Community Health Insurance and Family Health Protection (FHP) Plans for India.

I. Population Coverage:

A. Families with income below the poverty line:

1. All families living below the poverty line (BPL). The poverty line is fixed on the basis of consumption expenditure required to meet minimal food and clothing. The poverty line, in India, is defined by inverse interpolation of per capita total expenditure that average households actually incur while meeting the normative calorie requirement for the respective category (Dubey and Gangopadhyay, 2002). Thus, there is no normative medical and health expenditure built into the poverty line. The inverse interpolation based on normative food basket and observed consumption pattern of households ensures that average medical and health expenditure incurred by the households consuming food below the normative level is built into the poverty 4 budget speech, has proposed to introduce a health insurance scheme for the poor (Times News Network, 2003). The scheme proposes to cover hospitalization costs upto 30000 rupees per annum for an annual premium of Rs365 / person. Families below the poverty line will be eligible for a 100 rupee subsidy per person. However, many operational difficulties have to be overcome for successful implementation of a comprehensive health insurance scheme (Jain 2003).
2. One restriction over and above the below poverty line status, from the Family Welfare Program perspective, is to require adoption of family planning measures. Ideally, from this perspective, adoption of any family planning measure including spacing methods should be sufficient. However, administrative feasibility is an issue. Families adopting permanent measures such as tubectomy or vasectomy are easily classified. Inclusion of those who adopt spacing measures, may give scope for administrative leakage in the sense that some families who are not actually practicing spacing methods, may manage to get in. These arguments probably weighed in the National Population Policy (GOI, 2000), which has clearly specified that couples below the poverty line, who undergo sterilisation with not more than two living children, would be eligible for a family welfare linked health insurance scheme. However, since the "family planning adoption" criterion is to be superimposed on the "below poverty line" criterion, there will be a built in cap on the potential leakage due to false declarations about adoption of spacing methods. More over an inclusive "family planning adoption" criterion recognising the spacing methods will be consistent with the "target free" approach (Khan and Townsend, 1999). Furthermore, improvements in infant mortality, and overall family health status has been found to contribute towards adoption of fertility control measures.

B. Health Insurance Coverage for Community Risk Rating:

1. Relative merits of different forms of health insurance were discussed in the seminar on health insurance in November, 1999 by the Government of India and the World Bank (Peters, Ramana and Sujatha Rao, 2000), and more recently in the Workshop on Health Insurance at New Delhi, 3-4 January 2003, organised by the GOI and WHO.

2. Community rating of health risks is preferred because of its usefulness to promote solidarity concept and to keep the incidence of adverse selection and cream skimming down. Adverse selection and cream skimming have been found to substantially contribute to health care cost escalation. Hence social insurance and community-based insurance options are preferred over private voluntary health insurance.
3. Garg (2000) has summarised for the National workshop mentioned above, key features of social and community health insurance schemes, which are reproduced below.
   i. Social Insurance:
      equity in finance if premiums are graded according to incomes. Costs and quality of care can be controlled through payment mechanism to the provider. Moral hazard could be minimised by introducing supplementary payments for expensive treatment. Compulsory and lifetime enrollment can help to reduce the risk of adverse selection. Supply side limitations can be influenced through provider payment mechanisms. Consumer redress mechanisms can ensure good quality care at the cheapest rates. In India, the social insurance is limited to only a small proportion of people in the organised sector and to central government employees. With a large rur
      inherent problems. There will be problems in assessing the incomes of people and collection premiums from small, unregistered firms and from those in the unorganized industries and rural sector, just as there are problems in collecting income tax. Further, the consumer redress mechanism will not function effectively because of a large percentage of illiterate population.
   ii. Community Insurance: Community financing can complement formal social security schemes that cover regularly employed or self employed, particularly in rural communities. These are 'soft compulsory' implying that there is a local pressure on individuals to take a cover and also the term of insurance is long so that insurance funds could be planned as if the insurance is compulsory (Ensor 1997). Community based insurance schemes are important as they cover primary care, which is difficult for private insurance to administer. Another advantage of the community-based schemes is that they have low administrative costs and most of the expenditure is on providing drugs and paying doctors. For community schemes to sustain, the demand should be from within the community. Funds have to be locally managed and benefits and premiums should also be decided at the local level for people to trust the scheme. Inherent problems visualised in these schemes are low coverage, poor cost recovery and limited ability to protect the interest of the poorest both in terms of access and financing. Also, these schemes are based on the demand on the demand for those services / facilities for which there is local demand and not on professionally perceived needs.
4. The International Labour Office (ILO) Medical Care and Sickness Benefit Convention, 1969 provides that at least 75% of economically active population or at least 75% of residents should be covered in a Social health insurance scheme. In all cases, the spouse and childre
   families constitute between 10 to 40% of population in different parts of the country. Targeting any health insurance scheme only to the poor will mean that only about 10- 40% population in any geographic area can be covered giving rise to the problem of adverse selection. Adding permanent sterilisation requirement will further reduce

coverage among the poor. Moreover, a health insurance scheme designed only for the poor goes against the solidarity principle. The Employees State Insurance (ESI) eligibility is yet another potential criterion for target group definition. Currently, the maximum monthly wage for ESI coverage is fixed at Rs. 6500 (ESI, 1997). As mentioned earlier solidarity principle is widely held as a valid ethical basis of addressing health care policy.

