If a project is well monitored, the chances of success are high and the chances of repeating mistakes during replication and upscaling are low. Help participants to do basic calculations. Some time should be spent on practical exercises.

The progress of the insurance programme should be monitored/measured on different parameters.

Monitoring Indicators

The most important indicators that need to be analysed regularly are:

- **Coverage rate -** Percentage of people insured from the target population. Even in some of the best schemes, the coverage rate ranges from 30–50%. Only in mandatory schemes or in GHI does the coverage reach 75–100%.

$$\frac{\text{Number of people / families who have enrolled during a definite period}}{\text{Total number of people / families who are eligible to enrol}} \times 100$$

- **Renewal rate –** Proportion of people who were insured in Year 1 and who renewed in Year 2. This is a good proxy indicator of the quality of the insurance programme. Good schemes have a renewal rate of about 50 per cent. This indicates that people are happy with the scheme and are willing to rejoin it.

$$\frac{\text{Number of people who were members in Year 1 and also in Year 2}}{\text{Number of people who were members in Year 1}} \times 100$$

- **Utilisation rate -** Percentage of people who had accessed healthcare. This depends on the benefit package. For general hospitalisation – the rates range from 2–4%. In rare cases, it can be as high as 7–10%.

$$\frac{\text{Number of insured patients who used the services}}{\text{Total number of insured individuals}} \times 100$$

- Profile of the people who have accessed healthcare – region wise, village wise, community wise, social and economic group wise. This is important to assess the equity in accessing care. There may be instances where the better-off have accessed the scheme more than the poor. Or those near the hospital have used the hospital more than those in the remote areas.
- Monthly progress of the claims and reimbursements sent by different providers (if there are more than one), indicating the number of claims and the amounts claimed/ reimbursed. This is important to see the cash outflow and to watch out for sudden increase in claims – either numbers or amounts.

- **Claims Ratio -** The ratio of the amount of reimbursements made to the total premium amount received by the provider. This gives a financial overview of the scheme, whether it is viable or needs to be modified.

$$\frac{\text{Total amount of claims made}}{\text{Total amount of premium collected}} \quad \text{X } 100$$

- **Status of the insurance fund –** A kind of income and expenditure statement, indicating the cumulative premium amount collected under the scheme, reimbursements made, the administrative expenses incurred and the interest income earned.
- **Liquidity Status -** The liquid cash available in the insurance fund at the end of every month (that has not been invested in any instruments/banks). A ratio of this amount to the average claim amount per month will give us the number of months the fund can service the claims.

$$\frac{\text{Available cash}}{\text{Short term payables (e.g. 3 months)}}$$

- **Report of the rejected claims –** Reasons for rejection and the claim frequency. An analysis of this report will help the insurer plan an awareness campaign either among the Members or among the hospitals about the provisions of the insurance scheme.
- Profile of the diseases with which the insured members are getting admitted and the average costs of treatment.
- If there is more than one provider, then a comparative statement showing the number of members accessing healthcare, the profile of diseases and the costs of treatment across different providers will be a useful management information report.
- **Promptness of claims settlement –** This gives an idea about the efficiency of the insurer. Many schemes have suffered from delays in reimbursing the patients/ providers leading to loss of the scheme credibility.
- **Solvency ratio –** The assets divided by the liabilities of the programme. It indicates the financial strength of the insurance programme and its ability to pay its obligations now and in the future.

$$\frac{\text{Admitted assets}}{\text{Liabilities}}$$

Through a good Management Information System, periodic reports should be generated to show the latest status of these parameters and if required, any corrective steps can be taken. The insurer and the intermediaries will have all the required data and these reports can be generated from the data.

Data to be collected

To monitor the above-mentioned indicators, one needs to collect the following data:

Table 7: Data to be collected with frequency of collection

Data to be collected	Frequency of collection
Total number of people eligible for enrolling	Annual
Total number of people enrolled	Annual
Total number of people who renewed	Annual
Total number of people who utilised the services	Quarterly
Total amount of premium collected	Annual

Data to be collected	Frequency of collection
Total amount of claims disbursed	Annual
Total amount of claims rejected	Quarterly
Time between claims and reimbursement	Quarterly
Assets	Annual
Liabilities	Annual
Available cash	Monthly
Amount of claims	Monthly

Monitoring Mechanisms

One needs to constitute a Monitoring Cell or an insurance committee at the District and/ or State level to look at the MIS reports so generated by the insurance team on a regular basis. Any regional imbalances, shortfalls in the utilisation of healthcare, high claims ratio, suspected malpractices by some providers, etc. can be picked up by this monitoring cell and suitable instructions/suggestions can be passed on to the concerned insurance team. The monitoring cell can then submit a monthly/quarterly report to the Governance cell for their information and action.

Exercise – Monitoring a health insurance scheme

Out of a population of 7,20,000, 48.3 per cent were females. Of these, 30 per cent were in the reproductive age group. A Health Insurance scheme was devised by an NGO exclusively to provide hospital services for women of all socio-economic groups at Rs.150/person/year and renewal at Rs.100/person/year. In the first year, 10,312 women enlisted. Of these, 379 claimed insurance in the first year of which 12 were rejected. The total claims reimbursed in the first year were Rs. 19,81,800. The next year there were 4,500 renewals and 5,367 new enrolments.

Answer the following questions.

1. What is the total number of females in this population?
2. What is the total number of women in the reproductive age group?
3. What was the coverage rate? What could be the reasons for this coverage rate?
4. What percentage of insured women claimed insurance in the first year?
5. What is the claims ratio? What are the possible reasons for this claims ratio?
6. What percent of enrolments were renewed in the second year? Any reason for this enrolment rate?
7. What should the organiser do to make the scheme sustainable?

Negotiations and contracting

Learning objectives

- To incorporate basic components of effective negotiation into the learning process
- To gain an in-depth knowledge of the legal aspects of health insurance
- To learn about the four key principles of a health insurance contract
- To know the content and importance of the health insurance contract with relevant examples of each

Materials required:

- ☐ Power point presentation on 'Negotiating and Contracting'
- ☐ Handouts for the exercise "Negotiating' either as a hard copy (handout) or a soft copy (on a pen drive)

Time Requirements

Presentation:	30 minutes
Exercise:	60 minutes

Note to Faculty

Participants must understand that good negotiation means a 'win win' situation for all stakeholders. This goes a long way in ensuring the success of the programme because a common goal is developed by the different stakeholders. Since large sums of money may be involved, understanding legal terms and contract procedures are very important for the participant. This chapter may be dry, but the facilitator should try to make it as participatory and interesting as possible.

The trainer should also emphasise to the participants that they should go back and refresh their memory by reading the relevant chapters from the Training manual.

SUMMARY

NEGOTIATING AND CONTRACTING

Need for negotiation

Negotiation ensures the best possible deal with both the insurance company and available providers.

Art and Skill of Negotiation

This includes:

- Preparation – for a realistic assessment of what can be achieved
- Build trust – by honouring commitments, and no attempt to mislead or deceive with any tricky statements
- Effective communication – Listen to the other party and keep it cordial. Avoid negative attitudes.
- Creating a win-win situation – the other side is a potential partner, not an adversary. Both parties must feel it is a fair deal.
- Take a break – if negotiation is blocked, take a break and come back to it later.

Introduction

The planners of an insurance scheme will need to engage in a process of negotiation, or at least a discussion, with a multitude of stakeholders, including insurers and/or reinsurers for the scheme, the providers, and perhaps also with the government, community bodies, organised groups of potential members of the scheme, etc. The outcome of most of these negotiations is also likely to include a written documentation of the understanding arrived at. As part of the design or structure of the scheme, there will also be need to enter into contracts with the insurers, reinsurers, providers, members/beneficiaries of the scheme, etc., which implies that the planner of the scheme needs to be aware of the basics of negotiating and contracting as relevant to the field of health insurance. This, precisely, is the subject matter of this module.

Need for negotiation

The need for negotiation for the planner of a health insurance scheme is pretty much obvious. This negotiation could be about securing the best possible deal with the chosen insurance or reinsurance company, which provides the scheme with maximum value at the lowest possible cost. Alternatively, it could be about negotiating with the available providers in the community, to secure their support for provider payment mechanisms which are more favourable for the scheme. Sometimes, the negotiation could be with the government itself, for direct or indirect support to the scheme, for example, as a grant or subsidy to the scheme, or for favourable tax treatment. Similarly, there could also be the need to engage into a dialogue, which effectively would tantamount to negotiation, with the organised groups of the intended beneficiaries, to understand their needs from the scheme and to design a structure which meets their needs at costs affordable for them, while also addressing the concerns of the planner of the scheme.

The Art and Skill of Negotiation

While a detailed discussion on the art and skill of negotiation is beyond the scope of the present training, our discussion would be incomplete without laying down the ground rules and handy tips for effective negotiation.

Preparation

Preparation is the key to a successful negotiation. Before starting with the negotiation, it is essential to acquire all relevant information, and also some clarity on what we expect as an outcome of the process. In fact, even this expected outcome can be graded, with careful preparation and planning, as to what the best possible outcome from this process is, what is the least that we are expecting from this process without which the exercise would be useless, and finally, something in between - what is a more realistic assessment of what can be achieved as an end-result of this process. To be able to arrive at these conclusions, it is important to understand the context of the other party, their expectations, needs and concerns. Then attempt to find a common point where the needs of both sides converge.

Build Trust

The second key requirement is to build trust. It is important to honour any commitments, as we are building a long-term relationship - and so make commitments only when they can be achieved. There should be no false promises or assurances, and maintaining a true and fair stand is important at all times. There should be no attempt to mislead or deceive with any tricky statements, as that may sometimes yield an apparent short-term success, but at the cost of the relationship itself, which is too high a cost to pay.

Effective communication

Effective communication comes in next. Listen to the other party, avoid confrontation, and keep it cordial. In long-term relationships, like a health insurance plan for the community, even the process of negotiation could have an effect on the relationships between the stakeholders. Negotiations conducted with hostility, disrespect, confrontation or contempt can seldom build long-term relationships, and these traits are to be avoided at all costs.

Creating a Win-Win Situation

The other side in a negotiation is not an adversary - rather, in the health insurance context we are negotiating with potential partners. It is therefore, important to create a situation where both parties are able to 'win' the negotiation, creating a win-win situation. Such a 'win' for either party should be viewed as an outcome anywhere in the

acceptable range, between the minimum acceptable outcome and the most desirable outcome. To create a win-win situation, it is also important to realise where to stop negotiating, as continuous 'pushing' for concessions will work only till a point, beyond which they may be counterproductive. The best outcome of a negotiation is a mutual agreement, which is acceptable and comfortable for both parties, where both parties perceive it as a 'fair deal' and walk out with a smile.

Take a Break

Finally, if a negotiation does not seem to be working, take a break, and try again later. A polite exit to "think it over" is a strategy that leaves scope for future agreement on the issue. It is certainly better than any recourse where future options stand closed. So, once we have had a successful negotiation with another stakeholder, it is time to write it down and formalise the understanding. The next section of this module deals with the role and characteristics of contracts in the health insurance sector.

Legal Framework of health insurance

Defined from a legal perspective, "insurance in itself is a contract, where one party (the insurer) agrees to pay a defined amount of money or to provide defined services if a covered loss occurs during the term of the insurance policy, in return for a consideration, known as the premium."[17]"

However, laws pertaining to the insurance contract have evolved over time, which has largely been driven by the information asymmetry in the insurance market. This information asymmetry actually works both ways between the insurer and the insured - the technical and legal intricacies of the policy document may be incomprehensible for the insured, while the insurers can also be misled, or taken unfair advantage of, by insured persons, due to adverse selection and moral hazard problems, which have been discussed in an earlier chapter. Legal aspects of the insurance contract largely aim at minimising at any unfair advantage being taken by one of the parties to the contract. These legal aspects include the regulatory framework for insurers (IRDA Act, for example) and the insurance contract itself. In this section, we shall attempt to learn more about the health insurance contract and its specific features.

Growing complexities of the health insurance market and various court decisions regarding insurance contracts, have all contributed to the contract document becoming highly technical and also exhaustive (which could be quite exhausting for a layman!). While it is desirable that the insurance clauses be kept to the minimum and the simplest possible in the interest of the policyholders/beneficiaries, often this simplest possible is also not simple enough. There have been statutory provisions towards this cause, like the Life and Health insurance Policy Language Simplification Model Act in the US.[18] However, simple and easy health insurance contracts are easier said than done, due to the inherent complexities of the subject matter of insurance. This is because, in the health insurance contract, there is a wide spectrum of the nature of losses, which in turn could also be interlinked to a varying degree, and losses could also occur any number of times during the period of the contract, and finally, the cause, extent and costs of the loss are a highly subjective issue. To illustrate this, it is worth mentioning that one health insurance policy issued by a prominent non-life health insurance company in India has a policy document which runs into 17 pages of printed text.

Principles of Health insurance contracts:

The four key principles of health insurance contracts are similar to those in other insurance contracts, and are briefed below:

[17] Black K, Skipper H. Life and Health insurance, 13th ed. Pearson Education, USA. 2000.

