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HEALTH MICRO INSURANCE: A STUDY OF UDUPI DISTRICT

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ABSTRACT

The types of risks are multitude in complex forms. As the poor do not have access to adequate risk-management tools, they are often forced to deplete their financial, social, physical and human assets during their fight against multiple risks. The poor are considered to be more vulnerable to illnesses and epidemics .Health problems not only impact expenditure of the household, but also reduce the productivity and lessen the opportunity for growth. Any poverty alleviation strategy, must therefore, enhance the ability of the poor to deal with risks. Insurance is one of the risk dealing strategies. Insurance is a mechanism of pooling the risks and resources. However, India's landscape of health insurance has undergone tremendous changes in the last few years with the launch of several health insurance schemes, largely initiated by central and state governments. Designing valuable and sustainable product in a cost effective way is inherently more complex for Health Micro-Insurances. Many exciting projects worldwide are working in the field and testing the innovative solutions. In this regard, an attempt has been made to analyse the impact of three main Health Micro-Insurance schemes prevailing in Udupi district, *viz*, Yeshaswini Scheme, Sampoorna Suraksha Programme and RSBY Scheme, in promoting health and economic status of the low-income people.The article also tries to understand the demand side and supply side challenges and delivers empirical insights for policy decision.

INTRODUCTION

Although the type of risks faced by the poor such as death, illness, accident, old age, unemployment, crop-loss etc. are no different from those faced by the others, the poor are more vulnerable to such risks. They are often forced to deplete their financial, social, physical and human assets during their fight against such multiple risks. As these people do not have access to adequate risk-management tools, they are forced to dwindle in the vicious circle of poverty due to the losses from negative shocks. Any poverty alleviation strategy, must therefore, enhance the ability of the poor to deal with risks. Insurance is one of the risk dealing strategies.

Insurance is a mechanism of pooling the risks and resources. When, however, the risks and resources are pooled among a larger group of persons, the security of each individual is enhanced. Micro insurance is the new term used to refer insurance services that are specially aimed at poor that involve modest premium and coverage amount. In common parlance, micro insurance is the provision of insurance services to low income households. It serves as an important tool to reduce risks and hardships of the vulnerable groups. Micro insurance is also referred to as community based insurance. UNDP opines that the micro-insurance is specifically designed for the protection of low income people with affordable insurance product to help them cope with and recover from common risks. (UNDP, August 2006) The mechanism used in this scheme is generally the provision of mutual support through the pooling of resources. Furthermore, micro insurance makes it possible for poor to fight against the risks. Hence, micro insurance is recognized as a useful tool in economic development.

Although the micro insurance schemes in India cover a variety of risks, life and health - are the two most popular risks for which insurance is demanded. Health risks are the prime risks which the low-income families frequently face and against which protection is desperately needed. Indeed, health expenditure is the prime cause of their destitution. The emergence of Health Micro-Insurance programmes provides hope that the poor will receive, at a minimum, a reliable, adequate level of access to affordable healthcare. Research shows that access to Health Micro-Insurance reduces out-of-pocket health expenses, especially for catastrophic health events, and improves access to quality health care for those who are insured. More specifically, Health Micro-Insurance is a micro insurance product that provides a defined set of health benefits and services. Such benefits can include catastrophic events such as surgery or more routine events such as outpatient services or maternal care.

Health Micro-insurance - referred by different names such as community-based health insurance, micro-health insurance, mutual health insurance, community-based health financing, community health insurance etc. - is a form of micro-insurance in which resources are pooled to mitigate health risks and cover health care services in full or in part. Health micro-insurance schemes are more complex in nature compared to life insurance schemes, as they provide services towards specific risks or illnesses and involve the role a health care provider, whether independent of or in partnership with the scheme. The scheme can be provided by government, a private insurance company, an NGO or a Community Based Organisation.

IMPORTANCE OF THE STUDY

Health micro-insurance is important for the poor because health risks are often considered by the poor as the greatest and costliest threats among all other natural, social, economic etc threats faced by them. Health problems not only impact expenditure of the household, but also reduce the productivity and lessen the opportunity for growth. Long-term illnesses have serious implications on the poor, leading to other unhealthy social conditions such as alcoholism, domestic violence or psychological complications. The poor are considered to be more vulnerable to illnesses and epidemics than the rich as the former usually live in unhygienic conditions; they have low-levels of health awareness and fail to take up preventive measures. One of the reasons for lack of a proper health-seeking behaviour within the poor community is the expensive medical treatment especially at private health clinics in addition to the bad facilities available at public health centres. There is a close relationship between the health conditions of the people and the economic growth of the country in which they live. It becomes necessary for the government to ensure affordable services for the poor to improve and maintain their health well-being. Some of these factors prove that Health Micro-Insurance is critical to reduce poverty and improve household conditions in poor and developing countries.