C. Recommended community based health insurance coverage model:

1. Thus we recommend a community health insurance scheme targeting all residents of an area with a premium structure that incorporates graded state subsidy for various low income families.
2. Community enrollment:
   i. The health insurance coverage will be available to a community, if it guarantees that at least 75% of its constituent families will purchase the policy.
   ii. Communities will include all constitutional local bodies such as the Gram Panchayat, and municipality, but not limited to them. Other formal and informal communities will also be eligible. For example; employer affiliated groups, women self help groups etc..
3. Subscription by families living in an enrolled community:
   i. To purchase the Community Health Insurance Policy a family should be the constituent of at least one enrolled community. If a family happens to be simultaneously a constituent of more than one enrolled communities, then such a family will have the option to indicate any one of the said communities.
   ii. Low income families will be entitled to graded subsidy as described below.

D. Income lines for health and housing (ILH):

1. There is one important problem with all of the above criteria primarily based on the poverty line. The expenditure now allocated towards medical and health care by below poverty line family is usually inadequate to meet the need. Thus many families with income marginally above the poverty line, when faced with high medical and health expenditure would end up below the poverty line. It is well known that many lower middle class people are not able to afford the cost of medical care. Health and housing are the next order of need of families as their income goes above the poverty line. Research in the US shows that families with income less than twice the poverty line account for a majority of the uninsured (Economic Report of the US President, 2002, p.160). Hence it is desirable to adopt the concept of a low income line for health and housing.
2. The Housing Development Corporation (HUDCO) assigns families into the following four income classes to target its housing loans.
   i. The Economically Weaker Section (EWS) with household income of Rs. 2,500 per month or less.
   ii. The Low Income Group (LIG) with household income not more than Rs. 5,500 per month. This is slightly less than the current ESI eligible income limit of Rs. 6500 per month.
   iii. The Middle Income Group (MIG) with household income not more than Rs. 10,000 per month.
   iv. The High Income Group (HIG) with household income more than Rs. 10,001 per month.

3. It is recommended that Government of India should periodically fix income lines for health and housing. The monthly income limit for employees social insurance zed. We recommend the a technical group on income lines for health and housing be set up jointly by the planning commission, the ministries of health, housing and labour to develop the technical basis for computation of these income lines and their periodical updates. A permanent official mechanism should be put in place for updating of the income lines for health and housing. We recommend the following income lines for health and housing as a starting point.

Table 1: Income lines for Health and Housing

Income Category for Health and Housing	Recommended Definition	Recommended Health Insurance Premium Subsidy
Poor Families	Official Poverty Line for food subsidy or targeting of anti poverty programs	High State Subsidy 75 - 90%
Low Income Families	An income figure around the current official Low Income Limit for Housing Finance (Rs5500/mo) and salary limit for ESI coverage (Rs6500/mo).	Substantial State Subsidy or Mandated Employer Contribution. About 50%
Middle Income Families	Families with monthly income more than low income limit but with no taxable income.	Marginal subsidy equivalent to health insurance premium subsidy enjoyed by income tax paying families through income tax concessions. About 20%.
High Income Families	Families with income above the Official Low Income Limit for Housing Finance	Subsidy available through income concessions for health care expenditure.

E. Coverage of States and Districts:

Wiesmann and Jutting

insurance schemes in rural Sub S

the success of such health insurance schemes. These are; (a) scheme design and management, (b) availability and behaviour of health care providers, and (c) community characteristics. Scheme design and management issues are addressed elsewhere in this document. The other two aspects, namely availability of health care providers and community characteristics, imply that, ceteris paribus, a well designed health insurance scheme is likely to succeed in certain areas and may not establish well in certain other areas, depending on availability of health care providers and community characteristics. The scheme designed by us envisages some degree of competition among primary ambulatory care providers. This will be feasible only if there is scope for mu

centres which may, if the respective state governments grant them operational autonomy, compete to serve the proposed community based health insurance policy holders as a clinic. However, public sector primary health centres acting as clinics can not provide the required provider competition alone. Additional clinics in the private nonprofit and for-profit sector should be available to give choice to policy holders. Thus Wiesmann and Jutting's (2001) observation about the importance of health care provider availability for success of health insurance schemes sounds reasonable. Mahapatra and others (2002), based on a study of the private health sector in Andhra Pradesh, found strong correlation between the Centre for Monitoring Indian Economy (CMIE) infrastructure development index and private hospital bed capacity. Much of these private hospital beds are actually in small nursing homes of 1-10 beds (Mahapatra, 1998). These are potential candidates to serve as clinics for the health insurance scheme designed here. In addition, private hospitals and nursing homes are known to be closely associated with clinics. So areas having substantial private sector nursing homes are likely to have more number of private clinics, some of which may qualify and be willing to serve as the clinics to deliver ambulatory medical care to health insurance policy holders. Wiesmann and Jutting (2001) observe that widespread absolute poverty among potential members can be a serious obstacle to the implementation of any form of health insurance. If people are struggling for day to day survival, they are less willing to pay advance premium for possible use at a later date.

Hence, we propose that these community health insurance plans be implemented at the district level in a phased manner. In the first phase, districts with high infrastructure development, lower levels of poverty and higher levels of literacy should be taken up. In addition, scope for development and sustenance of Mutual Health Organisations (MHO) that will be responsible for management of the health insurance scheme is also important. The public sector health centres, and hospitals will continue to be the primary source of health care for most of the local population living in less developed districts. In subsequent phases, the community based health insurance schemes can be extended to other districts commensurate with socioeconomic and infrastructure development. Actual phasing of districts is ideally decided at the state level. Phasing should also be flexible, so that emerging opportunity if any can be tapped to introduce community health insurance schemes. Key

criteria for inclusion of districts in earlier phases should be based on an overall assessment of the probability of success and sustainability of health insurance schemes.

II. The benefit package and entitlement to benefits:

We have first conceived of two levels of health care coverage, namely; (a) ambulatory primary care, and (b) hospital access services.