[18] Internet- www.niac.org

Utmost Good Faith:

Each party to the contract is entitled to rely upon the disclosures and representation of the other party in good faith, and neither should attempt to mislead or to take unfair advantage of the other by virtue of its having prior knowledge of superior information about a certain material aspect of the contract.

Indemnity:

Upon suffering a covered loss, the insured is entitled to receive a compensation from the insurer, which would make good in full or in part the loss suffered by the insured, but would not place the insured at an advantage over his/her pre-loss position.

Insurable Interest:

The insured should have an insurable event in the subject matter of insurance, i.e. the insured must suffer a loss if the insurable event takes place, or the insured continues to receive financial gain by the non-occurrence of the event. Insurable interest does exist in the case of one's own illness or that of a close member of the family.

Proximate cause:

The loss should be directly caused by a covered peril, and should not be due to a peril which is not covered. For example, if complications due to HIV positive status are not covered in the insurance, costs incurred on opportunistic infections occurring because of the immuno-compromised state in HIV will also not be payable by the insurer.

In the legal parlance, health insurance contracts are aleatory, wherein the element of chance exists and eventually one party may receive more in value than the other. They are also said to be conditional - the insurer's liability to cover the risk depends upon the fulfilment of certain conditions, like punctual/unbroken payment of premiums, on the part of the insured. They are also unilateral, in that only one party, the insurer, gives a legally enforceable promise - the insured makes no legally enforceable promise to pay premiums, but timely payment of premiums is the condition for the insurer honouring its obligations under the contract. The contract is also often one of adhesion - where the terms and conditions are fixed by one party (the insurer) and are accepted by the other party (the insured), though this could be customised to the needs of a large client, for example, a large group seeking insurance.

Contents of the health insurance contract:

While the content of the health insurance policy will broadly depend on the scheme and the nature of cover offered, certain common characteristics hold true in most health insurance policies. For example, in a bid to contain moral hazard and adverse selections, the contracts include a number of exclusions, which have a bearing on the benefits ultimately available under the scheme. Also, as many of these clauses could go unnoticed by the insured persons as 'fine print', when such clauses result in denial of claims by the insurer, there could occur a sense of betrayal and loss of faith in the scheme itself. Therefore, it is important to be aware of these clauses, so that they could either be negotiated with the insurers and taken off, or otherwise should be appropriately made known to all the intended members of the scheme.

Common examples of such clauses to contain adverse selection and moral hazard, or for cost-containment, which are included in health insurance contracts, are:

- Clauses for exclusion of pre-existing conditions: The excluded pre-existing conditions could include those disclosed by the insured at the time of the proposal for availing insurance. These could also include conditions not disclosed at the time of proposal, but later found to already exist at the time the insurance cover began to operate. Certain policies do cover even pre-existing conditions at a

higher premium, or after a particular period (for example, ICICI Lombard covers pre-existing diseases after 4 years of consecutive renewal of the policy[19]).

- Waiting Periods or Elimination periods: Certain diseases may not be covered in the first few days, months or years of commencement of the policy. The insurer may also not cover the illnesses requiring hospitalisation lesser than a particular length of time specified in the policy.
- Maternity: Expenses are a common exclusion, though these are covered on payment of additional premia, or under group plans where adverse selection can be avoided.
- Certain Diseases or conditions (e.g. HIV-related illnesses, STDs, Mental Illnesses, etc.) may be specifically excluded under certain policies
- Self Induced Damage or Sickness is a common exclusion
- Substance Abuse: including alcoholism or drug addiction, is also a common exclusion in many policies
- Medical care required due to an act of war or civil commotion is often excluded.
- Certain types of care, e.g. dental, ophthalmic, cosmetic surgery, hormone replacement therapy, etc. may be excluded from the scope of the cover.
- Certain devices or prosthesis may also be excluded, e.g. spectacles/contact lenses, hearing aids, dentures, etc.
- Individuals engaging in certain occupations or activities may also be excluded from availing of cover under the policies, for example, military service, adventure sports, airline crew, etc.

These clauses should be well understood by the planners of the scheme, and also made known to the members of the scheme, as discussed above.

In certain countries, due to the regulatory framework, the policy document could also include provisions for the protection of the policyholders, for example, from non-renewal of policy or from arbitrary hike in premia, as otherwise these could be used by insurers for cream skimming. Thus, the policy could provide for an obligation to renew the policy, provided the insured is not deficient in discharge of his duties like the timely payment of premiums, though renewability could be subject to a restriction up to a specified age. Similarly, there could be provisions for protection from arbitrary hikes in future premia for such renewable insurance - such premiums could be constant or level premiums, or these could be modifiable but subject to regulatory control thereupon.

Similarly, where specific provider payment mechanisms are proposed to be employed, fairly detailed contracts will need to be drafted and used by the insurance scheme with its provider network. Even today, such contractual relationships do exist between third party administrators (TPAs) and the medical providers on their network, which provide for, inter alia, payment terms, discounts, billing procedures, payment cycle, fraud prevention measures, reporting requirements, etc.

Conclusions

To sum up, while negotiating and drafting/vetting contracts could be resource-intensive activities, they are well worth the effort that goes into them as these provide the basic foundation on which the future operation of the health insurance scheme will depend. Appropriate external legal support may also be considered as an option where the requisite expertise is not available within the core group implementing the health insurance plan.

[19] Internet- http://icicilombard.com/app/Personalproducts/Health/10KTax.asp

Exercise – Negotiating and contracting

Read through the policy document below and comment

Health insurance policy for a community health insurance programme

Cover – Hospitalisation

Benefits: Standard hospitalisation Cover up to Sum Insured.

- Pre- and post-hospitalisation covered for 30 and 45 days respectively
- Charges payable under hospitalisation cover
  - Room/bed charges
  - Professional fees
  - Investigations
  - Medicines including oxygen
  - Ventilator charges
  - Consumables during hospitalisation
- Pre-existing diseases covered
- Maternity is covered only for proven complications which requires C-section with sub-limit of Rs. 4000/-
- Fixed Travel cost of Rs. 300 per hospitalisation
- Daycare procedures are covered.
- Cashless hospitalisation in network hospitals only, reimbursement mechanisms only in case of emergency.
- 20% co-payment in case of treatment in private hospital.

Sum Insured: Rs. 15,000 on Family Floater basis

Other Features

Admissions only in General Ward

Both Government and Private hospitals

Eligibility Criteria - Residents of a particular state, family maximum of 6 members would be covered on family floater basis (Self, spouse, 2 eldest dependent children and parents)

Premium

Option 1 for the sum insured up to Rs. 15,000

Rs. 130 per individual (Rates exclusive of Service Tax)

Option 2 for the sum insured from Rs. 15,000 up to Rs. 30,000 (all other features remaining the same)

Rs. 180 per individual (Rates exclusive of Service Tax)

Proof of Identity to be produced for claims processing: Ration Card, driving licence, voter ID card, etc.

Enrolment for the Scheme

To be managed by GTZ/local organisations

80 per cent of the total population of the gram panchayat must be enrolled to avoid adverse selection.

This would include filling of application forms, premium collection and distribution of cards. Premium to be paid upfront.

Servicing of the Scheme

List of all applicants along with details of all covered family members would be sent to Insurance Company in soft copy before commencement of the cover.

On payment of premium, a health card will be given.

Insurance Company In House Claims Management Team will service claims arising out of the policy.

Claim servicing

In case of network hospitals

In the event of planned hospitalisation, the insured will get in touch with the Hospital and the Hospital in turn will contact the in-house CMT. The CMT will issue an approval letter to the hospital. The insured will avail of treatment and at the time of discharge he/she will sign the required documents and the CMT will settle the bills with the hospital later.

In the event of an emergency, the insured will first be admitted to the hospital. After admission, the patient's relatives/friends will produce the health ID card. Then the Hospital would get in touch with CMT. The CMT will issue an approval letter to the hospital and at the time of discharge the patient will sign necessary documents. The CMT will settle the bills with the hospital later.

In case of non-network hospitals

In the event of planned hospitalisation, the insured will avail of the treatment and at the time of discharge will settle the bills with the hospital. The customer will forward these bills to the CMT for reimbursement along with the ID proof through local representative.

Role of Local organisations

- Responsible for smooth functioning of the scheme
- Distribution of promotional material and awareness-building activities
- Collection of Premium
- Selection of hospitals for empanelment
- Monitoring of the scheme

Role of Insurer

- Provide Risk Coverage as per policy terms and conditions
- Provision of services as defined under the insurance policy
- Issuance of ID Cards
- Claims administration and disbursement of claim amount

Exclusions as per standard group health insurance

the expenses on treatment of diseases, or illness such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal Diseases, Fistula in anus, piles, Sinusitis and related disorders during the first year of operation of this policy. If these diseases or illnesses are pre-existing at the time of proposal, they will not be covered during subsequent renewal of the policy.

Diseases, illness, accident or injuries directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war-like operations (whether war be declared or not).

Circumcision, whether or not necessitated by vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery unless necessary for treatment of a disease not excluded by the terms of the policy or as may be necessitated due to treatment of an accident.

The cost of spectacles and contact lenses, hearing aids.

Dental treatment or surgery of any kind unless requiring hospitalisation.

Convalescence, general debility, run-down condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury (whether arising from an attempt to suicide or otherwise) and use of intoxicating drugs and/or alcohol.

All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV .III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-Ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any diseases, illness or injury whether or not requiring Hospitalisation/Domiciliary Hospitalisation.

Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Medical Practitioner.

Diseases, illness, accident or injuries directly or indirectly caused by or contributed to by nuclear weapons/ materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.

Treatment arising from or traceable to pregnancy, childbirth, including Caesarean section.

Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.

Naturopathy treatment

Creating awareness

Learning objectives

- Identify and understand the key messages that need to be shared with the community.
- Be able to explain the value of Health Insurance in monetary and non-monetary terms

Materials required:

- ☐ Power point presentation on 'Creating awareness'

Time Requirements

Presentation: 30 minutes
Exercise: 60 minutes

Note to Faculty

The participant should be able to understand and explain to the community the principles and benefits of health insurance. People have to make informed choices as this avoids a loss of trust in the scheme at a later date when actual facts are disclosed.

Introduction

One of the most important aspects of any successful health insurance programme is the number of enrolments. As the old saying goes, "More the merrier". But how does one ensure adequate enrolment for a programme to be an economically viable process?

So what does a manager of an insurance programme do to ensure this? Very simple mantra… talk to people …Listen to what they want …Accommodate their needs …And let them know about what is that you are offering …Tell them in many ways so that your messages go out loud and clear.

Conceptual Messages

- Health events are unpredictable. Health insurance is a tool to handle unpredictable health events - therefore by taking health insurance a family can plan for this unpredictability and be prepared to face the health event.
- Health events are costly - A family may not always have enough money to pay for a health event as healthcare is expensive. The burden of paying a large sum of money for treatment can thus be reduced with a health insurance cover.

The principles guiding health insurance

The two principles underlying the concept of health insurance are 'risk pooling' and 'community solidarity'.

- The families in a community contribute an amount of money towards health insurance. Together this will form a large pool of resource. In case of an event of illness a family can take a share from this pool. Because of risk pooling the burden on individual families comes down enormously, both financially and emotionally.
- The families contribute to this pool of resources with a sense of solidarity towards each other. By making a contribution they are asserting the fact that they would stand by each other in times of need.

One common wrong message that is given is "if you pay Rs X, you will get a benefit upto Rs Y". Naturally people pay and then expect this benefit either in cash or kind. At the end of the year, when they do not receive it, they are disappointed and frustrated. So the cardinal message should be changed to the following:

"If you pay Rs X, we can assure you that you will sleep peacefully, because you will not worry about medical expenses"

Administrative Messages

These messages directly relate the insurance programme. The questions usually pertain to the

- Amount of premium to be paid
- Benefits that can be availed
- Hospitals where benefits can be availed
- Who are eligible to enrol
- Why some ailments are excluded
- How I will get the benefits?

Try to picture this scenario.

If you went into a house in a village 25 years ago, what would you see? Bags of grain? Straw mats? Banana leaves to eat on? Local beedies?

Imagine entering a house in a village now – what would you find? A television set? A sofa? Plates to eat in? Commercial cigarette packs?

What is the reason for this difference? Is it because needs have increased? Or is it because people's perception of their own needs has increased?

Spend a moment to think about why products are being manufactured and sold in spite of not really being necessary.

The reason is simple – effective marketing!! Commercial products reach the market because of aggressive marketing. Some of the same principles can be applied to social marketing. Social marketing is defined as 'using marketing principles to influence human behaviour to improve health or benefit society'. One does not have to be an expert at marketing to reach the product to the target audience, but one would definitely benefit from applying simple techniques during product introduction.

1. Understand your target group. For this you need basic data on what is available within the community and what is perceived to be a lacuna. For example, there may be an area where several pathology laboratories are providing basic laboratory services. The population in this area may not feel the need to go to a centralised point to obtain laboratory services even if they are slightly cheaper or of better quality, so if you are trying to market a product for a community from a centralised laboratory, there may not be many takers.
2. Have specific objectives about what you want from the target group. If your aim is to start a Health Insurance programme, you should communicate effectively all the details of what the target group has to do. This sometimes is a big barrier to implementing a programme. People may be ready to enrol in a programme, but if the steps of initiation are not clear, you may wait forever for them to enrol. The awareness you raise should be action oriented. Having a clear policy on steps to be taken by the target population and widespread dissemination of that knowledge is important.

