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Institute for Financial Management and Research Centre for Insurance and Risk Management Delivering MicroHealthInsurance Through the National Rural Health Mission A Strategy Paper Rupalee Ruchismita, Imtiaz Ahmed and Suyash Rai August 2007 Rupalee Ruchismita (rupalee.

ac. in) and Imtiaz Ahmed (ac. in) are with the Centre for Insurance and Risk Management at IFMR, Chennai (<http://ifmr.ac.in/cirm>). Suyash Rai is with the ICICI Centre for Child Health and Nutrition, Pune. The views expressed in this note are entirely those of the authors and do not in any way re? ct the views of the Institutions with which they are associated. . Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission Contents 1 Introduction 2 Health Financing in India 3 Key issues in Health Financing 4 Exploring Risk Transfer and Pooling Strategies 5 Proposal for a National Apex Body 6 Conclusion 7 Annexures 7. 1 ANNEXURE I 7. 2 ANNEXURE II 7. 3

Objectives, Activities, and Services 1 1 3 4 8 13 14 14 19 22 0 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission 1 Introduction The Indian health scenario is fairly complex and challenging with successful reductions in fertility and mortality offset by a signi? cant and growing communicable as well noncommunicable disease burden¹ , persistently high levels of child undernutrition² , increasing polarisation in the health status of the rich and the poor³ and inadequate primary health care coexisting with burgeoning medical tourism!

This situation is further complicated by the presence and practice of multiple systems of medicine and medical practitioners (several of whom are not formally certified and recognised) and very limited regulation. In such a context, this paper highlights the challenges in financing health in India and examines the role of health insurance in addressing these. It proposes an operational framework for developing sustainable health insurance models under the National Rural Health Mission, responding to the contextual needs of different states.

2 Health Financing in India

The total spending on the health sector in India is not low.

According to the National Health Accounts 2001-02, the total health expenditure in India for the year was Rs. 1, 057, 341 million, which accounted for 4.6 percent of the Gross Domestic Product (GDP). The concern lies in the fact that households are the major financing sources, accounting for 72 percent of the total health expenditure incurred in India. State Governments contribute 12.6 percent of the total health expenditure, Central Government 6.4 percent and the public and private firms 5.3 percent. External support from bilateral and multilateral agencies accounts for 2. percent of health expenditure in India, a majority coming in as grant to the Central Government. So, only about 20% of the overall funding comes from India accounts for only 16.5% of the global population, it contributes to approximately a fifth of the world's share of diseases: a third of the diarrheal diseases, tuberculosis, respiratory and other infections, parasitic infestations and perinatal conditions; a quarter of maternal conditions; a fifth of nutritional deficiencies, diabetes, cardiovascular diseases, and the second largest number of HIV/AIDS cases in the world. Report of the National

Commission on Macroeconomics and Health. 2005. New Delhi: Ministry of Health and Family Welfare.) 2 National Family Health Survey III, 2005-06. Mumbai: International Institute of Population Sciences. 3 The poorest 20 percent of Indians have more than twice the rates of mortality, malnutrition, and fertility of the richest 20 percent. (Peters DH et al. Better Health Systems for India's Poor. 2002. New Delhi: World Bank. 1 Although 1 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission the government, which is one of the lowest in the world. This is a significant problem in a country where the government has mandated itself to provide comprehensive quality health care to all. The problem of household expenditure for health care is compounded by the fact that 98 percent of this is " out-of-pocket", which is fundamentally regressive and burdens the poor more. Also, the absence of proper pooling and collective purchasing mechanisms for the households' money further worsens the situation because of the resulting inefficiencies.

Most of the household expenditure on health goes to the fee-levying and largely unregulated private providers. The share of household consumption expenditure devoted to health care has also been increasing over time, especially in rural areas where it now accounts for nearly 7 per cent of the household budget⁴ . This situation is not surprising since public and private expenditure on health are closely linked. Given that government spending on health stands at less than 1 per cent of the GDP, which is very low by international standards, the need for private out-of-pocket expenditure increases.

Seventy percent of the total financial resources flow to health care providers in the for-profit private sector. Only 23 percent are spent on public providers. In an environment of minimal regulation, this provides significant opportunity for the exploitation of health care seekers. In addition, there are significant inter-state differences in health financing. Among the major states, Himachal Pradesh ranks highest in terms of per capita public spending on health (Rs. 493 per year) and also has the highest public expenditure as percentage of total expenditure (37.8%).