A. Ambulatory Primary Care:

1. Out patient consultation including clinical examination and ambulatory medical care.
2. First aid; wound cleaning and dressing services including removal of foreign bodies, suturing of clean wounds, abscess drainage etc..
3. parentrals.
4. Primary eye care including diagnosis and treatment of Conjunctivitis, eye lid infections, removal of conjunctival foreign body, Vitamin A deficiency; first aid and referral.
5. Dispensed primary medicine
   30% co payment.
6. priateness and access
   procedures of hospitals and health care institution and specialists.
7. Access point for services provided by Public Health Authorities such as; (a) Immunisation (b) Contraceptives (c) Ambulatory treatment under disease control programs.
8. Ante natal care.
9. Prophylactic dental treatment including dental hygiene advice, dental examination and advice and scaling.
10. , urine and stools, plain X
    ray and collection and dispatch of samples to referral laboratory.

Most participating clinics should be able to provide bulk of the ambulatory medical and primary health care services at serial 1-6, on walk in basis during regular clinic hours. The clinic would act as access point for services provided by public health authorities according to the cycle and periodicity to be mutually developed by the concerned local health authorities and the clinic. For example, immunisation services would be available on certain days, and directly observed anti tuberculosis treatment may be delivered on another day of the week. The specific days of the week for such services will, naturally, vary according to local practices and the clinics convenience. Ante natal, and dental care may also be delivered on certain day of the week. This will encourage clinics to affiliate with suitably skilled personnel, in case the primary care physician does not feel comfortable enough to deliver these services. Some clinics will have their own laboratory and some may out-source these services from another laboratory / clinic or hospital. Most clinics will probably out-source

X-ray services. However, the clinic will have to pay for these services from out of its capitation receipts.

B. Hospital Access Services:

1. Facilitation, assistance and advocacy to access Government Hospitals and Health Care Institutions (HCIs).
2. Direct settlement of user fees charged by public hospitals and health care institutions.
3. Supply or cost reimbursement of medicines and materials required but not available in government hospitals.
4. Cost of treatment in designated non profit hospitals and health care institutions.
5. edicine, cost of diagnostic tests performed outside the public or designated non profit hospitals subject to 30% co payment by the policy holder. Reimbursement will be limited to price of generic drugs where available and rates of diagnostic test set by appropriate public agency or the insurer.
6. Emergency treatment in any hospital.
7. If treatment is not available in the first referral hospitals stated in clause 2 & 3 above, service charges of speciality / tertiary referral hospitals.
8. In case of major medical conditions/ catastrophic illnesses requiring very high expenditure, facilitate appl

There will be a financial cap of Rs 30000 / annum on the cumulative value of medicines, materials and reimbursement stated in clause 2-7 above. The medicine (drugs), material (therapeutic) included in the appropriate formulary will only be admissible. Appropriate formulary will be the hospital/health care institution formulary approved by the mutual health organisation, where such a formulary is not available, the formulary of mutual health organisation and if neither the above two are available, the list of essential drugs approved by state government, central government or WHO as the case may be.

Three alternative policies, giving different benefit packages, have been developed. These alternative policies, numbered 1-3 are given in the annexure 1- 3. The following table summarizes, the benefit package of each policy.

Table 2: The benefit package and entitlement to benefits in three Family Health Protection (FHP) Plans.

The benefit package	FHP1	FHP2	FHP3
Primary Ambulatory Care:			
Out Patient services and First Aid	✓	✓	
Immunization and Access to Public Health Programs	✓	✓	
Preventive Dental and Eye care	✓	✓	
Diagnostic tests for ambulatory care.	✓	✓	
Drugs and Referral Services	✓	✓	
Hospital Access and Services Upto Rs30000 / family / annum			
Facilitation and advocacy services to access Govt. Hospitals and Health Care Institutions	✓		✓
Supply / cost reimbursement of medicines and materials,	✓		✓
Emergency hospitalization treatment	✓		✓
Catastrophic Illness & Major Medical Expenses			
Facilitate access to major medical relief from public or charitable sources.	✓		✓

We have given three alternative health insurance policies. Comprehensive ambulatory medical and primary health care is the foundation for two of the three policies. Although, the Primary Health Centres (PHCs) were originally set up to provide both curative and preventive services, the curative service component is least reliable and is a major source of popular dissatisfaction with these centres. However, some public health officials and policy executives do argue that the PHC is meant to provide primary medical care. Hence government should not pay for primary medical care again through a health insurance

favour with this school of thought. But our reason for including this third alternative is to provide a lower cost alternative to the government in case enough finances are not available.

Our preference is for the first policy consisting of comprehensive ambulatory primary care and access to first referral hospital services. The second policy covering ambulatory primary care is our second preference.

III. Organisation of health services:

A. Overview:

These policies are designed to work through existing health care infrastructure and eventually stimulate growth of required infrastructure. Various component services covered by these policies will be delivered through; (a) the clinics, (c) public hospitals, (d) private

nonprofit hospitals, (e) private for-profit hospitals (f) participating pharmacies, and (g) diagnostic facilities. The role of each of these component institutions is described below.

B. The Clinics:

Note that the ambulatory primary care is the foundation of the two policies preferred by us. We envisage that this ambulatory primary care services will be provided by the participating clinics. A participating clinic is defined as an ambulatory medical care facility having a contract with the Mutual Health Organisation to deliver ambulatory primary care services to the MHO's policy holders.