A Health Micro-Insurance project can cover the following benefits under its plan of operation:

(1) Basic Health Care: Preventive health care, health education, immunization, family planning etc; part of curative care such as medical consultations, nursing care, medical care etc
(2) Hospital Treatment: Hospital accommodation, medical, surgical, technical expenses and medicines.
(3) Specialised Treatment: Includes consultations with specialist doctors (gynaecologists, paediatricians, surgeons, dentists etc) and medical interventions such as radiology and clinical biology, which are carried out either during hospitalisation or during an external consultation.
(4) Dental Care: Administered through dental clinics
(5) Medicines: Medicines under prescription
(6) Transportation: Transportation costs of bringing patients to health centres
(7) Other categories of health care coverage include paying a fixed rate for loss of compensation during the hospitalised period for the earning member of the family, maternity cash allowances, funeral allowances etc. However, it has been observed that these extra services require a large contribution from members.

As per National Health Accounts, Total Health Expenditure for the year 2014-15 is estimated at Rs. 483259 crore which accounts for 3.9 percent of GDP. This share is very low when compared with other countries like Australia – 9 percent of GDP, USA – 17.1 percent of GDP, Germany – 11.3 percent of GDP, France – 11.7 percent of GDP, Russia – 6.5 percent of GDP. Current Health Expenditure in India accounts for Rs. 451286 crore which shares 93.4 percent of Total Health Expenditure. Government Health Expenditure is estimated at Rs. 139949 crore which amounts for 29 percent of Total Health Expenditure, 1.13 percent GDP and for about 3.94 percent of General Government Expenditure. Out-of-Pocket Expenditure is estimated at Rs. 302425 crore accounting for about 62.6 percent of Total Health Expenditure, 2.4 percent of GDP for the year 2014-15. In this regards, I think, this the high time to discuss about the Health Micro-Insurance which is specially designed for the protection of low-income people, with affordable insurance products to help them to cope with and recover from common health risk. The paper discusses the existing scenario of Health Micro Insurance in Udupi district.

OBJECTIVES

1. To identify the status of Health Micro-Insurance schemes in the study area.
2. To assess the availability, accessibility and affordability of quality care among health insurance subscribers.
3. To study the impact of Health Micro-Insurance on financial vulnerability of the poor in the study area.
4. To identify the demand side and supply side challenges.
5. To suggest measures for betterment.

METHODOLOGY

The data for the study has been collected from primary and secondary sources. A cross-sectional study was carried out in Udupi district. Health care services are being provided by PHC, CHC and private hospitals in the study area. In addition there are a number of private clinics and nursing homes. Survey being the pilot study, the sample size is small, i.e., 45. The families are randomly selected across various social and occupational groups. Out of 45 families 15 each are enrolled to three different schemes, viz, RSBY, Yeshaswini and Sampoorna Suraksha. The survey was quantitative and qualitative. Data was collected through structured questionnaire and was analysed with the help of simple averaging. The materials collected from the print and electronic media are secondary sources.

ANALYSIS

Table – 1: Comparative outlook into the three schemes (2016-17)

Scheme	Network hospitals		Beneficiary Contribution	Subsidies	Premium	Implementing Agency	Coverage Amount (in Rs.)
	Public	Private					
RSBY	2267 (32%)	4923 (68%)	No (Rs. 30 as registration fee)	100% - Centre 75% & State 25%	440 to 750	MOLE+ State Nodal Agency	30000 per family per year
Yeshaswini	29(6%)	421 (94%)	Yes	Rs. 30 by the State Govt.	250	Govt+ Trust+ TPA	200000 per family
Sampoorna Suraksha	3(2%)	123 (98%)	Yes	No	380	SKDRDP (NGO)	60000 per family

(Source: website of the respective scheme)