On both these parameters, Uttar Pradesh is the lowest ranking state, with a per capita public spending on health of Rs. 84 per year, and only 7.5% of the total health expenditure is public expenditure. All India per capita expenditure on health is Rs. 997 (207 from public and 790 from private)⁵. There are also indications of declining state government spending in crucial areas. Overall health spending declined over the decade 1993-94 to 2002-03 in 3 states, and declined between 1998-99 and 2002-03 in 64 Government Health Expenditure in India: A Benchmark Study. 2006. New Delhi: Economic Research Foundation. All India public expenditure including expenditure by the Ministry of Health and Family Welfare, Central Ministries and local bodies, while private expenditure includes health expenditure by NGOs, firms and households. 2 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission states⁶. There are also sharp and generally growing rural-urban disparities in spending in most states. 3 Key issues in Health Financing Drawing from the above analysis and other related literature, the following emerge as the key issues in reforming health financing in India. Increasing government spending on public and more

speci? cally, primary health care As discussed earlier, the government spending on public health in India, constituting about 4% of its total expenditure and less than 1% of the GDP, is very low. In per capita terms, the government spends only USD 4 annually on public health. According to the World Health Report (2000), only twelve other countries spend less than India on public health, most of them in Africa. For most other nations, government spending on health is more than 10 percent of the total government expenditure.

The Commission on Macroeconomics and Health has estimated that public spending in low income countries should be within the range of \$30-\$45 per capita to ensure achievement of public healthgoals. In India, most of the government spending is on medical colleges, into tertiary centres, and very little trickles down to theprimary and secondarylevels. There is therefore a strong case for increasing government spending across the board, with a much higher focus on primary care services. This will reduce the need for spending by the poor and also improve the overall health status. The options for increasing public ? ancing of health include reallocation of the government budget (possibly by re-routing other direct and indirect subsidies) and earmarked taxes (such as the taxes levied for ? nancing the Sarva Shiksha Abhiyan). Addressing the supply and demand-side factors that prevent the poor from bene? ting from the health sector In general the poor bene? t much less from the health sector than the rich do largely because of their inability to seek timely and adequate health care. The poorest quintile of Indians are 2. 6 times more likely than the richest to forgo medical treatment when ill7 . Government Health Expenditure in India: A Benchmark

Study. 2006. New Delhi: Economic Research Foundation. 7 Peters, D. et al. Better Health Systems for India's Poor: Findings, Analysis, and Options. 2002. Washington 3 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission However, whatever care they do access, the poor are found to rely significantly on the public system for preventive and inpatient care including 93 percent of immunizations, 74 percent of antenatal care, 66 percent of inpatient bed days, and 63 percent of delivery related inpatient bed days.

Improvements in the public system through increased and more effective spending would therefore benefit the poor significantly. Increasing the effectiveness of public health spending would require attention to supply side factors such as facility location, availability of staff, medicines, equipment and quality of care as well as demand-side factors such as indirect costs (travel, wage loss), non formal charges, awareness levels, perception of quality and uncertainty about payment. Mitigating risks due to out-of-pocket expenditure, particularly catastrophic expenditure for the poor. At least 24 per cent of all Indians fall below the poverty line because they are hospitalised⁸. It is estimated that out-of-pocket spending on hospital care might have raised the proportion of the population in poverty by 2 per cent. Risk-pooling and collective purchasing mechanisms could increase the efficiency and equity with which the households' money is collected, managed and used, so that the households' burden is reduced. 4 Exploring Risk Transfer and Pooling Strategies

Exploring Risk Transfer and Pooling Strategies in the context of the NRHM In attempting to understand the potential of risk pooling or risk transfer <https://assignbuster.com/health-financing-in-india/>

mechanisms such as insurance (which immediately addresses the cost which a household spends on hospitalization) in achieving public health goals within the overall NRHM mandate, the following issues become relevant: 1. The potential value addition that insurance could provide 2. The various models of health insurance for the poor 3. Implementation of the insurance programme in the context of the NRHM D. C. : The World Bank. 8 Ibid 4

Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission 1. Health Insurance leads to: • Risk pooling for in patient care (hospitalization): As discussed, one of the major causes of poor households slipping into the poverty cycle is out of pocket expenditure incurred for hospitalization. In such a scenario, insurance, which allows for risk pooling, helps in making available additional source of financing for the household thereby reducing overall vulnerability and smoothening expenditure shocks for larger unpredictable catastrophic health events. Increased utilisation of health services: It is expected that the introduction of health insurance will lead to greater utilisation of health care services. Across the world it has been found that the overall use of curative services for adults and children was up to 2-3 times higher for members of health insurance programmes than non-members^{9, 10}. • Standardization and cost effective quality health care: Insurance as a mechanism attempts to standardize protocols, procedures and bring down cost through rate negotiations.