1. Public, private nonprofit, and private for-profit ambulatory medical care facilities will all be eligible to participate, provided they satisfy the required quality of service standards.
2. Automatic participation by public sector clinics will not be allowed. On the other hand, a public sector health care institution will have to satisfy the quality of service standards and in addition demonstrate evidence of its operational autonomy[1].
3. The clinic may have registered medical practitioner from any system of medicine including Indian systems of medicine and homeopathy as the primary care physician. The clinic will be expected to clearly state the system of medicine practiced by the prima ich clinic to register.
4. The clinics will compete with each other by seeking policy holder options in their favour. It is hoped that, unpopular clinics will eventually get voted out by the policy holders annual option to choose a clinic from among the participating clinics in the area.
5. A participating clinic must satisfy the required quality of service standard. The quality of service standards will be as prescribed by the concerned mutual health organisation and may be based on a minimum quality of service standard prescribed by the concerned state public health authority. A draft minimum quality of service standard for clinics is enclosed at annexure-4.
6. A MHO may use credible third party accreditation status information, in addition to its in house quality assurance system, to determine initial and continuing satisfaction of quality of service standards by a clinic. It will be desirable for governments to encourage appearance of voluntary accreditation services to improve the quality assurance environment for the health sector.

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[1] The operational autonomy requirement of public sector clinics is to ensure that a participating clinic is in a position, to locally utilize the capitation fee received by it to provide services to the policy holders registered by it for primary ambulatory care. It may be argued that a private nonprofit or for-profit clinic, which is branch of a large organisation or firm, would be subject to central control as is a public sector clinic. This is possible in case of private health care chains. As of now, such chains are not very prevalent in India. Almost all private for-profit and nonprofit health care facilities in India, enjoy reasonable degree of operational autonomy. We view the societies registered by governments as public sector institutions. Many such societies are subject to centralized control as are government facilities. Hence, de-facto autonomy of these de-jure autonomous institutions needs to be established on a case by case basis.

C. The Hospitals:

The first referral hospital services will be accessed from the public and selected nonprofit (which term includes voluntary and charitable) hospitals. These would be mostly public hospitals. The hospital access component in the benefit package is to facilitate access to the public hospitals. Only emergency treatment in private hospitals is considered to be eligible.

D. Public hospitals:

It is envisaged that the bulk of first referral hospital services can be accessed from the public hospital network. The public hospitals are duty bound to provide free service to the poor. A good part of the health sector resources are allocated to these hospitals on the ground that they would provide free services to the poor. Some may argue that the quality of services in public hospitals is not as good as it is in private hospitals. Hence the poor, covered by state funded health insurance scheme should not be denied access to private hospitals. It turns out that evidence in support of this argument is lacking. On an average, and ceteris paribus, there is no difference in quality of services by private and public hospitals or nonprofit hospitals. On the other hand, private hospitals are more likely to be sources of provider induced demand. One of the important factors, why poor are unable to access the public hospital services is that they are unable to meet marginal costs of accessing these services. For example; purchase of drugs not available in the public hospital, surgical materials, and more recently user charges levied by some public hospitals. By restricting the first referral hospital services component to be delivered through the public hospitals, we are actually seeking to keep the cost of the insurance policy down. Since the policy holder will be assisted with required social work and advocacy support and will have access to funds to meet any additional costs arising during the course of hospitalization, this policy will stimulate better utilization of the public hospitals. Experience from the Swablamby Swasthya Yojana in Ratlam district of Madhya Pradesh suggests that this a feasible strategy. (Mahapatra and Reddy, 2003). A detailed report is enclosed as annexure 5.

E. Private nonprofit hospitals:

In addition, we have provided for payment of costs of treatment in nonprofit hospitals. Since most nonprofit hospitals work with some amount of volunteer workforce (salary costs of non profits have been found to be comparatively lower than the public hospitals) and have access to some capital subsidy by way of donated land, building and / or equipment, cost of

treatment in these hospitals is likely to be less than private for-profit hospitals. In many districts there are very active nonprofit hospitals with excellent reputation of social service. The recommended policy allows for selection of such hospitals where policy holders may avail hospital services.

These community health insurance schemes have been designed, with a liberal health care coverage package and very modest premium cost. One of the ways these plans seek to manage the coverage is by accessing already subsidized public hospital services or low cost charitable hospital services for the health insurance policy holders. So the enlistment of nonprofit hospitals by the mutual health insurance firm has substantive implications for viability of the scheme. The nonprofit charitable hospitals have to be carefully chosen, so that the scope for provider induced care is minimised. Some non profits are strategically organised as such to claim tax benefits, and other government support. The MHO has to follow appropriate administrative practices for enlistment of non profits that include primarily altruistic or service oriented non profits and exclude strategically organised non profits. Other relevant criteria for enlistment of nonprofit hospitals would be; (a) good organisational governance, (b) social service track record, (c) high incidence of low income and underprivileged clientele served by the hospital, (d) lower service tariff compared to customary and usual for-profit tariff for similar health care services, and (e) adherence to high quality of service standards.

F. Private for-profit hospitals:

Policy holders may meet with accidents or suffer from such other calamities. Accessing public or the enlisted nonprofit hospitals in such emergencies may not be feasible on account of various factors. For example, a private for-profit hospital may be available near by and accessing such a hospital to mitigate the impact of an accident or injury would be the most sensible thing to do. In such cases, the plans allow for settlement of cost of emergency treatment in private for-profit hospitals.

G. Participating pharmacies:

1. Covered people referred to first referral hospitals would require access to drugs and therapeutics not available in those hospitals. In case of large public hospitals, the health mutual may operate a special drug store. In case of smaller public hospitals, where incidence of referred clients is less, it may not be cost-effective to maintain dedicated medicine stores. For example, in Ratlam district of MP, the SSY maintains a drug store in the District hospital. SSY covered people attending this hospital go to

this counter to seek access to the hospital and to get drugs and therapeutics indented by the hospital for outside purchase. But no such drug stores are maintained in sub district hospitals (Mahapatra and Reddy, 2003). In such cases, a network of participating private drug stores located closer to the public hospitals will be useful. The Mutual Health Organisation should identify and enter into Pharmacy Participation Agreements (PPA). The agreement should provide for regular stocking of the drugs and therapeutics included in the health mutual hospital formulary, price concession to the health mutual, responsiveness to the health mutual clientele, etc..