The above table gives a comparative picture of the three schemes. RSBY, being the centrally sponsored scheme, is funded by the Centre and the State Governments at the ratio 5:25. (But the beneficiaries have to pay registration fee Rs. 30). The BPL people are the beneficiaries of this scheme. Yeshaswini is implemented by the Government of Karnataka and the members of cooperative societies are eligible to subscribe the scheme. The Government pays Rs. 30 of the premium. Sampoorna Suraksha is the Health Insurance programme implemented by NGO, viz, SKDRDP of Dharmasthala and the members of SHGs of SKDRDP are eligible to enrol to the programme. The subscribers are liable to pay the premium under the programme. Premium rate for different schemes is also different. It ranges between Rs. 440 to Rs. 750 in case of RSBY, while under the Yeshaswini (Rural co-operative members) scheme the premium is Rs. 250 and the premium for Sampoorna Suraksha is Rs. 380. Benefits also vary with the schemes. RSBY covers impatient and tertiary care only. Yeshaswini covers inpatient, secondary and some tertiary care services. Sampoorna Suraksha also covers inpatient, secondary and tertiary care services. Benefit coverage under RSBY is Rs. 30000 per family. Under Yeshaswini the coverage is up to Rs. 200000 per family floating to 4 years. Sampoorna Suraksha financial medical care benefits cover the amount Rs. 10000 to Rs. 60000 per family per year.

FINDINGS

1. Number of families surveyed is 45 and the total number of members in these families is 208. Average number of members in a family is 4.62.
2. Socio-economic Status

2.1 Family income

Table - 2: Annual Income of the Families

Annual Income of the Family	Number of Family	%
Less than Rs. 10000	18	40%
Rs.11000 to Rs. 25000	23	51%
Rs. 26000 to Rs. 50000	3	7%
More than Rs. 50000	1	2%
Total	45	100%

Source: Primary Data

Annual income of 18 families (40%) is less than Rs. 10000 per annum. 23 (51%) families earn income between Rs. 11000 to Rs. 25000.

2.2 Occupation

Table - 3: Occupation of Household Members

Occupation	Number of members	%
Coolie	73	59%
Other informal	14	12%
Housewives	10	8%
Agriculture & allied activities	9	7%
Self-employed	7	6%
Unemployed	8	6%
Formal sector jobs	3	2%

Source: Primary Data

Majority of surveyed people i.e., 73 (59%) are coolie workers while 12% are other informal workers like painters, artisans, bus-cleaners etc.

2.3 Educational Status:

Table - 4: Educational Status of Household Members

Level of Education	Number of members	%
Primary	87	42%
Secondary	23	11%
PU	3	2%
Higher/Technical Education	-	-
Students	84	40%
Illiterate	11	5%

87 respondents (42%) got only primary education while 23 (11%) got secondary education. 11 people (5%) are illiterate.

3. The total number of members enrolled to Health Insurance Scheme is 136 at an average of 3.02 per family. In Sampoorna Suraksha and RSBY enrolment unit is family whereas in Yeshaswini scheme it is individual, but he can enrol any number of his members into the scheme though they are not the members of Co-operative societies.

4. Health Risk: 4 households opined that they are exposed to work-place risk and hence health insurance is more beneficial to these people. Most of the families (43 – 96%) have either clinic or medical shop within the periphery of 1 km of their home. This has made them to avail health care easily.

5. Beneficiaries: 24 members out of enrolled 136 have received health care benefits under the health insurance schemes. Majority of them are hospitalisation benefits followed be maternity benefits.

Benefits	Number of claims	%
Hospitalisation benefit	15	64%
Maternity benefit	5	21%
Accident death/disability	1	4%
Natural death	3	13%
Total number of claims	24	100%

6. Denial of benefits: 5 cases were rejected at the rate 10%.

7. Financial Protection: The primary aim of nearly all insurance is protection from large financial losses. Following observations are made in this regard.

7.1 Ability to Save: 43 households (96%) out of 45 opined that payment of Health Insurance premium has not reduced their ability to save.

7.2 Debt-repayment Capacity: 41 (91%) have the opinion that their debt-repayment capacity has not been reduced by the HI premium payments.

7.3 Consumption Expenditure: All the households (100%) feel that their consumption expenditure is not adversely affected by the payment of HI premiums.

7.4 One among the 45 households sold out their asset to meet the healthcare expenditure prior to the enrolment to the scheme. Now they hope there will be no such fear as such.