This ensures the availability of cheaper healthcare, controlling fraud and possibility of rent seeking behaviour which is high in the case of the poor who have comparatively lesser knowledge about their health status or

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possible treatment required. Further due to Health Insurance, the out of pocket expenditures per episode of illness are significantly lower for members as compared with those for non-members¹¹. Under the NRHM it is hoped that a national level expert committee will play a pivotal role in standardizing treatment protocol and rates. Presently such an activity has been undertaken by World Health Organisation (WHO), India-Office, in collaboration with Armed Forces Medical College (AFMC).

- Cover for access barriers (loss of wage, transportation cost) and new and emerging diseases:

It has been seen that since most of the micro insurance models evolved from community institutions and NGOs, they packaged critical P., and F. Diop. Synopsis of Results on the Community - Based Health Insurance (CBHI) on Financial Accessibility to Healthcare in Rwanda. HNP Discussion Paper. 2001. Washington, D. C: World Bank. 10 Preker, A. S, Carrin, G. S Health Financing for Poor People - Resource Mobilisation and Risk Sharing.

T 2004. ? ? Washington D. C. : World Bank. 11 Preker, A. S and G Carrin. Health Financing for Poor People - Resource Mobilisation and Risk Sharing. 2004. Washington D. C. : World Bank. 9 Schneider 5 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission access barriers as part of their insurance cover. Also, insurance as a concept works on the principle of risk pooling and cross subsidization for low frequency events. The cost of healthcare for life style diseases like diabetes or critical illnesses and HIV/AIDS, is very high.

Community Insurance models delivered at a large aggregation can cover for these rare events and ensure that the poor do not fall back into poverty in the process for paying for this high cost event. This has been tried in some

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schemes like the Arogya Raksha Yojna (ARY)¹² .

- Development of stronger referral linkages: Insurance as a mechanism to be sustainable requires developing strong upward as well as downward referral mechanisms. Strong referrals ensure non escalation of cases, thus ensuring 'right care at the right time', reducing possibilities of collusion and fraud.
- Efficiency in the health system in terms of:
 - Allocative efficiency in addressing the most risky event a household faces i. e. hospitalisation and by diverting the surplus premium to strengthen the health infrastructure and incentivise manpower.
 - Value for money: Presently the expenditure on health by the poor includes leakages such as transport costs, spurious drugs, unlicensed medical practitioners who offer health care of sub optimal quality.

2. Various Models of Health Insurance for the Poor

Models of micro health insurance may be categorized into the following:

- Social Health insurance: Such insurance models are found in about 8 countries across the world.

The overall model works with a differential premium payment mechanism where the economically secure pays a relatively higher premium than what their risk profile dictates and the poor pay a comparatively lower premium commensurate with their income. This leads to cross subsidization across the rich and poor category. In India it is mostly seen in the formal sector in the form of ESIS and the CGHS scheme. ¹² With Narayana Hrudayalaya, Biocon and ICICI Lombard in Anekal Taluka of Bangalore district of Karnataka. ⁶

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Community Based Health Insurance (CBHI):

There are three basic designs of CBHI, depending on who the insurer is. In Type I (or HMO design), the hospital plays the dual role of providing health

care and running the insurance programme. In Type II (or Insurer design), the voluntary organisation is the insurer, while purchasing care from independent providers and ? nally in Type III (or Intermediate design), the voluntary organisation (NGO/CBO) plays the role of an agent, purchasing care from providers and insurance from insurance companies. This seems to be a popular design, especially among the recent CBHIs¹³ .

The merit¹⁴ of the last model is the aggregating role and the context specificity that the NGO/CBO assumes. Since the NGO has systematically addressed information asymmetry, and also shares the community's trust, these initiatives show better results (as seen in case of Dhramasthala insurance programme). In the case of a national roll out this can be the best model as it will capture the diverse nature of health requirements in the different NRHM states. The provider model or insurer model may not work out as customisation to local condition becomes the main crux of success or failure of the scheme.

Further an NGO along with an insurer will be in a better position to retain the large risk of the community as compared to an individual entity like a provider or an NGO alone. It is crucial to ? nd NGOs that have a long term stake and therefore would act as ' conscientious players' who will ensure that the insurance programme, generates long term positive impact on the health system of the speci? c geography. 3. Some suggestions for the proposed Health Insurance Programme As discussed earlier, the health system in India is characterised by grave inequities leading to a political economy that makes health care access income and class dependent.