H. Diagnostic facilities.

1. primary care will be the responsibility of the participating Clinics. A clinic may either provide for these investigations, in house, or out-source them from private or public diagnostic facilities.

I. Community service providers:

1. It is expected that the Mutual Health Organisation will provide social workers who will enable policy holders requiring hospitalization to access public or designated nonprofit hospitals. In case, however the MHO is unable to play this role or there are more effective social activist organizations available in an area, they may be engaged community service providers have to be voluntary or nonprofit institutions.

J. The Mutual Health Organisation (MHO):

1. These fiduciary nonprofit health insurance organizations will underwrite the risk and issue health insurance policies.
2. MHOs may arise from an existing public or nonprofit hospital base, community health or other social service organisation, or may appear first and then develop affiliations with health care providers.
3. To minimise scope for conflict of interest, a Trustees, or Director of MHOs should not have any financial or proprietary interest in any forprofit health care provider, medical and health equipment supplier, pharmaceutical concern or such other suppliers largely dependent on business from the health care sector in the area of operation of the MHO.
4. About two to three MHOs should be encouraged in each district or a region.
5. MHOs will compete in enrollment of communities and affiliated groups. A community can enroll with any one MHO only. Communities can review their enrollment with a particular MHO once in three years.
6. Although, India does not have many mutual health organizations as of now, enough civil society formations and voluntary health care delivery efforts exist to facilitate development of mutual health organizations. The MHOs have to be carefully developed and should be governed by people with demonstrated potential for fiduciary trusteeship, and commitment of social work. Special institutional and consultancy support will be required for organisation and monitoring of the MHOs. The supporting institutions should have a program to enable the MHOs to gradually be self sufficient and manage its own affairs.

IV. Provider payment mechanisms:

A. Recommended provider payment mechanisms:

Table 3: Recommended provider payment mechanisms.

The benefit package component	Basis of Provider Payment[1]
Primary Ambulatory Care:	
Out Patient services and First Aid Immunization and Access to Public Health Programs Dental and Eye care Lab services Drugs and Referral Services	Capitation fee to participating clinic nominated by the policy holder.
Hospital Access and Services Upto Rs30000 / family / annum	
Facilitation and advocacy services to access Govt. Hospitals and Health Care Institutions,	Capitation fee
Supply / cost reimbursement of medicines and materials	Price per item
Emergency hospitalization treatment	Case payment based on a schedule of diagnoses.
Catastrophic Illness & Major Medical Expenses:	
Facilitate access to major medical relief from public or charitable sources.	Capitation fee

[1] Note: For description and interpretation of terms under this column refer to chapter - 8 in Normand Charles; Weber Axel WHO; ILO Social Health Insurance. A Guidebook for Planning.; Geneva: WHO, 1994.

The ambulatory primary care component should be provided through a clinic with a subsisting participation agreeme

to catastrophic illness relief funds, and major medical expenses access services will vary. The service organisation may chose to directly provide all of these services and subcontract parts of it. We anticipate that, in some areas, there may be a scope to enlist support of local social service organisations, or social workers.

B. Quality of health care services:

1. All policies provide for annual nomination by policy holders, of clinics for ambulatory primary care services. This is designed to facilitate demand side pressure on quality of services. If a clinic is not responsive to its registered clientele, then it would run the risk of loosing many of the clients in subsequent years.
2. Policy holders will have the option to chose from a panel of clinics who have a continuing participation agreement with the service organisation. The process of empanelment of clinics and execution of participation agreement will have built in mechanism to assure that the clinics satisfy minimum structural, process and outcome standards. This empanelment process will then help assure the policy holders a minimum medical facilities and technical quality of care.

V. Cost estimation and cost control

Major determinants of health insurance costs are; (a) demand for services by the covered population, (b) cost of production or price of medical care, (c) transaction costs of the insurance.

A. Demand for Services:

Major determinants of demand for health care include; (a) population health status and burden of disease, (b) cash price of healthier, (c) transportation and access costs, (d) waiting time, etc.. The effect of population health status and burden of disease on demand for health care is difficult to predict. Rich or educated people clearly enjoying better health status are known to demand more medical care. Socio-economically poor people carrying a higher burden of disease most often do not demand as much medical care as the educated, rich and well informed (Murray and Chen, 1992; Murray, 1996 p24-27). On the other hand factors like price, access cost, and waiting time have predictable influence on health care demand (Besley, 1989; Leopold and Langwell, 1979). The proposed health insurance coverage will reduce the cash price, and is also likely to reduce access costs, and waiting time. The net effect of all these will be to increase usage of health care, which will of course be limited by

Table 4: Healthcare Usage per Person Year - Some Empirical Estimates.