3. Ask yourself one question: "Would you buy the Health Insurance programme if you were marketing it to yourself?" Would you choose a relatively new option over other tried and tested options? It is important to offer the population something that they are willing to pay for because they BELIEVE that it enhances their life in some way, or will offer them a measure of relief in a potential crisis. Your product must offer a reason for people to invest.
4. Be aware – you must be aware of existing laws and policies and other competitive offers of a similar nature. Once you are aware, you are more likely to offer a product that lies within a legal framework while offering more than another similar or lesser-priced product.
5. The four Ps of marketing are Product, Price, Place and Promotion. Use this wisely to obtain the fifth and sixth Ps – Performance and Positive outcomes.

The steps of this process of social marketing are:

1. Do a SWOT (Strengths, Weakness, Opportunity, and Threat) analysis of your product. Discuss with your team how to enhance the strengths, minimise the weaknesses, utilise opportunity to the maximum and reduce threats to a minimum. Identify staff with specific skills to address issues and put them on the job.
2. Conduct a market research – Your target audience is like an unknown entity. Beware of making too many assumptions. Find out how the intervention you envisage, adds value or reduces costs to your target audience. Can you really bring about the change you hope to? If you have doubts, revisit your programme, even at the cost of annoying your funding agency or boss!!
3. Create a strategy. Taking an idea and jumping into a community with it is equal to a recipe for failure. Your time and money are not worth investing if you do not have clear-cut plans to maximise your outputs. Allocate resources, set timelines, ensure legal factors, and then go into the community.
4. Identify other players – Choose key stakeholders carefully and they will support you and carry you through bad times, choose bad stakeholders with a 'hidden agenda' and you may find yourself in a mess difficult to get out of. Using the media, Government, elected representatives, leaders and other publicity sources can enhance uptake of your product.

Proposal writing

Learning objectives

- To create a proposal for health insurance by the participants as a practical exercise
- To identify barriers and facilitating factors within the participant's area of work to implementing an effective Health Insurance programme

Materials required:

Time Requirements

Preparation of the Health Insurance programme: 3 hours
Presentation: 2 hours

Note to Faculty

This exercise is extremely important and will give the participants specific skills for implementation of all the knowledge acquired during the training. It also gives the participants a sense of confidence of being able to implement the programme in their own communities. It helps them to structure all the steps before implementation like raising awareness, empanelling providers, governance and monitoring/evaluation.

The participants are now at the end of the course and have a varied skill set. This is a good time to put those skill sets into practice to develop a proposal that is specific to each participant's field of work, geographical area, demography and budget.

Exercise – Finalising the proposal for the Health Insurance Scheme

The objective of this exercise is to develop a health insurance programme using the results of the exercises and the theory that you have learnt over the past few days. This exercise is to help you finalise the proposal. Given below is a tentative structure to the proposal for your convenience. So kindly finalise the programme as per this. Remember to use the results of all the exercises for this final proposal.

1. Title
2. Authors
3. Executive summary (optional)
4. Problem statement
5. How will health insurance solve this problem?
6. Design of the health insurance scheme
7. Community – details
8. Benefit package – details. What is included, what is excluded? In detail
9. Premium – details of the calculation
10. How will this premium be collected? Including formats, documents
11. How will awareness be created?
12. Who are the providers? How will you empanel them?
13. Who is the implementing agency?
14. What are the administrative roles that this agency has to perform?
15. Who will govern this scheme? What are the monitoring indicators?
16. Who will be the insurance company?
17. What are the measures against moral hazard (patient/doctor)?
18. What are the measures against adverse selection?
19. What are the measures against cost escalation?
20. What are the measures against fraud?
21. Total budget required and the sources of funds
22. Conclusions

Presenting the Health Insurance programme –

Participants present their Health Insurance programmes and feedback is given by all the participants as well as the facilitator on positive aspects of the presentation as well as potential areas of improvement.

Appendix 1 - Glossary

Glossary - Health Insurance and Related Terms

Actuary: A mathematician who specialises in estimating risks, rates, premiums, and other factors for insurance companies.

Actuarial analysis: The technique of calculating the insurance premium and the reserves required; using actuarial methods. This involves mathematical modelling using the life expectancy of the population, the frequency of hospitalisation, the costs of healthcare, etc. All insurance company premiums are usually based on actuarial analysis, but in India, because of the lack of adequate data, this analysis is based on a weak foundation.

Administrative costs: Costs related to the operations of the health insurance. This included costs incurred in marketing the scheme, in premium collection, in claims processing, in quality assurance and underwriting fees. In India, the insurance companies load the premium by about 20 per cent to cover these costs.

Adverse selection: It occurs when those who anticipate needing healthcare choose to buy insurance more often than others. It is because insurance suppliers lack full information about the risk of individual insured persons. Adverse selection may result from the tendency among patients to seek or continue insurance coverage to a greater extent than healthy people. An example of adverse selection is when only the baby in a family is insured. This is done because the family knows that the chances of the baby falling ill are higher. Adverse selection needs to be prevented; else it affects the financial sustainability of the insurance programme. It can be controlled to a certain degree by making the insurance mandatory and/or by enlarging the subscription unit, e.g. if the entire family is insured rather than an individual.

Age Limits: Stipulated minimum and maximum ages below and above which the insurance company will not accept applications or may not renew policies. Most Mediclaim policies in India have age limits of 3 months to 70 years.

Agent: An insurance company representative, licensed by the regulator, who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Ambulatory Care: Medical services that are provided on an outpatient (non-hospitalised) basis, services may include diagnosis, treatment, and rehabilitation.

Association Group: A group formed by members of a trade or a professional association for group insurance under one master health insurance contract.

Asymmetry of information: The situation where two people in a transaction have different amounts of relevant information. For example, in a health insurance transaction, the insured knows best about his health status. Asymmetry may allow the agent with more information to practice opportunistic behaviour, e.g. a patient with diabetes will suppress the information, so that he can avail of a lower premium.

Beneficiary: A person who is eligible to receive, or is receiving, benefits from an insurance policy. Beneficiaries usually include both people who have contracted for benefits for both themselves and their eligible dependents. (See also subscriber)

Benefits: Benefits are the sum of money received by an insured or an assignee (e.g. a hospital) as reimbursement for medical costs incurred due to illness. Benefits may also be in the form of health services received. These benefits are in lieu of a premium paid to an insurance provider.

Blanket Medical Expense: A provision that entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Brochure (also called Certificate of Coverage): The booklet showing the complete details of a plan's benefits, limitations (or limited benefits), exclusions, and definitions. The brochure is a plan's contractual statement of benefits.

Cap: A limit of the benefit amount that an insurance company will pay. The cap may be an overall maximum, such as a maximum of Rs. 10,000 per patient per year, or may apply to specific services, such as a cap of Rs. 500 per year for outpatient services.

Capitation: A method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person treated, regardless of the actual cost of the services provided, e.g. Rs. 2000 for normal delivery.

Catastrophic insurance: A 'top-up' insurance (or re-insurance) to cover individual cases with severe or prolonged illnesses resulting in very high costs. See also co-payments.

Catastrophic Limit: A benefit feature to limit the amount you would have to pay in a calendar year if you or your family incurred large and unusual medical bills. This is the opposite of the 'cap'. Here the beneficiary pays a certain amount of the bill. The insurance company pays any amount above that.

Cherry picking: A practice by private insurance companies of offering medical insurance to individuals they believe to be healthy while denying coverage to those they believe to be unhealthy (see also cream skimming).

Claim: A request to an insurer by an insured person (or by the provider of a good or service on behalf of the insured individual) for payment of benefits according to the terms of an insurance policy.

Claim Amount: It is the amount/benefit payable by the insurer under a policy on a claim occurrence.

Co-insurance: A cost-sharing provision of a health insurance policy that requires the insured beneficiary to pay a percentage of the cost of covered services. The rest is then paid by the insurance company, e.g. the beneficiary pays 10 per cent of the bill, the rest 90 per cent is reimbursed by the insurer. (See also co-payments, cost sharing and deductibles)

Collection period: A definite period during which the insurance premium is collected.

Community financing: Ways of raising money that are organised and controlled by communities themselves. Contributions may also be provided in the form of materials and community or individual labour.

Community rating: A method of establishing premiums for health insurance based on the average cost of actual or anticipated healthcare used by all the subscribers in a specific geographic area or industry. Community ratings do not vary for different groups or subgroups of subscribers or according to such variables as the particular group's claims experience, age, sex, or health status. It is usually a flat rate applicable to all the members of the insurance programme.

Compulsory insurance: An insurance programme in which legislation defines the population covered, benefits, the conditions of eligibility, and the sources of funds. An insurance plan may be compulsory only for an employer or for individuals as well. Any universal public plan is necessarily compulsory regarding the payment of taxes (which support the plan), and thus not optional for the individual.

Contributory: A group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan.

Co-payment: A type of cost-sharing arrangement whereby insured or covered persons pay a specific, flat amount per unit of service or time and the insurer pays the rest. The co-payment is incurred at the time that the service is rendered. Unlike co-insurance (see above), which involves payment of some percentage of the total cost; the co-payment paid does not vary according to the cost of a service. E.g. the insured beneficiary pays the first Rs 100; the rest of the bill is reimbursed by the insurer. (See also co-insurance, cost sharing and deductibles.)

Cost-sharing: Sharing the costs of providing a particular type of healthcare between the patient and agencies such as the provider of care and the employer of the patient. The main aim of this is to reduce frivolous/small claims.

Coverage: The guarantee against specific losses provided under the terms of an insurance policy. Frequently used interchangeably with benefits or protection, coverage is the extent of insurance afforded by a policy. It also often means insurance or an insurance contract.

Cream-skimming: A process whereby an insurer tries to insure the healthiest individuals in order to increase profits. Cream-skimming can make it difficult or impossible for individuals with high risks, e.g. children, elderly, etc. to purchase private insurance.

Declination: The insurer's refusal to insure an individual after careful evaluation of the application for insurance and any other pertinent factors.

Deductible: The amount of money an insured person must pay "at the front end" before the insurer will pay. In health insurance with a Rs. 1,000 deductible, the insured must pay any medical bill under Rs. 1,000 in its entirely, and the first Rs. 1,000 when the total is over that amount. The reason for introducing this concept into healthcare coverage is primarily to discourage 'unnecessary' use of services, and also to reduce insurance premiums, since all claims have a minimum amount, which the insurer will be spared on every claim. (See also co-insurance, cost sharing and co-payments.)

Diagnosis-Related Groups (DRGs): A system that reimburses healthcare providers fixed amounts for all care given in connection, with standard diagnostic categories.

Dread (or Specified) Disease insurance: Insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis, and spinal meningitis.

Eligibility conditions: Conditions that insured persons must meet in order to be entitled to the benefits of the scheme. These include a maximum duration of benefits (the time during which the insured may receive benefits); a qualifying period (a minimum period of contributions before the insured person or dependents can qualify for benefits); and a waiting period (the time an insured person has to wait before qualifying for specific benefits).

Eligibility Period: A specified length of time, frequently ninety days up to one year, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Evidence of Insurability: Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions: Specific conditions listed in an insurance or medical care policy that is not covered by benefit payments. Common exclusions include pre-existing conditions, such as heart disease, diabetes, hypertension,

or asthma, which began before the policy was in effect. Because of exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage either for a particular disease or in general. Sometimes conditions are excluded only for a defined period after coverage begins, such as nine months for pregnancy or one year for illnesses. Exclusions are often permanent in health insurance coverage for individuals and temporary (e.g. one year) for small group insurance. They are uncommon in large group plans that are capable of absorbing extra risk.

Experience Rating: The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Ex Gratia: A payment made where there is no legal liability.

Family Policy: A policy that insures both the policyholder and his or her immediate dependents (usually spouse and children).

Fee schedule: A listing of accepted charges or established allowances for specific medical or dental procedures. It usually represents either a physician's or a third party's standard or maximum charges for the listed procedures.

Fee-for-service: A method of charging whereby a physician or other practitioner bills each encounter or service rendered. E.g. separate fees for consultation, medicines, laboratory, procedures. This is the usual method of billing by the majority of India's private physicians. Under a fee-for-service payment system, expenditures increase not only if fees go up, but also if charges are made for more units of service or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or prepayment systems, where by payments do not change according to the number of services actually used or if none are used.

Grace Period: A specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues. (The premium can be paid without any late fees.)

Group Contract: A contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity. .

Group insurance: Any insurance plan under which a group of employees (and their dependents), or members of a similar homogeneous group, are insured under a single policy that is issued to an employer or the group itself. Group health insurance is usually rated based on experience (except for small groups, all of which are given the same rate by an insurance company). Group coverage is less expensive than comparable individual insurance, in part because an employed population tends to be healthier than the general population, and in part because of lower administrative costs, particularly in marketing and billing). Note that a policyholder or insured is the employer or group, not the individual employees or group members.