This creates the need to explore various types of innovations and changes that could improve this unacceptable situation. Insurance is potentially one such et al. Community-based Health Insurance in India: An Overview. July 10, 2004. Economic and Political Weekly. New Delhi. 14 The Yeshaswani insurance programme (the large health insurance programme in the country) follows this model through the various cooperatives facilitated by the department of cooperatives. Other example is the Dharamasthala insurance programme where the NGO (Dharmastahala trust) is the aggregator and has about 1 million insured under its scheme. 3 Devadasan 7 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission innovation. However, for health insurance to effectively improve the efficiency of health spending and ultimately improve health status, it would need to be conceptualised as a part of a larger effort to improve the accessibility and quality of health care services, especially for the poor. In the Indian context, any health insurance programme will have to take into account the plural nature of the health system, especially the presence of a large fee-levying, unregulated and ill understood private sector.

It will have to explore synergies and integration with the widespread public health system and its current financing mechanisms. Questions such as who should pay the premiums for the poor and how should incentives be aligned will have to be carefully thought through to ensure the management of problems such as adverse selection, inadequate monitoring and moral hazard, exacerbated because of extreme information asymmetries inherent in health services and goods. Internationally and within India, there is a

significant body of literature regarding the impact of different health insurance programmes on the health system. For the Indian context, it would be important to learn from these various experiences, develop a theory about the mechanisms through which insurance can contribute to public health goals, run pilots in different contexts within India to understand feasibility and impact, and determine the national programme based on these learnings.

5 Proposal for a National Apex Body

Proposal for a National Apex Body Working as a Coordinating Centre for Micro Health Insurance: It is proposed that a National Apex Body, ideally placed within the Insurance Regulatory and Development Authority (IRDA), be established to monitor and coordinate the implementation of the micro health insurance operations in the country (see ANNEXURE 2). The Apex body should have capacity in the areas of public health and insurance, host national and state-level dialogues on the idea of insurance in the context of health systems, implement pilots in specific geographies and take forward the learning, and ensure knowledge sharing so that progressively larger regions can be covered under the micro health insurance scheme. ANNEXURE 2 provides details of potential roles this apex body (tentatively named Micro-insurance Coordinating Centre) could play in taking forward the agenda of usefully employing the strategy of insurance to get closer to the public health goals of the country, focusing on the vulnerable.

It is envisaged that this body should play a knowledge-building, technical advisory, policy advisory, facilitative coordination role with a long-term aim of achieving universal health insurance coverage by an optimal combination

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of social and micro health insurance mechanisms, in a manner that it integrates seamlessly with the overall health system. The proposed apex body should host a process that ‘ arrives’ at a framework of implementing health insurance under NRHM. Based on our understanding, the following emerge as important aspects of any national level health insurance programme developed under the NRHM.

The health insurance model under the NRHM should explore the Partner-Agent approach which includes both the insurance partner (risk partner) and the agent (NGO). Based on experiences from the pilots, the insurance cover could be a compulsory, cash less health insurance product with a family ? oater with minimum initial deductibles. Depending on the availability and quality of providers, the insured should have the choice to access the nearest (private or public) health care facility and should be allowed to choose between any provider within a given geographical parameter.

The client could be issued a biometric ID card which is updated withdiagnosticinformation and refers her/ him to the desired care provider to control overcrowding at the tertiary facility. 1. Product Cover: To begin with, the product should cover basic hospitalisation at the secondary care level (either at the cluster of village, block or district level). It should include the cost of: • Hospitalisation • Diagnostic services • Medicine and consumables • Consultation andnursingcharges • Operative charges 9

Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission The product should also try to cover for access barriers like transportation cost (with a initial deductible to control frauds

and limited to only the cheapest mode of transport available, customized according to the district), loss of wage (in case of the male or female member of the household as defined by the state according to the minimum wage guaranteed by the state government.

This could be done in tandem with the National Rural Employment Guarantee Scheme (NREGS). In geographies where investment in directed preventive and promotive services can bring down the need for seeking in-patient care, directed primary care primary level care can be provided by the insurance programme. For example, Directed preventive promotive community health education could lead to reduction in the frequency of inpatient care due to vector borne diseases in several geographies¹⁵. Thus based on the specification package of additional community health intervention will be developed, which can be paid from the insurance model. The insurance programme can work with District Health Societies to offer rehabilitative care and financial help to patients who have recovered but are disabled due to diseases like leprosy or polio. It can also help the People Living with HIV/AIDS (PLHIV) by providing additional services like providing nutritional supplement and other additional services which will supplement the current care being provided by the national programme for control of HIV/AIDS. 2.