8. Affordability: 9 households (20%) feel that the premium is high. Average amount they can afford per member per year is Rs. 150-200 and per family ranges from Rs. 750 to Rs. 1000. As we observed above premium under Yeshawini is only Rs. 250 per member and in case of Sampoorna Suraksha it is i.e., Rs. 380 per member. It is inferred from the analysis that the amount willing to pay for health insurance is less than amount actually paid which indicates loss of consumers' surplus (except for RSBY).

9. Awareness: All the households are aware about the scheme but the extent and depth of awareness is different. Only 3 households (7%) have complete knowledge about the scheme.

10. Accessibility: Empanelment of the public and private hospitals in villages, taluk centres and district centres improved the accessibility of the health care services to the poor households especially, the most vulnerable BPL people.
10. All the households (100%) opine that health insurance schemes are good and useful in reducing the financial burden for medical care.

11. Majority of the households (93%) expressed the opinion that the health insurance schemes should cover all types of deceases including outpatient care.

12. Willingness to Continue in the Scheme: 40 (89%) households are willing to continue to subscribe the scheme.

CHALLENGES

The recent growth of health micro insurance scheme in India, in many ways, marks a new phase in India's quest to provide quality health care to all especially to the poor at an affordable cost. But the sector faces various challenges like moral hazard, adverse selection, limited benefits, product design etc. which are common to any form of health insurance scheme. The challenges faced by the sector in the study area are as follows:

1. Extent and Depth of Awareness and Knowledge: Though a good number of people are aware about the scheme, the level of awareness is different. Extent and depth of awareness is an important question. People are aware about the scheme i.e., they have heard about the scheme, but they possess little knowledge/information about the scheme. They are not aware of empanelled hospitals, types of services provided, members eligible and the procedures. This has resulted in unnecessary admission, high billing, ineligible claims which cause financial burden to both insurer and insured.

2. Denial of the Benefits: Little awareness also led to the denial of services sometimes. Many a time the households have little knowledge about the hospitals empanelled and deceases covered, because of which the benefits are denied. In case of RSBY, delay in the issue of smart cards, mistakes in the card like miss-match of photos, thumb-impressions etc. are also resulted in the denial of benefits.

3. Dissatisfaction among the Members: High expectation of the members and misunderstanding that scheme covers all hospitalization expenses sometimes evoked small dissatisfaction.

4. Delay in Claim Settlement: Hospital and patient induced admissions, heavy flow of claims, absence of control gate in hospital has led to the pendency and rejection of claims and delay in claim settlement.

5. Premiums: Destitute poverty is not allowing poor to pay relatively higher premiums. People with very low income

standard are not willing to part with their hard earned money for unforeseen ailments/events. Many families earn on daily basis. During the camp to get enrolled they have to sacrifice a day's wage for this sake. If all the members in the family are wage earners, loss will be very high.

The above problems made the people to discontinue the scheme. Studies also proved that due to these problems various schemes failed to reach the set targets.

SUGGESTIONS

1. A comprehensive and consumer need-based package is necessary to achieve 100% coverage. Diseases like TB, HIV and mental illness, outpatient care, chronic diseases like diabetes, and hypertension can also be included in the benefit package. Though the level of education/awareness is low they are able to express their ideas about the programme.

2. To increase the coverage to the poor, insurance programmes could be linked with the existing poverty alleviation programmes.

3. Creating Awareness: Awareness can be generated by undertaking 'melas' or exhibitions for displaying the devices which focus on the need and importance of the HI schemes. SHGs, Co-operatives, Anganvadi workers and ASHA workers best reach the rural people.

4. Connecting the People: To enlarge the connectivity, focus on women is necessary, as they are the catalyst of the change. Connectivity can also be enhanced by inculcating knowledge involving local celebrities and renowned personalities.

CONCLUSION

Health insurance has a great potential to improve the welfare of the poor and help to fulfil the vision of an inclusive growth. The health insurance providers should bring out the clear-cut policy details, as many have vague ideas about the benefits and risks involved in a policy. The middle and low socio-economic groups are a potential market as they are ready to spend a reasonable amount due to huge medical expenses in the absence of HI provision. To develop a viable HI scheme, it is important to understand consumers' needs and offer a package that is accessible, available, affordable and acceptable to all sections of the society. It is also important to create awareness to achieve 100% coverage.

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