Health insurance: A financial instrument that, in return for payment of a contribution (or premium), provides members with a guarantee of financial compensation or service on the occurrence of specified events. The members renounce ownership of their contributions. These are primarily used to meet the costs of the benefits.

Health Maintenance Organisation (HMO): An organisation that provides a wide range of healthcare services for a specified group at a fixed periodic payment (akin to a premium). The main advantage of a HMO is that it has an inherent interest in keeping costs low.

Health sector: The part of the economy that is involved in activities intended to improve health. The term may be used to mean health services but it is often used synonymously with the term health system, to cover both health services and health-related activities.

Home Nursing Care: Skilled care in the home provided by a nurse. The care generally must be ordered by a physician, is usually limited to a specified number of hours per day and visits per year, and does not include homemaking services of any kind.

Hospice Care: A coordinated programme at home and/ or on an inpatient basis, offering easing of the patient's pain and discomfort, and providing supportive care, for a terminally ill patient and the patient's family, provided by a medically supervised specialised team under the direction of a licensed or certified hospice-care facility or agency.

Hospital Indemnity: A form of health insurance that provides a stipulated daily, weekly, or monthly indemnity during hospital confinement. The indemnity is payable without regard to the actual expense of hospital confinement.

Indemnity: Benefits in the form of cash payments rather than services. In most cases, after the provider of a service has billed the patient in the usual way, the insured person submits to the insurance company proof that he/she has paid the necessary bills. He/she is then reimbursed by the company for the amount of covered costs and makes up the difference him/herself. In some instances, the service provider may complete the necessary forms and submit them to the insurance company directly for reimbursement, thereafter billing the patient for costs that are not covered.

Individual insurance: Policies that provide protection to the policyholder and/or his or her family. Sometimes called 'personal insurance', as distinct from group and blanket insurance.

Inpatient Services: The care provided to a bed patient in a covered facility.

Insurance Company: Any company primarily engaged in the business of furnishing insurance protection to the public.

Insurance: The contractual relationship that exists when one party (the insurer) agrees to reimburse another (the insured) for loss caused by designated contingencies. The contract refers to insurance policy, the consideration is a premium, the loss is the risk, and the contingency is a hazard or peril. Insurance is a formal social device for reducing the risk of losses to individuals by spreading the risk among groups.

Insuring Clause: The clause that sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Insured: A person covered by an insurance policy, to whom protection is provided under the policy terms.

Lapse: Termination of a policy upon the policyholder's failure to pay the premium within the time required.

Limitations (or Limited Benefits): Statements in a brochure showing services or supplies that are not fully covered, only partially paid by a plan, or covered only if the service or supply provided meets certain specified criteria, e.g. pre-authorisation for surgery.

Limited Policy: A contract that covers only certain specified diseases or accidents.

Loading costs: Administrative and other costs associated with underwriting an insurance policy. See also loading factor.

Loading factor (or load): The percentage of total premiums used for administrative costs, profits, and all items other than medical benefits.

Long-Term Care: The range of maintenance and health services to the chronically ill or physically or mentally disabled. Services may be provided on an inpatient (for example, rehabilitation facility, and nursing)

Managed Care: Healthcare systems that integrate the financing and delivery of appropriate healthcare services to covered individuals by arrangements with selected providers to furnish a comprehensive set of healthcare services, explicit standards for selection of healthcare providers, formal programmes for ongoing quality assurance and utilisation review and significant financial incentives for members to use providers and procedures associated with the plan.

Manual Rate: The premium developed for group insurance coverage from the company's standard rate tables, normally referred to as its rate manual or underwriting manual.

Maternity Care: Prenatal and postnatal care and delivery by a covered hospital, physician, or other covered practitioner, including, in many cases, nurse midwives.

Minimum Group: The least number of employees permitted to effect a group for insurance purposes. The purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Moral hazard: The tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have insured. Can be classified into 'supply side Moral Hazard' (when the doctor provides unnecessary care because the patient is insured) or 'demand side Moral Hazard' (when the patient demands unnecessary care because he is insured).

Morbidity: The incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

No Claims Bonus: A reduction in the premium of an insurance policy effected through an increase in risk cover offered, because no claims have been made on it in the past years.

Non-contributory: A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. All eligible employees must be insured.

Out-of-pocket payments or costs: Costs borne directly by a patient who lacks insurance benefits; sometimes called direct costs. Unless covered by insurance, they include patient payments under cost-sharing provisions.

Outpatient Services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Overheads: The costs pertaining to general services (e.g. administration) which do not necessarily arise from the operation of a given programme.

Payroll deduction: A specific amount withheld from the earnings of an employee to finance a benefit. Payroll deductions may come in the form of a set payroll tax or a required payment for a benefit, such as a group health insurance premium.

Policy: The legal document issued to the policyholder that outlines the conditions and terms of the insurance; also called the 'policy contract' or the 'contract'.

Policyholder: A person who pays a premium to an insurance company in exchange for the insurance protection provided by a policy of insurance.

Pre-admission Certification: A procedure whereby the insured or his doctor is required to contact the insurance company before admission to a hospital, and get the latter's permission.

Pre-existing condition: An injury that occurs, a disease that is contracted, or a physical condition which existed prior to the issuance of a health insurance policy. Such conditions usually result in an exclusion from coverage under an insurance policy due to costs of care for the condition.

Premium: The amount of money or consideration paid by an insured person or policyholder (or on his or her behalf) to an insurer or third party for coverage under an insurance policy. Premiums are related to the actuarial value of the benefits provided by the policy, plus a loading fee to cover administrative costs, profit, etc. Premiums are paid for coverage whether or not benefits are actually used. They should not be confused with cost-sharing mechanisms, such as co-payments and deductibles, which are paid only if benefits are actually used.

Private health insurance: Health insurance that is sold by either by commercial firms or non profit-making organisations to individuals or groups. Such insurance is voluntary for the individual or group as a whole (though it may be compulsory for members of the group).

Provider: A person or institution which physically delivers healthcare goods and services. E.g. a hospital or a doctor.

Referral: The practice of sending a patient to another practitioner or to another programme for services or consultation, which the referring source is not prepared or qualified to provide.

Regulation: The intervention of government in the healthcare or health insurance market in order to control entry into or change/monitor the behaviour of participants in that marketplace through specific rules.

Reimbursement: Payment by an insurance scheme to a healthcare provider, or to insured persons, as a refund for all or part of fees for services.

Reinsurance: The acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Renewal: Continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Rider: A document that amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage, or in any other way amend the original contract.

Risk: Any chance of loss.

Schedule: A list of coverages or amounts concerning things or persons insured.

Self-insurance (Self-Insured Plan): A programme for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial insurers.

Skimming: The practice in health programmes and insurance companies that are paid for on a pre-payment or capitation basis of seeking to enrol only the healthiest people as a way of controlling programme costs. This is possible since the income of a programme or company is constant whether or not services are actually used. Skimming is also called creaming and contrasts sharply with adverse selection (see above).

Social health insurance: An insurance scheme set up and controlled by government or public agencies to provide protection against sickness. Social insurance is usually compulsory for the whole population or for certain group. The contributions are usually from payroll deductions of employed citizens, but the benefits are usually for the entire population.

Stop loss: The quantitative level up to which an insurer is liable for costs, beyond which risk is passed on to a re-insurer. Stop-loss clauses usually cover either overly large single claims or excessively high aggregate claims of any one member within a defined period.

Substandard Risk: An individual who, because of a health history or physical limitations, does not measure up to the qualifications of a standard risk.

Third-Party Administration: Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Third-party payer: Any organisation, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. The individual generally pays a premium for such coverage in all private and in some public programmes and the organisation then pays bills on his/her behalf. Such payments are called third-party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organisation paying for it (the third party). (See also service benefits and indemnity benefits.)

Time Limit: The period of time during which a notice of claim or proof of loss must be filed.

Underwriter: The term as generally used applies to either: (a) a company that receives the premiums and accepts the responsibility for the fulfilment of the policy contract, or (b) the company employee who decides whether or not the company should assume a particular risk.

Underwriting: The process by which an insurer determines whether or not to accept an insurance application and on what basis/terms it will be accepted.

Uninsurable Risk: One not acceptable for insurance due to excessive risk.

Universal coverage: Coverage of all the citizens of a country under a particular insurance scheme or variety of schemes.

Utmost Good Faith: A duty imposed on both parties to an insurance contract. The legal duty implies full disclosure of all facts material to the contract during negotiations of the contract.

Waiting period: The period of time that an individual must wait either to become eligible for insurance coverage or to become eligible for a given benefit after overall coverage has commenced (see exclusions). Some Policies will not pay maternity benefits, for example, until nine months after the policy has been in force. Another common waiting period occurs in group insurance that is offered through a place of employment, whereby coverage may not start until an employee has been with a firm more than 30 days.

Waiver of Premium: A provision included in some policies that exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract,

Waiver: An agreement attached to a policy that exempts from coverage certain disabilities or injuries that are normally covered by the policy.

Appendix 2 – Frequently asked questions

What is health insurance?

Health insurance is a mechanism whereby the community finances healthcare in an equitable manner. All the members in the community contribute a small amount towards an insurance fund, which is then used to meet the specific healthcare costs of the contributors. Usually the contribution and the benefits are limited for a period of one year.

Why should we become members of a health insurance scheme?

By becoming members of a health insurance scheme, you do not have to bear the full burden of your medical costs. This is shared with other members in your community. So by paying a small amount, you are part of a group that will take the responsibility of financing your healthcare needs. This is a way of demonstrating solidarity in illness. All the members are contributing a small amount so that when somebody in the community falls sick, their medical costs are taken care of by the community and the individual ill person does not have to suffer.

Why do we have to pay when we are healthy?

It is true that normally one pays when one is sick. But this also implies that one has to pay a large amount of money at the time of illness. And the burden of payment is only on one person. Health insurance overcomes these problems by asking everybody to pay WHEN THEY ARE HEALTHY. This means that people pay when they can pay. And both healthy and sick pay. And this small contribution, when pooled helps in meeting high medical costs. So the patient does not have to worry about money at the time of illness. And the healthy subsidise the medical costs of the sick.

If we do not fall ill, will we get our premium back at the end of the year?

The answer to this is NO. Though you did not fall sick, your money was used to treat somebody else who did fall sick. So in essence, your money was used. Hence it cannot be returned. You may think that your money was 'wasted'. But remember that next year, you can fall sick and then another's money will be used to pay your hospital bill.

Will we get our premium at the time of death?

The answer to this is NO. We are talking about health insurance, wherein your medical expenses will be covered. To get money at the time of death, you need to take a separate life insurance policy.

What are the benefits that I can get if I join the health insurance scheme?

If you join the health insurance scheme and IF you fall ill, then your admission costs will be covered by the scheme.[20]

Why are OP expenses not covered?

OP expenses could be covered, but because usually OP expenses are small in amount, we feel that the individual patient can bear it without much burden. On the other hand, IP expenses will be more problematic for the individual patient and hence will be covered. Also, OP expenses take place frequently, and so are difficult to administer and monitor.

[20] Depends on the CHI. Some CHIs may want to include OP expenses, travel costs and other expenses.

Are all diseases covered?

This depends on the health insurance scheme. Some diseases may need to be excluded as they are not necessary for the well being of the individual, e.g. cosmetic surgery.

What is the premium?

This depends on the health insurance scheme.

Is there a maximum limit?

Yes, our health insurance will cover IP expenses up to a maximum limit. This is so that our premium incomes can be used for the maximum number of people. Else a few patients will use all the money and others will not be able to benefit.

Where can I get the benefit?

The health insurance scheme has chosen specific hospitals in this region. You can go to these hospitals and get your treatment free of charge.

How will they know that I am insured?

When you pay your premium, you will get an insurance card with your name and other details. If you show this to the hospital, then they will give you free treatment.

Do I have to pay at the time of hospitalisation?

This depends on the method of payment in that health insurance scheme.

IF it is a cashless system, the answer would be NO; you do not have to pay any amount. At discharge you can return home without any payment. Of course, if your bill is more than the maximum limit, then you will have to pay the amount above the maximum limit.

IF it is a reimbursement system, then the answer is YES, at discharge, you will have to pay the hospital bill. And make sure that you get the proper documents (discharge summary, receipts). These documents have to be submitted to us, so that we can reimburse you the money.

How many years will this insurance run?

God willing and with your cooperation, we shall try and make this insurance run forever.

How do we know that you will not run away with our money?

You have to trust us. We have been working in this area for so many years and have you heard of us cheating any of you. And remember that all the accounts are available at the office; you can come at any time and inspect it. And ideally we would like you to be a part of the management, so that you can see how the insurance programme runs for yourself.

Will we get interest on our premium?

Remember that this is not a savings programme, it is an insurance programme. So when you give your money, it is used – either for you or for somebody else. So there is no question of interest.

What is the benefit for me, if I do not fall sick?

We are talking about a long-term programme. Today you pay a small amount for your family, e.g. Rs 200 for a family. Over 10 years, this is still a small amount, just Rs 2000. But over 10 years, it is definite that somebody in your family is going to fall sick and will easily run up a medical bill of more than Rs 2000. So isn't it beneficial for you to join this health insurance scheme? Don't think of one or two years, think in the long term.