Health providers: Both private and public facilities at the secondary care level could be empanelled as providers. Private care hospitals could include nursing homes or 20 bedded medical facilities as seen in the Missionary hospitals as well as entrepreneur led inpatient care. For the government hospitals such as the district hospital, the difference in rates could be used for improving infrastructure and incentivising staff. 3. Building information <https://assignbuster.com/health-financing-in-india/>

systems: There is a need for a reliable transparent MIS sys¹⁵ For Insurance covering hospitalization due to events that can be impacted by Sspeci? S preventive promo? tive health education, it makes economic sense to proactively invest in Community Health Education, which will reduce the probability of hospitalization due to the event. Vector borne diseases show a high degree of sensitivity to such Community Health Education programmes.

10 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission tem to improve the overall ef? ciency of the system. This would reduce paper work, streamline referral linkages and aggregate data helpful for product customization. The community health insurance model could generate a much needed Electronic Health Records (EHR) system. This would imply that as per commonly agreed terms all health related information of an individual (parameters like diagnostic test results (blood pressure, body temperature, pulse rate, ECG), diseases to which he/she is prone; past illnesses etc) is stored onto a system or a database. This database can be accessed by all ensuring anonymity and therefore all insurers, health workers and policy makers can access and interpret the health data to be able to conduct community risk assessment.

This will encourage insurers to compete for risk pricing of the community in the said geography and lead to cheaper insurance premiums. The focus of the EHR system would be to ensure - Universality, Consistency, Open Standards, Non-Proprietary, and Acceptability. To institutionalize a reliable EHR system it should be made compulsory that any treatment/diagnosis/medical intervention be updated into the individual's EHR, such that the EHR is the most authentic source of health information

about an individual. The other challenge that needs to be addressed for development of better health insurance products as well as better health care delivery is the challenge of targeting and uniquely identifying the individual. Such identification could be achieved through a biometric identification smart card. The smart card can be used to not only help in identification, but also for storing of line health information. With an EHR and smart card system, the insured can freely access both the public and private health care facilities available in the geography.

This helps the insured as well as the medical practitioners and improves diagnosis and response time. The Smart Card can also be used to store health insurance related information of the client. The health provider can thus check the eligibility of the individual in terms of insurance before delivering treatment. The same card can also be used as a payment instrument to capture the payments that need to be made to the health providers. The card can be used to pass 11 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission incentives to clients as well as the hospital to keep using the card. The biometric card will have terminals (which can upload data of line) in the various network hospitals to upgrade data whenever the insured avail care.

4. Formative Research: a Community Needs Assessment (CNA) will need to be done to list down the health needs and the willingness to pay, a mapping of the healthcare facilities in the geography, an understanding about the type of premium and payout that the community are expecting from the insurance scheme and the broad range of social protection measures that they want the insurance to take up.

Based on the information provided above the product and the EHR can be developed. Initially, it is advisable to undertake health insurance pilots in different contexts to develop and ? nalise the health insurance programme.

5. Implementation and monitoring: The proposed National Apex body, should monitor and coordinate the implementation of the micro health insurance operations in the country (see Annexure- 2).

The following ideas can potentially strengthen the monitoring and implementation of the programme:

- The District Health Accounting System and the proposed ombudsman (to be created under NRHM to monitor the District Health Fund Management) will work closely with the NGO and the insurer to ensure the smooth running and monitoring of the programme.
- At the backend, the insurance programme with the EHR system will develop a rich data source and act as a Fraud control mechanism. This data will help in identifying disease patterns for the community and could be a critical tool for the NRHM team to de? e ? nancial allocations, target services and make evidence based policy recommendations. (While developing this EHR we should ensure that we are following international standards to be able to be coded properly and stored in a card).

In the long run, this apex body should aim at achieving universal health insurance coverage by combination of social and community based health insurance mechanisms. There is a case for building facilitative institutional arrangements of the ' right' stakehold12 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission rs who will pursue this goal. The learning from the challenges and processes involved in implementing Universal Health Insurance Scheme (UHS) will be very valuable.

6 Conclusion Promoting

health and confronting disease requires action across a range of challenges in the health system. These include improvements in the policy making and stewardship role of the government; better access to human resources, drugs, medical equipment, and consumables; and a greater engagement of both public and private provider of services.