Source	Study Year	Population	OP Visits	Hospital Adm.	Health Visits	Dental Visits
NCAER, 1998	1993	All India Sample		0.10000		
NSS-52nd Round	1995	All India Sample	1.02	0.02000		
NCAER (2000) Survey in Ahmedabad.	1999	SEWA	2.15	0.06000		
		ESIS	1.83	0.07000		
		Mediclaim	0.92	0.02000		
Bhaskaran and others, 2000.		Manipal - Medicare Scheme.	1.45	0.15000	Included in OP Visits	
Rand Health Insurance Exp.[1], USA.	1974-1982	Free plan	3.77	0.13300	0.790	1.330
		25% coinsurance	2.96	0.11000	0.640	1.060
		50% coinsurance	2.83	0.09900	0.720	0.970
Philippines [2] Institute of Dev. Studies, Survey.	1,991	No Insurance		0.01312		
		Social Insurance		0.13150		
		Universal Coverage		0.13480		

1

2 Estimate by Gertler & Solon, 2000 using data from Philippine Inst. of Dev. Studies (Solon et al, 1997).

To estimate demand for services by the covered population, we start with observed levels of health care usage reported by various studies (Table 4). The NCAER survey of 1993, and the NSS 52nd round give reported utilization of ambulatory and hospital care by largely uninsured population. All other estimates are for people enjoying some form of health insurance coverage. The NCAER study in Ahmedabad gives observed demand for health care by people covered by different health insurance schemes such as the VimoSEWA by SEWA, Employees State Insurance Scheme, and the Mediclaim policy holders of the general insurance corporations. The VimoSEWA insurance is operated by the well known Self Employed Women's Association (SEWA). This is a reputed self help nonprofit organised by women. The Medicare scheme in Manipal, Karnataka is operated by the Kasturba Hospital since 1972. The bottom three rows give estimates from the Rand Health Insurance Experiment in the USA. This was a randomised social experiment using 15 different health plans to estimate effect of variations in insurance plan on demand for health care. Estimates for three health insurance plan are shown in the Table 4. The Free plan means that policy holders do not have to pay any amount over and above the premium. The coinsurance policies require that policy holders pay a percentage of charges for services over and above the premium. The 25% coinsurance plans means that covered families have to pay 25% of the service charges, and the 50% coinsurance plan means that they have to pay 50% of service charges. The Rand Health Insurance study provides estimate of dental visits and preventive health care visits. The Manipal Medicare scheme includes coverage for dental care. The paper by Bhaskaran and others (2000) describing data from this scheme does not give a separate estimate of dental or preventive care visits. So we assume that the estimate of 1.45 OP visits per person year includes dental and preventive care visits. Outpatient visits and hospital services availed by the American population covered under the Rand Health Insurance plans are clearly higher than the figures reported from India. This is plausible, in view of the greater medical care supply capacity in the US. For our purposes, to compute the cost of proposed health insurance schemes, we assume 1.5 OP visits / person year, 0.075 hospital admissions / person year, and 0.3 preventive or public health program related encounters / person year. The preventive and public health program related ambulatory care encounters would include immunizations, directly observed treatment for tuberculosis, etc.. The general out patient visits would include visits for preventive eye and dental care.

B. Price of medical care:

Table 5: Marginal Cost (Price) of Healthcare Episodes.

Source	Study Year	Population	OP Visits	Hospital Adm.	Pblc Hospl - Av. Out of pocket Exp.
NCAER, 1998	1993	All India Sample	103	1,121	494
NSS-52nd Round	1995	All India Sample		3,562	2,218
NCAER, 2000	1999	Ahmedabad			
		SEWA	214	2,586	4,045
		ESIS	161	1,411	
		Mediclaim	686	4,045	
Mahapatra & others	2000	Pvt. Health Care Institutions in AP.	41[1]	3, 574[2]	
Bhaskaran and others, 2000.	1999	Manipal - Medicare Scheme.	173	4,031	

[1] Mean charge by general outpatient visits. Range between 5-200 rupees.

[2] Mean charge for admissions involving caesarian sections.

Mean charge or cost of an outpatient visit estimated from various sources fall into three distinct classes. The mean charge for general outpatient contact reported by Mahapatra and others (2002) from a study in Andhra Pradesh is the lowest at rupees 41 per visit. But this estimate does not include other costs such as drugs, laboratory investigations, etc.. The NCAER, SEWA, ESIS and Manipal Medicare estimates range from rupees 103 - 214 / ambulatory visit. The NCAER survey asked for all costs incurred by the household towards out patient treatment and hospital treatment. The other three are insurance schemes providing for coverage of diagnostic and medicine costs. Hence these estimates appear to include the cost of diagnostic services and medicines as well. The average Mediclaim in Ahemdabad was about rupees 686 per episode. This is distinctly higher from other estimates. Many factors contribute to inflation of Mediclaim costs. Firstly, this is a voluntary health insurance scheme with large scope for provider induced demand, and moral hazard. Secondly, the per episode cost estimate is based on a smaller denominator of those people who chose to raise a claim for out patient visit. Considering the high transaction costs of filing and processing of a claim, Mediclaim policy holders will generally be reluctant to claim for all outpatient visits unless the financial cost is substantial. We have seen earlier in Table 4 that the average out patient visits reported by Mediclaim respondents was comparatively smaller than that reported by SEWA and ESIS clients. Thus in most of the low cost outpatient visits by Mediclaim respondents is not reported, the average cost per out patient visit will be overestimated. So we turn to other estimates in Table 5 to arrive at a plausible marginal cost

of an outpatient visit. The NCAER all India survey was done quite some time ago, in 1993. All other surveys were more recent around 1999 - 2000. Hence we give a higher weightage to these numbers. Another important consideration is the applicability of these marginal cost estimates to the proposed health care delivery system. The provider payment system adopted by most of the schemes contributing to these estimates is largely fee for service, except of course the ESI. We have proposed a capitation based system of ambulatory care. The transaction costs of a capitation based system would be comparatively lower than a fee for service based system. The Manipal Medicare is more like the ESI, since most of the service is provided by the Kasturba hospital and its outpatient facilities. Considering all these factors we provisionally adopt an unit cost of rupees 100 per out patient visit.