Also, the main advantage is that you can sleep peacefully at night, because you do not have the fear of falling sick and paying large sums of money.

What happens if I pay regularly, but do not pay one year?

The premium is valid for only one year. So if you do not pay one year, technically you cannot get benefits in that year. But like you said, if you are paying regularly (e.g. five years) then if you are not able to pay for one year, we can give some concession, e.g. we can cover 50 per cent of the bill.

If I pay the premium, when will I get the benefit?

If you are joining for the first time, then when you pay the premium, you will have to wait for a month before availing of benefits. In other words, if you fall sick within 29 days of paying the premium, you will not get any benefit. This is to prevent only sick people from joining the scheme.

What are co-payments?

Co-payments are basically measures to reduce unnecessary use of services by the patients. This could be in the form of deductibles, i.e. patient pays a small amount for each contact. This will ensure that the patient will not use the services for minor ailments. Or it could be in the form of co-insurance, i.e. patient pays a certain percentage of the bill. Or it could be in the form of maximum limits, e.g. the insurer pays the initial amounts, up to a certain limit, after which the patient pays. The last two ensures that the patient is interested in keeping the bill down and will not ask for unnecessary services.

Training on Health Insurance – Facilitator's Manual

Introduction to adult teaching

Learning objectives

- To gain insight into factors affecting adult learning
- To identify the principles of effective adult learning
- To learn techniques to ensure adult participant attention
- To enumerate advantages and disadvantages of common teaching methods and Audio Visual aids

Materials required:

- ☐ Power point presentation on 'Adult learning methods and techniques'

Time Requirements

Presentation: 60 minutes

Note to Faculty

The facilitator must understand basic principles of adult learning and more important; incorporate it into his or her training programme. Even the best trainer can always improve and over-confidence can lead to stagnation in one's teaching methods.

The chapter gives a broad overview, but the facilitator is asked to refer to other material on adult learning to gain the maximum benefits.

Summary

Teaching adults is very different from teaching children. Adults have prior knowledge, experience and opinions about the topic that you are going to teach. So first understand these by giving them the space to share. The next step would be to provide the theory – which requires that the trainer has good knowledge and grasp of the topic. And finally, provide them with assignments that will help them apply their new knowledge to their reality. And all this while, remain respectful, participatory and enthusiastic.

Objectives of this section

The participants have undergone a five-day training programme on health insurance. They will have gained a working knowledge of key aspects of health insurance. However, some of the readers may now want to use this knowledge to orient people in their states on health insurance. An important objective of this training programme is to ensure that the participants are able to share and disseminate the knowledge gained to a wide range of target groups - the groups could be senior staff within the state government, middle level medical officers, medical college professors, non-governmental organisations, academic institutions, or any other interested individuals and organisations.

Mere knowledge is essential but not sufficient to teach. One needs to have other skills also to teach. A prospective teacher must be familiar with some of the key elements of adult teaching and should be able to use them while teaching.

This section of this book aims to equip the participants in the key principles of adult learning, different teaching methodologies through theory as well as practical micro-teaching exercises. At the end of the three days, the participants should be confident and comfortable in the role of a trainer.

Factors affecting adult learning

A good teacher is passionate, knowledgeable and an inspiration to the learner. The teacher must have a strong understanding of the subject through reading, talking and consulting. Listening is an important skill that the teacher must possess and this listening is not only verbal. Sometimes the teacher picks up important cues from the participants about the impact of the lecture - if the participants maintain eye contact, answer questions promptly and nod their heads, the teacher knows that the lecture is being listened to. However, if the participant looks bored, looks away and needs prompting to answer simple questions, then the teacher

must re-examine his or her teaching methodology. Thus a teacher constantly evaluates his or her own skills. Humour and style can ensure that the most boring subject is something that catches the attention of the learner.

Stop whatever you are doing and close your eyes. Try to remember a teacher who influenced you either in your school or college or even at home. What are the qualities of that person that really impressed you? Jot down a few of these. You will find that some of the qualities are directly related to teaching skills, but many others relate to the character and personality of the teacher. There is something beyond the classroom that influences and affects people. Some of these important qualities are listed below.

Knowledge – Adult learners are those who have their own experience and knowledge. It is therefore important that their teacher knows more than them. Adult learners will only respect those who have the expertise in their particular field. Thus knowledge is very important for a trainer who trains experienced personnel. This requires that a trainer is well prepared before taking the session. However, this does not mean that a trainer has to know everything about the topic. If the trainer is not aware of a particular issue, then it is better to be honest and say so, rather than trying to cover up.

Integrity - Imagine this scenario 'Dr. K. was the Associate Professor at Hariprastha Medical college. He was an important delegate at several International Conferences because of his work in the field of Paediatric HIV. He was a very powerful speaker and his command of the English language was excellent. However, the students of his own college knew that he accepted bribes to give them the Examination paper and would also increase their scores if an envelope was placed on his table with a specified amount of money and the name of the candidate.'

Now think about this same Associate Professor taking a session for the students. Even if he had good knowledge and communication skills, would he have the respect of the students? It is unlikely, because he lacks integrity.

Confidence - Have you seen teachers who talk a lot when they deal with you on a one-to-one basis, but panic completely in a group? These people may be good on a one-to-one basis, but will not be able to handle a crowd. So a good trainer needs to have confidence in himself and his ability to communicate. One of the essential requirements for confidence is of course good knowledge of the subject.

Principles of effective adult learning

Adults are different from children in several ways. Adults come with pre-defined notions and ideas, previous experiences, some knowledge as well as clear expectations. They may have time constraints and other pressing issues on their mind. It is therefore important that their learning is structured in such a way that works with these factors rather than against them. Some of the important principles that help when dealing with adults in the classroom are:

1. Work with their experiences - Adults come from diverse backgrounds and this could provide a rich source of information to work with. Draw out practical issues and build the course content on a need basis. For example, ask the participants what they feel are the problems they have personally faced with health insurance. These could be experiences with the insurers or providers. Later on the trainer works with each of these issues and shows them how they can be resolved or minimised through proper application of health insurance principles.
2. Integrate new ideas with existing knowledge - Most adults have some basic knowledge of any lesson or session that they undergo. A good trainer should thread the existing knowledge into the new lessons to be imparted.
3. Be conscious of egos - Adults are more likely to perceive and respond to insults or snide remarks - whether overt or covert. This is especially aggravated by the response of the trainer and others in the group. Promoting positive self-esteem of participants helps to ease the learning environment and learning objectives are more likely to be achieved.

4. Avoid long boring lectures - Remember most adults have not been in a classroom for a long time. Long monotonous lectures are sure methods to put them to sleep. Participatory methods of teaching have been demonstrated as the best method of teaching for adults. Adults remember 20 per cent of what they hear, 40 per cent of what they hear and see and 80 per cent of what they discover themselves.
5. Focus on 'Real world' problems - Giving examples and case studies of real situations is like a simulation exercise for participants. This draws the fine link between theory and practice helping participants in implementation at the field level. This can only happen if the trainer has such 'real world' experiences.
6. Emphasise how the learning can be applied - Relate the teaching to the learner's goal. The goals should be identified at the beginning of the session. For example, one person might say that she wants to start health insurance in her NGO. Use her situation to build the session. Retention is also much more with this kind of session.
7. Allow debate and challenge of ideas - Unlike children, adults may have had experiences much different from yours and completely contradictory to your own ideas. If you feel that you are the teacher and know more, you may find it very insulting if a participant questions your point of view. The problem here is your 'I know it all' attitude, more than anything else. You may be surprised at how much your own knowledge improves when you allow people to give you a different point of view.

Techniques to ensure adult participant attention

Adults find it very difficult to attend classroom sessions and also have very different agendas for attending sessions. Some may have been compelled to attend by their superiors, some may just want a certificate, and some may have specific learning objectives and not be interested in other things. The problem with a group like this is that they may have no real motive to listen to your session. The only way you can get a diverse audience to focus on a single point is through the technique you use to hold their attention. These techniques vary, depending on the amount of time available, the kind of participants, the number of participants and space available. Some of these techniques are

1. Ice-breakers - These are non-formal ways of participant interaction that are usually entertaining. Many people are under the wrong assumption that informal sessions do not need planning or guidance. If done improperly, it can lead to further boredom and disinterest in the group. The first day of class is usually spent in part by getting acquainted and establishing goals. Icebreakers are techniques used at the first session to reduce tension and anxiety, and also to immediately involve the participants in the course. Use an icebreaker because you want to, not as a time-filler or because teaching guides say one should be used. Listed below are several examples of icebreakers.
    - Self-Introduction - Participants introduce themselves and tell why they are there. They can also talk about why they took up the course, their favourite movie programme or books or about their home towns.
    - Introducing each other - The class is divided into pairs and asked to share some important information with each other, like 'what is your proudest moment…' 'One way of easily remembering your name…' 'Your most embarrassing moment… After five minutes, the participants introduce the other person to the rest of the class and share some of the information gained.
    - I have done something you have not - Have each person introduce themselves and then state something they have done that they think no one else in the class has done. If someone else has also done it, the student must state something else until he/she finds something that no one else has done.
    - Find me - Each participant writes three statements on a piece of paper - favourite food, hobby, colour, etc. Shuffle the cards and redistribute. Each participant should find the owner of the card and introduce themselves. This can be used towards the middle of the training programme to see how much each participant knows about the other.

- Guess the person - The group writes the name of a famous person or place and pins it on one of the participant's back. The participant has to ask questions from the group (this can be limited to around 10 questions) and has to guess the famous person or place.
- How do you feel? - Ask the students to write down words or phrases that describe their feelings on the first day of class. List the responses on the blackboard. Then ask them to write down what they think you as the teacher are feeling this first day of class. List them on the blackboard in a second column and note the parallels. Briefly comment on your feelings and then discuss the joint student/teacher responsibilities for learning in the course. This can be repeated at the middle and end of the training programme to see if feelings have changed over time.

These are just a few of the hundreds of icebreakers. Be creative and design your own variations. Don't be afraid to experiment and try different approaches, and above all, have fun.

2. Learning games - Games that are brief, participatory, adaptable and with a single focus help to drive in specific points. They can also be used as icebreakers but are more related to the topic and slightly more formal. They help in reinforcement and association.
3. Scaffolding - This is a process of 'empowering students with their own authority'. A trainer determined scaffold or structure is identified to achieve a task and the participant decides his or her means of performing the task. For example, the facilitator divides groups of participants into NGO and Government participants and asks them to develop an awareness-raising brochure. The groups will identify issues and methods of information dissemination that are uniquely related to their own background and experience. They therefore contribute much more to the quality of the session. Imagine the reverse situation where each group is asked to raise awareness for the other group - the contribution will be much less.
4. Praxis - This essentially means 'action with reflection' - here the participants are given practical situations and made to develop a theory behind it.
5. Encourage group activity - One of the benefits of group activity is increased social integration. Adult trainees do not go back only with memories of your sessions, they feel empowered by being able to relate with peers, contribute to discussions and accept different opinions. Your value as a teacher is greatly enhanced if you bring about these positive qualities in people. These qualities cannot be measured but are extremely valuable.
6. Body language - Stand in front of a mirror and try different funny facial expressions. Then get a video of yourself making a presentation and you may be surprised at the number of funny things you yourself do. Remember that what you say is a small part of your communication - you also speak with the tone of your voice, your eyes, your hands, and your head. If you are fixed in one place like a statue, with one hand clutching the table and the other desperately rolling a pen, staring only at the floor or ceiling, then this is what the participants see. They are unlikely to relate to you. Practise, practise, practise and constant feedback can convert even the most unlikely person into an excellent public speaker. Body language is not about the clothes you wear, but about the way you carry those clothes.
7. Encourage use of other resources - The objective of your training session is not for the participants to like your training method. Instead, you are offering them a set of skills to learn about the subject. Encourage them to read other articles or books, help them get into related websites (you could even have an informal training session on using the Internet for interested participants), network with other organisations of a similar field. Through this you encourage them to be active learners that go much beyond the classroom.
8. Needs Assessment - If this is done at the beginning of the training programme, it validates the participants as thinking adults who can contribute to the training programme. These needs can be incorporated during the training session.

Common teaching methods

Teaching can be done in several ways. A good teacher learns to combine methodology and chooses the most appropriate one for the group of participants. These are discussed briefly below and the teacher picks up the one most suited for his or her teaching ability. Any method can be adopted but requires genuine interest and confidence by the teacher to be really effective.

The first and commonly used method is the lecture. Many of you must have fallen asleep during the lecture. The speaker's voice is so boring and lifeless that it can put the most interested participant to sleep. When you are giving a lecture you must assess responses - if people are nodding their heads, asking questions, taking down notes and making eye contact with you (more important, are they laughing at your jokes?) then you are probably getting their attention. If they are fast asleep or nearly about to do so, if they are yawning and looking out of the window, you should probably think of ways to make your lecture more interesting, or use another method of teaching.