Insurance has a limited but important role to play in solving some of the health financing challenges. Innovative pilots of partner agent model led micro health insurance could give useful insights for designing a national level programme, led by an apex body. Such a programme could systematically impact the health system in the country. 13 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission 7 Annexures 7. 1 ANNEXURE I Beyond the pilot, the initial cover will be modified to cover primary and tertiary tier of the health systems in the country. . Primary level: The Insurance will cover: • Diagnostic charges incurred on low and high end diagnostic¹⁶ • Medications including expensive medication (like life saving drugs, higher antibiotics etc), injectibles and other consumables not usually available in the primary health centre • Based on the recommendation given in the NRHM document, practitioners of AYUSH and other specialties can be roped in to act as the Primary Physician • Based on the scale and/or the insurance experience in 1st year, further social security benefits can be added as follows: • Reimbursement of transportation charges, wage loss, financial compensation for attendant, compensation for disability and subsequent rehabilitation. 2. Impacting infrastructure and Manpower: • Depending on the claims experience and the volume, some monies can be utilized to

purchase new or replace old goods/equipment at the Primary Health Centre (PHC) and such activity monitored by District Health Mission through district health accounting system and the proposed ombudsman under NRHM.

Besides there is a need for 5-10 bedded hospitals to come up at the taluka or clusters of village level in severely resource constrained area for which emerging entrepreneurs like the Vatsalaya hospitals who have already set up such hospitals elsewhere in the country (especially in Karnataka in this case). Local doctors looking at running hospitals can set up such hospital and run it on a franchise model. In this realm may lead to cost effective and customised diagnostic solution. In this regard ICICI Knowledge Park is involved in coming out with such customised solution for the rural poor 16 Innovation 14

Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission • There is also a need for high end diagnostic chain to come in to the rural space with similar franchise model of commercial diagnostic companies¹⁷. Standardization of all the services will be done by a committee of experts in each state. These services will include outpatient, in-patient, laboratory and surgical interventions. • Manpower: The ANMs/CHWs/ASHA/MPWs can be incentivised to provide their services more efficiently and quickly from such fund given to the Panchayat either from the government or from the insurance fund.

It is assumed that with the introduction of ICT component (EHR and biometric cards) like smart card, the 40% of time wasted by ANM on documentation will be saved¹⁸. - To incentivise the doctors to work in the PHC: - Posting of qualified graduate doctors in PHCs can be made <https://assignbuster.com/health-financing-in-india/>

mandatory and also made necessary pre-requisite for eligibility to sit for Post Graduate Medical Entrance Examination. – Top 10 or 20 high performing PHC doctors in the entire state might be allowed to join specialty of their choice in P. G courses directly or some higher percentage of quotas may be assigned to them which will facilitate them to get admission.

Transparency and accountability in the whole service delivery can be brought about by making the health manpower within the PHCs and other levels accountable to the PRIs and the Village Health Committee through a rigorous and scientific accountability system¹⁹. • Additional Services: Needed amounts of fund can be made available to the local Panchayat or a certain percentage of premium collected be allowed to remain with them and be spent for these purposes according to their discretion¹⁷ This entity can set up satellite diagnostic centre at the taluka or district level.

They can have sample collection unit which collects the pathological samples from the villages and brings it to the satellite centre where it is examined. The report is either passed on to the patient the next day when the sampling collection team goes to the villages or can be sent directly to the referred doctor under the health insurance scheme.¹⁸ This will give her more time to cover more villages, services and bring about efficiency in the overall healthcare delivery. It will also reduce paper work and make information easily accessible at each level.⁹ Smart card technology will be used to increase transparency and accountability of the health staff bringing about good people governance. In this the gram Panchayat and the Village Health Committee will completely evaluate the work of ANM and other staffs (including the doctor). Their performance will be graded in a scale devised in <https://assignbuster.com/health-financing-in-india/>

consultation with the representatives of the PRIs and the District Health Mission and accordingly incentive/disincentive can be given based on the score. This information can be made available online for access to the general public. 5 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission and mutual decision (It can also cover other expenses like loss of wage and destitute supports). • Health Database management system: ICT component in the form of smart card technology (in the form of a biometric card) be introduced which will ensure the capturing of health and insurance data of the population and minimize fraud. • It requires a decoder cum uploading device which will be portable and hand held.

This can be used by ANM/Health staff/PRI/Hospitals to upload or read information starting from the primary to tertiary level • Will be able to transmit images and radiographic reports (X-ray and ultrasound, CT scan) apart from other routine test results. This can be done offline (Because in villages, the power supply is erratic or absent and the internet connectivity is lacking) and can be the precursor of telemedicine²⁰. 3. Tertiary level: It will cover all high cost, sophisticated care which may not be available at the secondary level.