C. Administrative cost of health insurance:

1. Rules 17-E of the Insurance Rules, 1939 limits the administrative expense in general insurance business to between 35 and 20%. (Insurance Laws, 2001)
2. We propose that these community based health insurance schemes be operated through mutual health insurance firms. The insurance function played by nonprofit mutual health insurance firms, coupled with the capitation based provider payment system, it is anticipated, will keep administrative costs down. Accordingly we propose that the administrative cost of mutual health insurance plans be limited to 10% of premium income. We have provided for a 10% administrative cost (insurance overhead) for computation of premium. There is some supporting evidence about the feasibility of a 10% administrative cost cap. For example; the average administrative costs of Minnesota Health Plans in the USA for the year 2001 (Minessota Department of Health, 2002) was 9.4%. The US Health Security Act, 1994 premium estimates allowed for 13% administrative costs, of which 4% was to be transferred to regulators to support medical research and regional health administration (American Academy of Actuaries, 1994). So the net administrative costs allowed for health plans was 9%. The Philippine Medicare spends about 12% on administrative overhead costs (Gertler and Solon, 2000, p26). This social insurance system pays the hospitals on the fee-for-service system, that is known to involve more transactions. If we take into consideration the fact that the community based health insurance system proposed by us, will pay providers on a capitation basis and hence the administrative costs should be less than what is observed in the Philippine Medicare System.

D. Premium Estimate:

1. Average cost per person:

Table 6: Average cost per person

Service component	Visits / Person Year	Rate	Amount
Out patient visits + Diagnostic ser.	1.5	80	120
Health Visits	0.3	20	6
Hospital	0.07	1,000	70
Sub total of service costs			196
Insurance overheads (Adm costs)		0.1	19.6
Total Premium / Person			215.6

2. Annual Premium per Family: The following premium structure is recommended.

Family situation	Rate / Annum
Basic enrollment premium for individual or family with upto three members.	600
Additional premium for family members exceeding three.	220

3. Total premium for a three member household works out to Rs660 / annum. In practice, the insured families will consist of one, two and three member families. Our conjecture is that the actuarial average may work out to about Rs600 / family / annum. More accurate actuarial average can be computed only after some experience about the composition of covered families is available.
4. A family will be enrolled only if premium is paid for all members of the household in which the family lives. Thus if two or more families share live in a single household, both families have to enroll.

VI. Financing social health insurance:

A. Current Levels of Medical expenditure and households' ability to pay:

The National Sample Survey (NSS) on household consumer expenditure gives details of the monetary values of consumption of various items classified as (a) food and (b) non food (NSSO, 2001). These surveys provide national and state level estimate of monthly per capita expenditure (MPCE) by economic status of the household, which is also identified by the MPCE. Households are assig

household income. Medical expenses is covered under the non food component in two different categories (a) medical institutional, medical treatment undergone as an inpatient and (b) medical non institutional, ambulatory care. Medical expenses include expenditure on medicines and medical goods including family planning appliances, payments made for medical treatment, and expenses incurred for clinical tests. Table 7 shows estimate allocations by rural households on medical expenses, as a percentage of total monthly per capita consumption expenditure. These estimates from the latest five rounds of the NSS,

show that poorer households allocate about 3% of their consumption expenditure on medical care. The average allocations on medical expenses by all households was between 5-6% of consumption expenditure. Most of these expenses are on ambulatory medical care. There is a slight increasing trend of household allocations for medical care.

Table 7: Household allocations for medical expenses. % of consumption exp. spent on medical out patient (Med-OP) and hospitalization (Med-IP) care.

NSS Round[1]	Year of Survey	Poor Households			All Households		
		Med-OP	Med-IP	Total	Med-OP	Med-IP	Total
51st	1994-95	2.62	0.3	2.92	3.78	1.20	4.99
52nd	1995-96	2.65	0.12	2.77	3.36	0.71	4.07
53rd	1997	3.35	0.2	3.55	4.13	1.58	5.70
54th	1998	2.66	0.17	2.82	3.86	1.60	5.45
55th	1999-00	3.09	0.46	3.56	4.72	1.37	6.09

[1] All data is from NSSO publications for respective rounds: 51st- 1995, July Tb 3-4, Appendix Pg A4-A5; 52nd - 1998, September, Tb 3-4, Appendix Pg A4-A5; 53rd - 1998, October, Tb 3-4, Appendix Pg A4-A5; 54th - 1999, June, Tb 3-4, Appendix Pg A4-A5; 55th - 2001, May, Tb 5R, Appendix Pg A 233, Tb 5U, Appendix Pg A266.

Table 8 shows estimate of per capita expenditure on medical care by rural households in India, in 1999-2000, from the 55th round of the NSS. Poor households were spending, in the year 2000, about 10-15 rup

annual medical care expenditure by the poor households in rural areas would range from 120-180 rupees per capita. Most households in rural areas have between 4-5 members. Thus an average rural household was spending about 480 - 900 rupees per annum on medical care expenses. This figures gives us an idea of amount of money that a poor household may be able to pay for a comprehensive health insurance coverage. The slight increasing trend, anticipated improvements in economic growth rate, and availability of a comprehensive health insurance coverage may all contribute to a further increase in the household allocation for health care. We use this information below in our financing recommendations.

Table 8: Monthly per capita expenditure on medical care by households in rural areas of India in 1999-00.