Some people may bring in a panel of experts. The experts have a discussion on topics and the audience are free to ask relevant questions. The danger with this is that experts may themselves be boring speakers or 'I' specialists in that they talk only about themselves and their experiences and forget to include other panellists, or they might start arguing about something completely unrelated. This is a dangerous method unless you are completely confident and can stop unpleasant or tangential arguments. Think carefully before you choose this method. You will also need lots and lots of time to prepare for this and may have to make several calls to the experts to make sure they turn up at the discussion. Some experts might even send a 'representative', which may leave you in a difficult situation!

Brainstorming is an innovative method of teaching. It basically helps a group to put in all their ideas together so that there is one nice and final product. It gets people excited because they feel that somebody/anybody is willing to listen to their ideas… But there is a danger, some may not talk at all and some may talk too much. Here again the facilitator or teacher has to be confident enough to keep the group in control. You can try it with a small and cooperative group before you address larger and more diverse groups. Requires three Ps - Practice, Patience and Perseverance - if you have these - then GO FOR IT! (Otherwise, don't even try!)

Group discussions are somewhat different from brainstorming. In the second one, the teacher controls the discussion whereas in group discussion, the teacher mainly observes. You may not get much information about the topic, but you get PLENTY of information about the participants - the lady who shouts, the one who is afraid to open his mouth, the jealous one, the selfish one, the smart one, the knowledgeable one - these can be picked up very well by the facilitator or teacher. Keep your eyes and ears open during group discussions.

Videotapes are great if you have good ones. Most of the time you just sit back with the group and enjoy the video (or sneak out quietly to get some unfinished work done) but that is most often not enough. Participants may watch videos but levels of understanding can be completely different. Always watch the video with the participants and make sure you have a discussion later, so that a common message goes through. Just watching a video is not enough, the most important learning happens at the time of the discussion after the video.

Case studies - Whatever topic you may be talking to people about, there are always real life situations that you can use to bring out your point. For example, if you want to tell people about the importance of health insurance, just make a case study for them.

Case studies are very useful, but need to be developed prior to the session. It requires some work, as one has to identify the appropriate case study, and ask the relevant questions.

Role play - Have you heard of a local saying, 'Like giving a garland in a monkey's hand'? Role play is like that - give it to a creative and energetic group, they can bring out any issue in a real and convincing manner

without even the need of a single lecture from you. Give it to a boring and dull group; they will make a complete mess of it. Assess your group before you decide on a role play. You can use this to elicit specific responses like anger, shock or humour but for real impact, your discussion at the end of the role play is what really matters.

Common visual aids

Two things to remember about visual aids are that they are Visual and they are Aids. The Visual component means that whatever you present catches the eye of the viewer and the Aids component means that you only use it as an Aid - it cannot be the main component of the training programme - it just supports you.

BLACK / WHITE BOARD

ADVANTAGES:

- Flexible
- Use is relevant to the discussion
- No need for much equipment
- Can be made colourful

DISADVANTAGES

- Can interrupt communication, if trainer writes long sentences on the board with his/her back to the class

POWERPOINT PRESENTATION

ADVANTAGES:

- Professional in appearance
- Allows for pausing and discussion
- Good for large or small group
- Animated
- Up-to-date technology
- Easy to update

DISADVANTAGES:

- Requires special equipment like laptop & LCD projector
- Requires initial training to create
- Requires significant time to create

VIDEOS

ADVANTAGES:

- Professional in appearance
- Good for large or small groups

DISADVANTAGES:

- Do not encourage discussion and interaction
- More expensive than other visual aids
- Can be dated or irrelevant to the current context
- Require special equipment
- Impersonal

OVERHEAD TRANSPARENCIES

ADVANTAGES:

- Easy for large groups
- Easy to create
- Easy to transport
- Can encourage discussion if used well
- Inexpensive
- Easy to update

DISADVANTAGES:

- Can discolour with age
- Require special equipment

SLIDES

ADVANTAGES:

- Look professional
- Good for large and small groups

DISADVANTAGES:

- Do not encourage discussion and interaction
- Require to be shown in the dark
- Difficult to update
- Require special equipment
- Impersonal and can be formal

Evaluation of teaching skills

Nowadays everybody wants to talk about evaluation. What does the word evaluation remind you of? Exams, tension, supervision, marks, poor performance? Many people have a negative association with the word evaluation. Before you read this Chapter, answer the following questions:

Question	Yes	No	Not sure
1. Am I a good teacher?			
2. At the end of my session do I want the participants to gain in terms of knowledge?			
3. At the end of the session, do I want the participants to gain in terms of Attitude?			
4. At the end of the session, do I want the participants to gain in terms of practice?			
5. Do I want to become a better teacher?			
6. Can I accept criticism to become better?			
7. Do I feel that the participants can help me become a better teacher?			

These questions help you to understand whether you are keen to improve your teaching skills to help participants gain more in terms of knowledge, attitude and practice. Only a genuine desire for this will make the evaluation process a useful and valuable tool.

The types of evaluation are self-monitoring, audio-visual monitoring, external observer or participant evaluation. In self-evaluation, you can constantly assess the response to your teaching, but the disadvantage

is that your assessment is biased by your own ego and prejudices. Audio-visual monitoring is expensive and requires some degree of investment in terms of material and time. It gives you a good idea of your body language, communication skills as well as general interest and involvement of the participants. External evaluation can be by your colleagues or persons specifically trained for this activity. Sometimes the feedback may be personal and subjective, like 'I didn't like the colour of your clothes' or 'you look silly when you laugh'. This kind of feedback is not really helpful to you as a teacher. Similarly, it is of no use to you if a close friend of yours says you were fantastic and have absolutely no flaws. Choose your critic carefully to help your own growth as a teacher. Participant evaluation has the advantage in that they are the learners and will know best how much they have learnt from you. You will also get a wide range of feedback and not only from one person. Pre- and post-test questionnaires give you a fairly good objective assessment of knowledge gained but may not really evaluate change in attitude or practice.

Conclusions

The above section has summarised some of the issues in teaching adults. To summarise, listen to their experiences, give them the theory (which builds on their experiences) and then ask them to apply this theory to their real life.

The next section is on how to take the health insurance module. As a participant, you have received the inputs. Now translate this input into an output – how will you train the senior officers on health insurance? Use the handbook, the slides, the lessons on adult teaching and your own experience to take the sessions.

Teaching health insurance – facilitator's manual

You have learnt about health insurance and acquired some knowledge about it. You return to your state and are considered as an expert on health insurance. Others also want to learn from you about it. The health secretary asks you to train the senior health officers on health insurance. What will you do?

The first step is to re-read this handbook so that you are comfortable with the theory of health insurance. Second, you read the previous chapter, which gives you an overview about training methods. And finally, you follow the steps listed below to take each session. Don't hesitate to ask for help, there is no shame in not knowing about a particular topic. It is better to re-learn rather than impart a wrong message.

Structure of the training section

The manual is divided into 12 sessions, each with a similar structure. The box on top usually has the learning objectives for the session, the methods to be used for teaching the session and finally, the amount of time that is required. While the time is a guideline, please try and stick to it, else the entire schedule may be disrupted.

This manual has to be used in close conjunction with the handout and the set of Power point slides. That has the theory that is required for a participant of this course.

Instructions for the trainer (text in italics): Explains step-by-step how to lead the session, and sometimes includes suggested methods for assessment of learning.

Supplementary material for the teacher (text in bold): Gives details of the teaching content for both theory and practice.

The training programme

Session No.	Session Name	Methods	Time (mts)
0	Self Introduction	Game	90
1	Health financing	Presentation, Exercise	90
2	Health insurance	Presentation, Exercise	90
3	Choosing a community	Presentation, Exercise	90
4	Choosing the benefit package	Exercise	60
5	Calculating the premium	Presentation, Exercise	120
6	Re-defining the benefit package	Exercise	30
7	Organising the programme	Presentation, Exercise	30
8	Empanelling the providers	Presentation	60
9	Negotiating the contract	Presentation and Exercise	90
10	Administrating the scheme	Presentation	90
11	Monitoring	Presentation and Exercise	90
12	Creating awareness	Presentation	30
13	Finalising the proposal	Group work	5 hours

Materials required for the sessions

Materials: This is a list of common materials that are required for all sessions. Materials required specifically for a session are listed in that session box.

- Flip chart
- Permanent marker to write on the chart paper
- LCD projector
- White board with markers and duster
- Pen and notebook to take down notes
- One mood metre

Self introduction

Learning objectives: At the end of this session, the participants should be able to:

1. Identify the other participants by name
2. List the objectives of this training programme
3. Understand the working of the mood meter

Methods: A game to break the ice

Materials: Please tick when you have acquired the material

- ☐ Flip chart
- ☐ Paired 'playing cards' (half as many pairs as there are participants)
- ☐ Questions to be asked on a flip chart – Sheet 1
- ☐ Pen and notebook to take down notes
- ☐ Chart paper (cut in 6" X 6" squares) – at least twice the number of participants
- ☐ Permanent marker to write on the chart paper
- ☐ Trainer's expectations on a flip chart – Sheet 2
- ☐ One mood meter
- ☐ Rules for the training programme on a flip chart – Sheet 3

Time: 90 minutes

***Notes to the trainer**: Try and keep the mood light during this session. Generate laughter by highlighting some of the ways people will spend money, etc. Even while talking about the rules try and keep it friendly so that the participants are not put off by this. Try and involve them at every stage.*

Steps for this activity:

Welcome all the participants.

Distribute the shuffled cards,[21] one for each participant. If there is an even number of participants, then there is no problem. If you have an odd number, request one of the co-trainers to join the game.

Now instruct the participants to find the participant with the paired number. So if somebody is holding a 5 of hearts, they should try and find somebody holding another 5 (of clubs or diamonds or spades). The participant should not show the card, but can announce the number to the others.

Once the pairs are formed, then the pairs are asked to introduce themselves to each other. The introduction should contain the following:

The name, designation, institution and city of the partner.

Does the partner have any experience with respect to health insurance?

What are the partner's expectations from this training course?

Ask your partner to describe one event in his/her life that really made her very happy.

If your partner won a crore of rupees (from KBC), what would he/she do with that money?

After 15 minutes, ask them to sit in pairs and then introduce their partner in rotation. Ask your co-facilitator to note down the participant's expectations on VIP cards, one card for each expectation. After all the

[21] The cards should be paired, i.e. 6-6, or 10-10, or J-J. It may be of any colour, which is not important.

introductions are over, introduce yourself and the co-facilitator along the same lines

Take each of the expectations and stick it on the wall. Club similar expectations together. Place those expectations that you will not be able to meet at a little distance from the others. Finally summarise the expectations and promise to meet them over the next few days.

Then share your own expectations from the course. This is basically the objective of the course. At the end of the course, the participant will be able to:

- List the elements of any health insurance programme
- Design an effective health insurance programme
- Implement an effective health insurance programme
- Monitor the health insurance programme
- Negotiate with insurance companies and with providers
- Learn the fundamentals of adult learning
- Put adult learning into practice

If there are any overlaps with the participants' expectations, highlight them.

Now explain about the mood meter[22] Explain that it is to capture the feedback from the participants about each session. Request them to fill it up when they go for a tea or lunch break or at the end of the day.

Conclude with the rules for the training programme

- We appreciate and respect your freedom of expression.
- If you disagree with another (including the trainer), then challenge the viewpoint, not the person.
- Punctuality would be appreciated.
- Logistic issues can be raised without any hesitation with the training coordinator.
- Any other… (ask the participants if they want to add any rules)

[22] The mood meter is a chart on which on the top horizontal axis, we will draw three faces (one is smiling, the other is indifferent and the third is frowning). On the vertical axis, are the classes for that day. So when the participant walks out of the door, s/he should put a tick mark at the intersection of the class and the face that corresponds to the mood of the participant at the end of class.

Health financing in India

Steps for the session:

Ask them to list all the sources of funds for financing health services. Group them broadly into 4 groups – government taxes, private firms, individual households and external donations.

Show this on your PowerPoint slide 2. Emphasise that this is the same anywhere in the world. Only the proportion from each varies from country to country.

Ask them to estimate how much the proportion in India is.

Next show them slide 3 with the sources of finances for healthcare in India.

So we know that there are 4 basic sources of finances. And usually there are 3 categories of providers – government providers, private providers and NGO providers. However, there are many channels by which the finances reach these providers.

It may be through government channels, e.g. Directorate of Health. Show Slide 4 to highlight this. This is called tax-based funding.

Or it may be through an independent body, e.g. an insurance company. Then it is called health insurance.

Or it may be directly from the individual households to the providers. In which case it is called out-of-pocket payments.

Or it may be directly from the private firms to the providers. In which it is called corporate financing.

And finally, it may be from donors to NGOs who then pay providers through health programmes. This is usually called charity mechanism.

In India, the most important ones are the OOP payments and the tax-based mechanism of financing. All others are small in comparison to these two.

Compare this with other countries, e.g. Uganda, UK, USA, Brazil, China, and Thailand. Use slide 5 for this.

Summarise the mechanisms of health financing – Slide 6.

Show them Slide 7 and discuss which is better. As you can see, health insurance is the middle mechanism, neither on top nor at the bottom.