The diseases that can be covered are as follows: • Cancer • Myocardial infarction • Major organ transplant • Paralysis • Multiple sclerosis • Bypass surgery • Kidney failure • Stroke • Heart valve replacement ²⁰ With internet connectivity through satellite (which are now provided free of cost by ISRO to interested NGOs and CBOs) which will mean that the patient will not have to travel to district level or tertiary level care and can walk in to such tele-
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consulting centre within the village where his diagnostic reports are accessed by punching in the unique I.

D number of the patient on the smart card. The specialist sitting at the district level can then assess the prognosis of the case and decide whether the patient needs to travel or else advises the local doctor on what is the line of treatment for the patient which then can be carried out locally. This will save a lot of money (on traveling and loss of wages), time and resources which the patient would have spent otherwise. 16 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission 4.

Impacting infrastructure, Manpower and Services: • It is envisaged that the government medical college hospitals, other government health institutions, central or regional health institution operating in the state can act as the tertiary care provider. • Insurance can start paying for upgrading these infrastructures and incentivising the medical work force in a similar way as was explained under primary level care. Besides private healthcare who will start the franchise model or other wise interested (and agreeable to the negotiated rate for the insured) will act as the tertiary care providers²¹ .

The government should play a central and leading role in developing a strong referral linkage in the state. • As most high level tertiary care hospital are charitable trust hospital and get substantial subsidies and exemption from the government in return for providing subsidized services for the poor (but in reality a very few actually provide such services) it should be made mandatory and compulsory for these hospitals to treat the insured poor. 5.

Health Database Management: • There will be a Central Data Warehouse which will develop from the EHR integrate all the information collected from the primary level upwards, making it accessible to each level and hence acting as a central store house of information. • Additionally it will have personnel(s) who will analyse such data. Such analysis will be invaluable for monitoring, evaluation and mid-course correction. This will help in achieving the following: – Help revise insurance premium – Incentivise and monitor providers 21 The bene? will be two fold - it will provide quality care to the poor (through a TPA and the District Health Mission and Rogi Kalyan Samiti which will empanel hospital) which will ensure compliance to a particular standard of care) and will also help reduce crowding in the government hospital. At the tertiary level, a working arrangement should be made with national level government hospital (like AIIMS, CMC etc), regional institutes, post graduate medical institutes (JIPMER) and large private/corporate hospital (Apollo, Wockhardt, Fortis etc) so that patient requiring advanced critical care can be referred to them. 7 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission – Control fraud The developing of referral linkages is very much possible with insurance playing a central role and ICT in the form of smart card technology will ensure equity, ef? ciency and quality in healthcare delivery at each level. The coupling of the whole machinery with tele-medicine will bring about synergy and help the poor in terms of saving money on traveling and also loss of wages. It has to be always borne in mind by all the stakeholders that all component of health care i. . preventive, promotive, curative and rehabilitative care as emphasized under National Rural Health Mission as well as the coming of all stakeholders to work together will ensure

harmonious and efficient delivery of quality healthcare with insurance playing a vital role. None of the components or stakeholders can be undermined as each will ensure that we will be able to see demonstrable impact in the health indicators of the community in days to come. 18

Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission 7. 2 ANNEXURE II

Setting up of a national coordinating and development entity: One of the key issues recognised by many is that increased coordination as well as sharing of knowledge and resources among the various actors in the sector would greatly stimulate success of NRHM as well as micro insurance development. This is especially true of health micro insurance for which few (if any) truly successful and sustainable programs have been observed to date. Hence it is felt that there has to be an apex body in the form of a coordinating centre which will initiate, regulate and monitor these activities.

Following is a matrix which delineates the various stakeholder who will be represented in such a supra structure. 19 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission

Stakeholders Stakeholder Needs Coordinating Centre's Criteria for Success 1.

Beneficiaries * Simplified claims procedures with minimal bureaucracy *

Solutions that result in fast claims payment 1. 1 BPL families * Timely

payments of * Service satisfaction from beneficiaries * Solutions leading to

affordable insurance products with quality servicing promised benefits *

Systematic increase in product coverage to ensure reduction of access

barriers * Access to health services and health risk protection services 2

Microinsurers, Insurers, reinsurers * Access to technical assistance, actuarial

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studies, EHR records and the Centralized Data Warehouse reports, exposure to international innovations * Long term sustainability of microinsurance programs servicing the poor * Effective, broad-based microinsurance delivery channels * Microinsurance products commensurate to investment risk * Competent pool of microhealth experts insurance technical Service packages developed and patronized * Service satisfaction from micro-insurers * Insurers aggressively competing to offer superior products and services to MICC client governments * Investment and financial support from insurers