MPCE		House holds		Persons		Monthly Per Capita Expenditure (MPCE)			
Class	Cl. Limit	%	Cum %	%	Cum %	Total	Med-OP	Med-IP	Med-All
1	225	4.4	4.4	5.21	5.21	190.98	4.29	0.55	4.84
2	255	4.2	8.6	5.01	10.22	241.82	6.24	1.05	7.29
3	300	8.7	17.3	10.01	20.23	278.69	8.21	1.22	9.43
4	340	9	26.3	10.01	30.24	321.04	11.09	1.66	12.75
5	**380**	**9.3**	**35.6**	**10.31**	**40.55**	**360.83**	**12.86**	**1.96**	**14.82**
6	420	9.2	44.8	9.71	50.26	399.9	15.34	2.71	18.05
7	470	10	54.8	10.21	60.47	445.49	17.53	3.56	21.09
8	525	9.6	64.4	9.31	69.78	496.74	21.58	4.93	26.51
9	615	11.1	75.5	10.31	80.09	566.62	25.76	7.35	33.11
10	775	11.3	86.8	9.91	90	686	37.46	11.17	48.63
11	950	6.1	92.9	5	95	851.58	49.07	16.89	65.96
12	>950	7.1	100	5	100	1,344.76	100.45	45.78	146.23
	All	100	100	100	100	486.16	22.94	6.66	29.6
Poor		35.6	35.6	40.55	40.55	294.2	9.36	1.41	10.77

[1] Source: NSS 55th Round Report No.457(55/1.0/3), NSSO 2001. Columns 2 & 3 from Table - 1R at page A-17, Columns 4-6 from Table - 5R at page A-233.

[2] The poverty line for rural areas has been estimated as Rs.229.14 per capita expenditure at 1993 prices. Adjusted for inflation, this corresponds to Rs359.57 per capital at 1999-00 prices.

B. Recommended financing of social health insurance scheme:

1. We propose a system premium subsidy graded according to the income line for health and housing discussed earlier. For the poor families a range from 75 to 90% has been shown. The actual subsidy will depend on situation in each state, their finances and decisions by respective state governments.

Income Line for Health and Housing	Reco. Health Insurance Premium Subsidy
Poor Families	75-90%
Low Income Families	50%
Middle Income Families	20%
High Income Families	None

2. In rural areas, premium collection cycle should be set locally by the MHO to coincide with peak cash income season. The MHOs should operate multiple premium collection cycles tailored to match high cash income periods of enrolled communities.
3. Enrolled communities are expected to work with their respective members for timely payment of health insurance premium. MHO should work with respective communities to tailor community specific premium payment procedures.
4. On average, a poor family of about four persons will spend about Rs 205 per annum to purchase the health insurance cover. We have shown above a poor family, on average, is currently allocating about 480 - 900 rupees per annum towards medical

expenses. Thus there will be a balance of about 275 - 695 rupees per annum from current levels of medical expense. This amount will cover for the 30% co-payment for drugs and medicines, envisaged in the various family protection plans.

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Note on important issues about implementation of Health Insurance Scheme announced by the Union Finance Minister

The announcement of a health insurance scheme by the Union Finance Minister has raised hopes among many. However, doubts remain about operationalization of the Finance Ministers vision. The information about the “community universal health insurance scheme” announced by the Union Finance Minister suggests that this is a group insurance variant of the Mediclaim.

cessful implementation of the insurance scheme. Firstly, we need to recognize that the public sector general insurance companies are offering what are called private voluntary health insurance schemes. Hardly any country in the world relies on voluntary health insurance to achieve its public health goals. In the United States of America, where voluntary health insurance schemes are some what in vogue, bulk of the voluntary health insurance schemes are offered by nonprofit mutual health insurance organizations, with affiliation to groups of hospitals. These are the Blue-Cross and the Blue-Shield. Some may argue that our General Insurance Companies (GIC) are publicly owned and hence can be treated as non profits. But this may change after disinvestment. Another contrast is the lack of domain knowledge on health care. The Blue Cross and Blue Shields were set up by group of hospitals. Hence they were strongly footed to some health care delivery knowledge. The primary domain of our GIC's is Marine and fire insurance. These are quite different from what is required for health insurance

Secondly, by community health insurance scheme, we mean community rating of risks. For example, the present proposal allows option to cover parents. A community risk rating system will not allow for such options. By universal coverage we mean NHS like universal coverage of all resident population by health care. It may not be feasible for us to straight away go for universal coverage. But community rating of risks will be feasible.

Thirdly, the administrative overhead of a voluntary health insurance scheme is very high. The IRDA allows for about 35 to 20% over head. We believe the scheme announced by the FM allows for about 25% administrative overhead (10% for business acquisition + 5% for claims processing and + 10% for intermediaries). Our estimate is that claims processing and

insurance administration overheads will take about 10%. We feel there is no reason to allocate 10% for business acquisition. If this is a universal and community health insurance scheme, where is the need for sales agents to sell the policies? This is one reason why voluntary health insurance schemes are expensive. On the other hand promoting nonprofit mutual health insurance organizations will help keep the administrative costs within 10%. Experiences elsewhere in the world support this view. Allowing for about 35% administrative expenses and grant of a 100 rupee premium subsidy per family essentially means that the government will be subsidizing the Insurance company administrators to operate a high cost profit oriented health insurance business. There will not be any money left from this 100 rupee subsidy to pass on to the poor. Although the FM's intention is to provide subsidy to the poor, the scheme may end up doing the opposite.

Fourthly, system of administration of subsidy has a bearing on the market. Traditionally, thus far, GOI have directly released subsidy or premium to the GIC companies. That system will further reinforce our suspicion about the likelihood of the subsidy going towards administration cost, instead of passing on to pay for health care costs of targeted families. Instead, giving vouchers to the target families and letting them encash it at the time of purchase of policies may be a better idea.

We believe that these provide feasible alternatives to implement the FM's vision of community health insurance and move towards universal coverage.