What is the effect of this high OOP payment? Ask them and list it on the flip chart. Highlight the main effects, i.e. loss of access to healthcare and impoverishment. Slide 8.

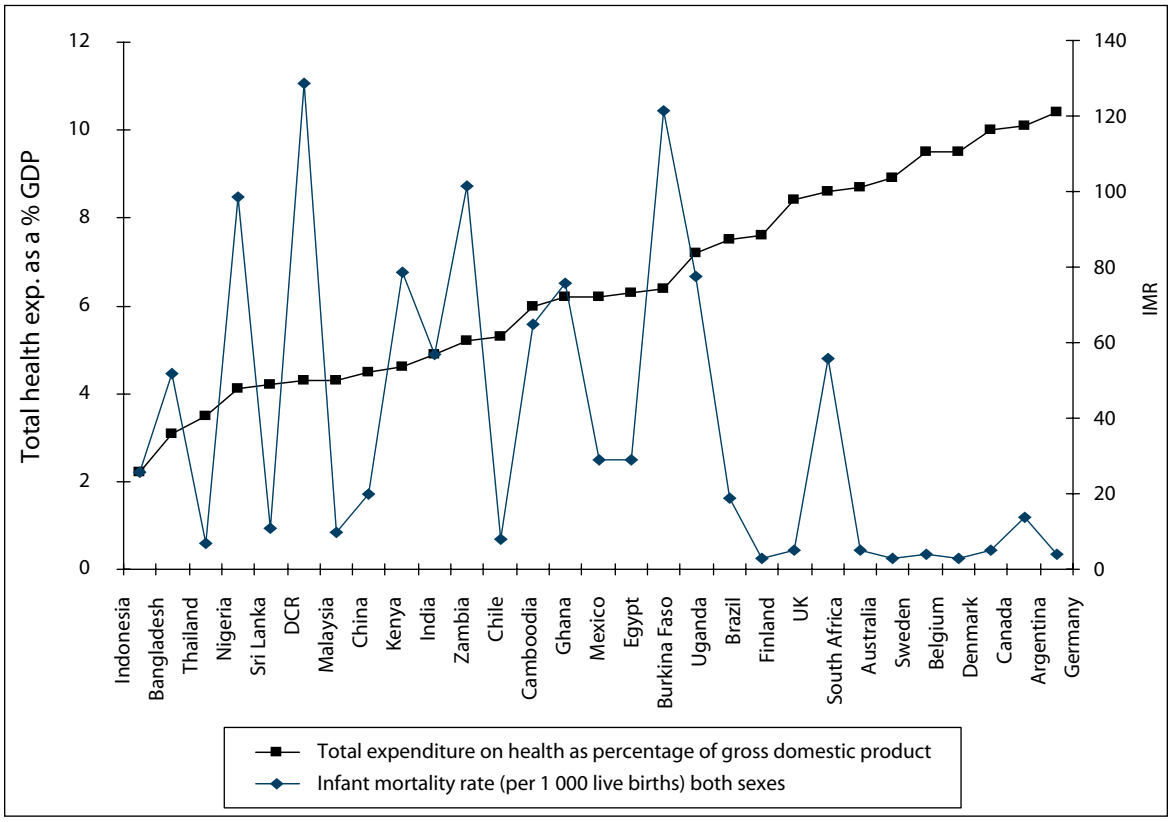
So it is important that we reduce this OOP payment. How can we do this? Again ask them to list some of the options. And then focus on health insurance. Say that the effects of additional government funding take some time to materialise. Till then, health insurance could be an option to protect the families.

What is health insurance will be dealt with in the next session.

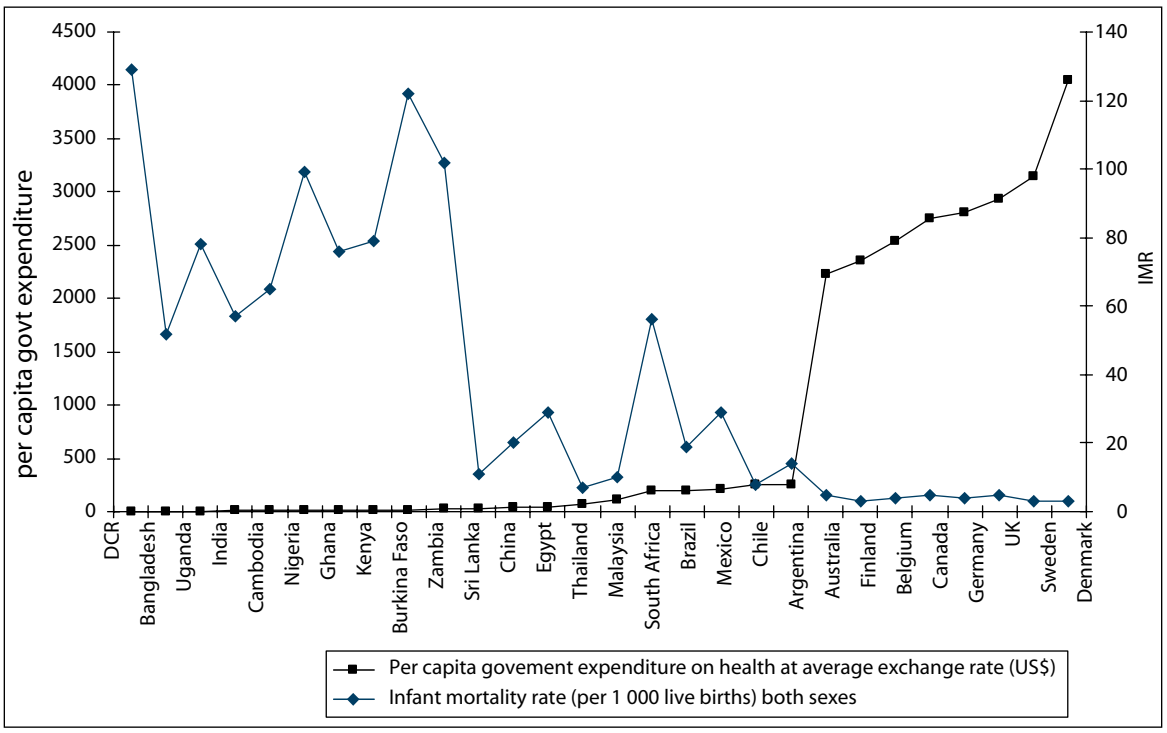
Now give the instructions for the exercise. Those who want the soft copy can be given it on the pen drive. Each group presents its findings and its interpretation of the same. Take-home message is that government funding of health services is desirable if one wants to improve the health status of the population.

Exercise: Association between health expenditure and health status

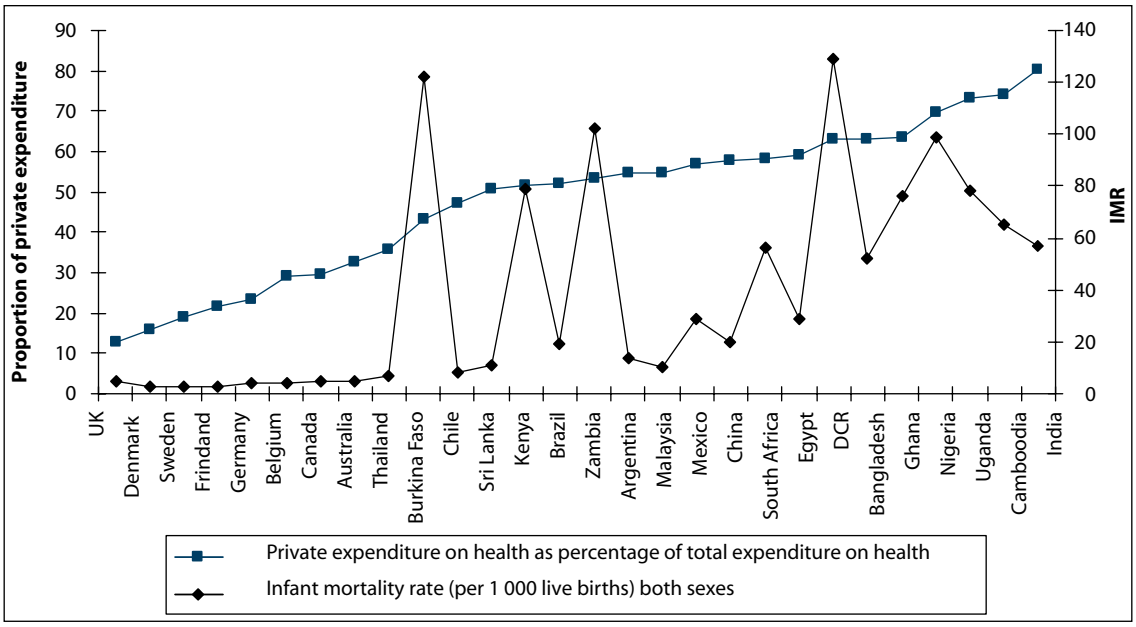
The answers to the exercise are:



There does not appear to be much correlation between total health expenditure and IMR, except when the THE increases beyond 6%. Then the IMR seems to fall drastically. Of course there are some outliers, e.g. South Africa.



Here, as long as the per capita expenditure by government remains low, the IMR is high. But once it increases, then the IMR falls. There are exceptions like Sri Lanka, China and Thailand that spend considerably less than other countries and have still managed to keep the IMR low.



Note that as the proportion of private health expenditure to THE increases, the IMR increases. Further indicating that government health spending has some effect on the health status of the population.

Health insurance in India

Steps for the session:

Show them the overview of the session Slide 2. Then recap with the three slides on OOP, tax-based financing and health insurance Slide 3-5.

Ask them to describe or define health insurance. List some of the key words like contribution, pooling. Then show them Slide 6 & 7. Use the story from the text about the 100 women in a group to further explain the concept. Finally close with Slide 8, which shows the basic model and the flow of finances.

Just take them through the history of health insurance (Slide 9). Emphasise that this is no new Western invention that is being thrust down our throats. It has been there in most traditional societies. Show them Slide 10 and point out that there are many countries and mostly high-income countries that have health insurance. Not just USA.

Now show them Slide 11 and explain that this is the most important slide in their entire class. They need to internalise this model completely if they want to understand health insurance. It will help them design a good health insurance programme, or improve the current one that is in their state. Take them through all the elements by just naming them and showing the relationship between them. Keep a flip chart with this diagram so that you can refer to it every time you go to another element.

Slide 12 - Why? This is the first step and one needs to be very clear on this. The reasons could be increased access, or financial protection or political pressure or central government programme. But it should be very clear.

Then go through the next series of Slides 13 – 27 to explain the elements of the HI. Take it slowly, and ensure that they understand the meanings of risk-rated premium, adverse selection, etc.

Next highlight the Strengths and weaknesses of HI. (Slide 28-29)

Then go to the three types of HI and emphasise that all HI is not private HI. There is a social HI that is as good as tax-based revenue. (Slide 30 – 35)

Spend some time on the coverage plan for India. (Slide 36-37)

Finally break the class into 3 groups and ask them to read the relevant case study and then answer the questions.

Exercise – Health insurance models - Answers

CASE STUDY 1

This is a good example of a micro health insurance (not community health insurance as there is no community involvement)

Community = Cooperative society members and their families.

Organiser = Cooperative department

Insurer = Yeshasvini trust + Cooperative Dept of Karnataka

Provider = Empanelled private and public provider

Between the rich and the poor, the healthy and the sick, and between the elderly and the young adult.

Strengths – large numbers, piggy-backed on existing cooperative societies, administration simplified, cashless system, high cover.

Weaknesses – Adverse selection because individual is the enrolment unit and because pre-existing illness is covered, so elective surgeries can enrol next year. Moral hazard, because doctors will induce unnecessary surgeries, e.g. hysterectomies. Cost escalation – not much because of the case-based payment mechanism. Fraud – doctors ask patients to purchase medicines and consumables. Too narrow a package – just surgical conditions. Claims ratio is more than 100% - so not financially viable without subsidies.

Suggestions for improvement – family as the enrolment unit, broaden the benefit package to include medical conditions, strict monitoring.

CASE STUDY 2

CHI – provider type

Community = those living in the catchment area of the hospital;

Organiser, insurer and provider = hospital

Negligible. Maybe from poor to rich.

Strengths - Enrolment is easy. As provider is also the insurer, so supply side moral hazard and cost escalation are minimised.

Weakness – No waiting period, no collection period, so high chance of adverse selection. Also, individual as the enrolment unit. Demand side moral hazard. Financially not sustainable.

Suggestions for improvement – fix period for collection. Family as the enrolment unit. Make the package more reasonable.

CASE STUDY 3

This is a private health insurance with premium subsidy by the government.

Community = BPL individuals and families,

Organiser + insurer = insurance company and

Provider = empanelled public and private hospitals

Risk pooling = Healthy and sick;

Strengths – affordable premiums, good cover

Weaknesses – no independent agency to promote it. Exclusions, reimbursement model.

Suggestions for improvement – cashless system. Minimise exclusions. Involve NGOs to enrol.

Choosing a community

Steps for the session:

Ask the participants to list some factors that are important before selecting the community. List these out on the flip chart. Make the participants feel that they have come with the answers on their own, but guide them in the right direction. You can do this by asking questions and acknowledging the correct answers.