20 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission Stakeholders Stakeholder Needs Coordinating Centre's Criteria for Success 3 NGOs, MFIs, trade unions, employer grassroots organizations, organizations, * Strong partnerships with hospitals, diagnostic players, NRHM team, AYUSH, ASHA workers and insurers Satisfaction with the coordinating agency's ability represents all stakeholders' interest and reflected by strong involvement and support and investment through time in the centres work corporate sector, co-operative sector, etc. * Successful delivery of risk protection services to their memberships and clientele 4 Insurance Regulatory Development Authority * Robust, vibrant health microinsurance industry * Insurance regulations followed * Robust and vibrant network of micro-insurer clientele * Mandate and support from the IRDA * Achievements towards supportive and enabling policy 5 Health

Providers * Timely payment from insurers * Reliable stream of BPL clients utilizing their services * Reasonable profitability * Positive ratings from health providers * Service satisfaction of BPL clients * Minimal problems with

* Fast claims turnaround Solutions that result in: fraud and overcharging, etc. 6 TPAs Innovative and effective collection, distribution, and servicing channel 21 Sharing best practices Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission

Stakeholders Stakeholder Needs Coordinating Centre's Criteria for Success 7

State Governments * BPL population covered Support and mandates from governments * Efficient utilisation of resources and resources leveraged through a resource center * Moving closer to the goals stated under NRHM 8 Government of India * Access to comprehensive and quality health care for all * Improvement in national statistics on accessibility of health care

services 8. 1 Ministry of Health and Family Welfare 8. Department of Insurance, Ministry of Finance* In synergy with existing programmes and structures * Proper utilization of departmental funds * National statistics on health insurance penetration * Increase in the number of legalized community health insurance programmes * Moving towards universal coverage * Regularising illegal community health insurance programmes

Other major stakeholders that will have to be consulted are the likes of Indian Medical Association (IMA), Institute of Public Health (IPH), Federation of Obstetric and Gynecological Societies of India (FOGSI) and Institute of Health Management Research (IHMR). . 3 Objectives, Activities, and Services

The stakeholders and clients of the Microinsurance Coordinating Centre envision a network of professionally-managed micro-insurers and accredited service providers offering 22 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission affordable, comprehensive, quality risk protection to the majority of poor people in India.

Similarly, the Mission Statement may read as follows: The Microinsurance Coordinating Centre aspires to facilitate delivery of innovative health financing and health insurance solutions in the country and improve the health indicators. It also aims to improve the capacity of insurance providers to provide risk protection services on a sustainable basis. The Centre is committed to building a vibrant health financing and risk pooling sector through collective advocacy and through concentration, leveraging, and focusing on resources and knowledge towards developing innovative technologies. More specifically, activities and services of the MCC may include the following:

- To diagnose the feasibility and requirements of proposed micro-insurance projects in specified districts of the identified NRHM states;
- To develop and offer comprehensive, feasible, customized technical solutions complete with onsite guidance and implementation assistance;
- To facilitate strengthening the technical and cost effective management capacities of the NRHM team at the district level;
- To analyze and document the leading and best practices in the health microinsurance industry;
- To provide a forum for regular exchange and dissemination of ideas, innovations, lessons learned, achievements, and international best practices;
- To develop and support EHR central data warehousing and tools;
- To develop health microinsurance performance standards and prudential indicators, and the supporting technologies and tools that will enable micro-insurers to meet these standards;
- To provide a rating service of NRHM districts with micro health insurance pilots micro-insurers with respect to the standards and indicators;

23 Ruchismita, Ahmed, Rai: Delivering Micro Health Insurance through the National Rural Health Mission To facilitate and strengthen collaboration and partnerships among the various microinsurance

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providers and Health Ecosystem partners • To establish linkages between insurers and resource institutions such as funding agencies, financial institutions, and research institutions; • To accredit a network of providers delivering affordable, quality health care through use of clinical protocols and negotiated tariff schedules; • To provide and manage a data repository and also a national helpline for query redressal. To conduct industry experience studies and share results for use in pricing and management purposes; • To represent the health microinsurance sector to the Government of India and lobby for favorable and enabling policy; • To identify and facilitate networking and business opportunities among the various stakeholders; and • To elevate the insurance consciousness through awareness campaigns and education. Some of the activities such as product design are already being carried out by insurance companies.

However, since microinsurance differs greatly from commercial insurance it requires unique design, marketing, and distribution strategies and skills. The MICC, with its personnel focused and specializing in micro insurance and health (health economists), with access to current data, and with concentration of knowledge about the industry would be positioned to facilitate superior solutions in these areas. 24