Once the list of factors has been made, ask them to rate them as desirable or essential. The group should realise that some things are 'nice to have' but may not be feasible. Still without those things, the programme can run. However, there are some factors that are essential and these cannot be compromised.

Ask the participants to read out aloud one by one from the Training manual about different experiences in the community. This will help them to see how choosing the community makes a practical difference in programme implementation.

Make the Power point presentation on 'Choosing a community'. Show the second slide and explain the differences between each community groups. In India, only 10 per cent of the adult population belong to the formal sector. The rest 90 per cent are in the informal sector. However, even within the informal sector, there are 'loose organisations'. These could be cooperative societies, traders' associations, drivers' unions, farmers' clubs, self-help groups, religious groups, caste-based groups, etc. And finally there is the informal sector that does not belong to any of the above-mentioned groups, e.g. landless labourers, vendors, servers in small hotels.

The approach to each of these groups will vary, depending on their characteristic. It will also depend a lot on the political climate, the level of solidarity, etc. (Slide 3). Before choosing a community, the reason should be very clear and explicit. It may be due to political reasons (e.g. BPL families) or a genuine problem with financial protection.

Slide 5 lists some of the suggestions that we make on how to cover the population in your region/state. What is important to note is that the poor will usually not benefit much from health insurance. It would be better to introduce a social assistance programme for them, rather than expecting them to pay and meet all the bureaucratic requirements of a health insurance programme.

Introduce the concept of UNIVERSAL COVERAGE (Slide 6). This means that all the citizens in a state/region are provided with health security. The mechanism may vary, but the important bottom line is that people do not have to worry about finances when seeking healthcare. There are many possibilities like top to bottom, i.e. cover all the formal sectors first, then move on to the informal sector. The opposite of this is a bottom-to-top approach. Or the coverage plan can be introduced simultaneously in all the population groups. And finally, the PM may announce the total coverage of his constituency through a grand statement.

Exercise - Choosing the Community

Give them 15 mts to discuss the community that they would choose. Supervise the discussions and ensure that the groups give enough importance to "the reasons for selecting" a particular community.

Allow them to present their decisions, especially the reasons why they have chosen the particular community.

Highlight the importance of focusing on a particular community, rather than opening it up for everybody. This may lead to the government subsidies being used by the better off. Also, it may be harder to implement.

Highlight the importance of approaching 'organised' segment first. Ask them to list out 'organised' segments within their community. E.g. SHGs, NGO GPs, cooperatives, unions, students, associations.

Highlight the fact that insuring BPL families is not the ideal way of going about starting an insurance programme. Better is to start with the formal sector and then expand to other levels, rather than insuring BPL. It would be easier to introduce a Health Equity Fund for BPL families.

Choosing a community may be a political decision. If however, it is possible, make a rational decision.

Choosing the benefit package

Steps for this activity:

When all the participants have assembled, tell them that there is no Power point presentation for this session, but the Exercise that they are about to undertake is key to developing any Health Insurance programme.

The participants are asked to divide into three groups. Ideally the same groups as in Exercise 3. A team leader is chosen and the group is asked to maintain the same groups over the next two days as well as it is a continuous activity.

The group is given the handouts of Exercise 4 - Selecting and Prioritizing elements of Health Insurance Coverage and then allowed to quietly read for a few minutes.

Then the trainer can say that this is a 'wish list' of possible benefit packages. Then the trainer goes on to explain that these are all the possible elements for which Health Insurance can be provided. The role of each group would be to select only those elements that they feel are very important for their community (Exercise 3) and also to rank them in order of importance.

The group is then given time. The trainer can go around and explain meanings but should not mention whether any of the elements is more or less important. Once the group have had the discussion they are asked to make a poster with clear bullet points about the elements of the benefit package in order of importance.

Once this is done, a person comes forward from each group to make the presentation. This should be different from the person who presented the previous two exercises to ensure that all participants take part in the practical exercises.

The presenter has to talk clearly, loudly and specifically giving one or two clear short reasons why they feel that the elements they are presenting are important and reason for the order of importance.

Once the groups have finished the presentation, the trainer tries to club some common elements, e.g. hospitalisation, OP. The trainer then highlights the strengths and weaknesses of these elements (see below).

The trainer also talks about some elements that they have not chosen, e.g. support for the carer's needs, travel expenses, food, loss of daily wages, bribes. Some patients may also be prescribed medical appliances which are expensive but not covered under regular insurance packages.

Exercise – Choosing a benefit package

Strengths and weaknesses of some important elements

To be used by the trainer to review the reasons for choosing a certain element

Element	Strength	Weakness
Outpatient care	The need of the community	Administrative nightmare Danger of Moral hazard Danger of Fraud
Inpatient	Need of the community Financial protection against high medical costs	Infrequent event, so people may not be satisfied
Transport charges	Increases access to health care	How do you keep the accounts? Prevent fraud?
Loss of wages	Increases access to health care	Can it increase demand side moral hazard – people come to hospital to get the loss of wages amount. Or stay longer to get some of this money
Delivery	Will have a positive impact on maternal mortality (national priority)	All pregnant women will deliver. So claims ratio will be high.
Critical illness	Useful for the sick	Very low incidence of this ailment. Rest of the community will be unsatisfied.
TB treatment	Increases access to health care	Already being covered by the government programme. So duplication.
Flat rate per hospitalisation day	Easy to administer	Danger of fraud.
Cosmetic surgery		Not the need of the community.
Immunisation		Government responsibility.

Premium

Steps for this activity:

The participants are asked to divide into the same group as the previous exercise and given handouts of Exercise. The participants have to cost each of the elements that they have listed and arrive at the premium per person per year. The trainer can go to each group individually to help them through the calculation process. Once they have arrived at the premium per person per year, request them to add 20 per cent as administrative charge. This is the final premium that they have to collect from a community member to provide this particular package. Now end this exercise with the question – do you think that your community can afford this premium?

Now move on to the lecture on premiums.

Define what a premium is (Slide 3) and then highlight the different types of premium (4-7). Emphasise the equity of the income-rated premium compared to others, especially the risk-rated premium.

Now expand on the constituents of a premium – claim related and administration related (10 – 14). Emphasise the constituents that are vulnerable to reduction, e.g. benefit package, reduction in adverse selection, reduction in costs, administrative costs and marketing costs.

One way of reducing costs of the premium is to minimise the administrative costs of collecting the premium (15-16).

Waiting and collection periods are important tools to minimise adverse selection that will have a positive effect on the premium.

How does one further reduce the premium? By choosing only relevant items in the benefit package.

Exercise 1 - Calculating the premium

Exercise 2 - Re-visiting the benefit package

Exercise: Redefining the benefit package

It appears that the benefit package as designed by you is too costly for your community. Now keeping the community needs and also the cost of the elements of the premium, can you reassemble in your groups and redesign the benefit package. Remember to maintain a balance between the community needs (acceptability) and premium amount (affordability).

Present your lists at a plenary.

The providers

Steps for the session:

Slide 2 gives the two key considerations of selecting a provider. Before displaying the Slide, the trainer can ask the participants what they feel are the key considerations. The benefit package would be the key determinant as well as availability.

With Slides 3 and 4, the facilitator talks about other experiences around the world - employing providers leads to quality issues whereas purchasing services would lead to cost issues. Discuss advantages and disadvantages of empanelled provider (Page 99 in the Trainer's manual).

Slide 5 is about negotiating with providers. This will be discussed again in detail in Session 9 so the facilitator does not have to spend a lot of time on this. The key points in this slide are that Negotiating with providers is important and ensure other benefits to the patients to improve the service experience of the insured. If provisions for Referral systems and Pre-authorisation are not made, mis-utilisation of services can occur, raising costs for insurer. (Slide 7)

Slides 8–9 introduces new concepts of essential drugs, STGs, generics. These are important cost-cutting tools and should be emphasised by the trainer. Yet another cost-cutting tool is deciding the provider payment mechanisms. (Slide 9 -17). This is a new topic and needs to be taken slowly. Emphasise that each payment mechanism has its advantage and disadvantage. Conclude by saying that we should shift from the current 'fee for service' mechanism to a better one.

Organising the health insurance programme

Steps for the session:

Before putting up Slide 2, ask the participants to list some of the administrative activities that they face in their own work situation. Put this up on a flip chart and then put up Slides 2-3.

Slide 2 gives an overview of major problems involved in administration. The facilitator has to read the trainer's manual Page 122 to be able to explain clearly all the terminology but you need not go into too much detail because each is described again in the next few slides.

Slides 4 – 11 highlights some of the main administrative activities that are required for a successful health insurance programme.

Slides 14–19 give details on how to monitor the programme. Only some key indicators have been chosen; however, there are many more in the text.

Exercise – Organising the Health Insurance programme

Steps for this activity:

Ask the groups to identify the organising agency in their health insurance programme. Now share with them the functions of this agency, especially the management and administrative functions. Also highlight the indicators that need to be monitored.

Monitoring

Steps for the session:

First define some of the important indicators. Highlight the data required for the numerator and denominator. More important, emphasise how to interpret the indicator. Then finally end with the methods on how to monitor – the need for a nodal agency that will do this, etc.

Negotiating and contracting

Steps for the session:

Before putting up Slide 2, ask participants to take turns to define negotiation. Write key words on the flip chart. This helps the participants to relate to the actual definition of negotiation. Make sure that the participants understand the meaning of each of the words in the definition and its relevance.

After showing Slides 3 and 4, ask the participants which would be the better method for a Health Insurance programme and also their reasons for the same. Highlight the fact that a deliberate method is more suitable for a long-term relationship and Health Insurance would definitely fall into the long-term category.

Slides 5, 6 and 7 give a very clear flow of action towards negotiation. A lot of time can be taken on this, as it can decide the success or failure of an otherwise well-planned programme. Many participants may be particularly weak in this area. Explain the concept of 'win win', particularly in a business venture. Ask participants themselves to give examples of situations which could be win-win. (Example - the mother says that she will cook a special meal for the child if he or she will do homework by himself/herself or the boss asks the administrator to stay back late to finish work, but will pay the administrator for the extra hours put in.)

Slide 8 gives the list of principle stakeholders and Slide 9 lists the four key principles of Health Insurance contracts. The facilitator should have read this section thoroughly as it may have unfamiliar definitions and may get a lot of questions from the participants. In case the facilitator is unsure, he or she can ask participants to read the answers out aloud for the group give it as homework or refer. It is important not to give wrong information.

Talk about lavatory Health Insurance contracts (where the elements of chance exist, conditional (where the insurer's liability depends on fulfilment of key conditions) unilateral (where only the insurer makes a legally enforceable promise) and adhesion (where terms and conditions are fixed by the insurer and accepted by the insured).

Slides 11, 12 13 give outline of the Health Insurance contract. Fine print is important here as it can later lead to unnecessary stress for the insurer and subsequent disillusionment with the concept of Insurance. Emphasise the main areas to look into – benefits, sum assured with or without limits, exclusions, waiting periods, discontinuation clauses, stop loss clauses, profit sharing clauses, etc.

Creating awareness

Steps for the session:

Highlight some of the key messages. Importance of emphasising that premium payment is not equal to benefit. Benefits will happen only if it is required. The main benefit is the peace of mind.

Exercise – creating awareness

Use the FAQs to emphasise the principles and practices of health insurance.

Presenting the Health Insurance programme

This is the final step in this entire course. They need to use all the outputs of the previous exercise to put together a proposal for a final programme.

Health initiatives for Healthy Communities

Institute of Public Health

The Institute of Public Health is an initiative by a few public health professionals in an effort to make a difference to the current health scenario in our country. We believe that there are enough resources and technology available to change the health status of our citizens, all we need are the people to do it, the knowledge and the skills and most important – the motivation.

This is why our focus is in building capacity – Training is one of our main activities. We train health professionals, managers and the community; anybody who can make a positive difference in their region. Our training is different in that it is not limited to providing knowledge. We also support the individuals/organisations to put their new knowledge and skills into practice – a form of 'hand holding'. And most important, our training is focused on the end user of health services – the community, the individual, the patient. So every single training programme will be centred on this fundamental core.

Along with capacity building, we need to have an evidence-based public health. Currently data on most health-related topics does not exist or is not easily available. We hope that by conducting health systems research, especially applied research, we shall be able to generate this evidence, evidence that can be used to answer many questions that trouble our planners and policy makers. This in turn will help them develop appropriate and effective policies that will help the common person. Thus research and advocacy will go hand-in-hand.

Today there is a dichotomy between academics and field reality. We hope to reverse this trend by insisting that our faculty are involved in field-based projects, so that they are aware of what is happening at the grass roots, at the frontiers of health services. Only then can their training and research be appropriate and relevant.

And who are our faculty? In this era of computers and telecommunications, we do not believe in having a centralised, top-heavy cadre of academicians. Rather, we draw on existing experts from the field. These 'experience experts' assist us when necessary. A core team at Bangalore coordinates this process and provides the necessary direction.

Bangalore
Tel: +91 80 2642 1929
mail@iphindia.org

Institute of Public Health
Bengaluru - India