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Health Insurance II

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In an earlier article this writer had argued for group-based/community based health insurance schemes. This article describes what such a pilot scheme could look like for replication at a larger scale. In my opinion, provision of medicines for *in-patient* treatment may serve as a good entry point for such a scheme enabling the government to focus its scarce resources towards treatment of higher order diseases, OPD and emergency.

As already argued, the scheme would target low income groups and for financial viability and for keeping transaction costs and insurance premiums low risks and contributions would have to be pooled for a heterogeneous group; insurance bought as a group contract. To make the scheme initially attractive for those bordering on poverty (such that they eventually realize the advantages of pooling of risks) the government should offer conditional matching grants-making their availability contingent upon participation of the entire community in the scheme.

Flexibility in the payment of premium and the system of certifying health care claims can be improved by introducing an agency to act as an intermediary between the target community and the insurer, although this would push up administrative costs marginally.

The scheme should be operational across all government hospitals. Government hospitals are being proposed because costs of medical consultancy are already borne by the government. Such an arrangement would enable greater patient coverage for cost of medicines. Therefore, for scheme viability, only government hospitals should be considered in the first phase.

Initially, the government would be expected to identify the t*arget area* and *target population;* if it is to provide a matching grant it should have the right to select the target community. The pilot scheme could target a reasonably sized *kaachi abadi* in urban areas while for rural areas a large sized village or union council could serve as the target area.

A mobile and accessible mechanism for receiving premium contributions, making payments and verifying eligibility of the beneficiary will have to be developed. The community would deposit the premiums (likely to range between Rs.2,000-2,500 per household per annum) at a collection centre located in the vicinity. It would make economic sense for this collection centre to be a mobile van as premiums would not be paid daily making investment in a permanent centre economically unviable. Even the services of Lady Health Workers (LHW) could be utilized. LHWs could become major actors in the health insurance scheme, serving as premium collection agents of the insurance companies, for a small fee. All those covered under the scheme would be issued a Membership Card as proof of eligibility.

Such schemes can run into adverse selection and moral hazard problems which would affect the efficient running of the scheme. Adverse selection would arise when a person who foresees the need for medical insurance buys insurance more often than an individual who does not require medical assistance. Enrolling the entire household would help in countering the adverse selection problem The moral hazard problem would be dealt with by the group insurance contract. Here individuals in the group or the community LHW could also keep a watchful eye and report to the insurance company if any member acts in a careless manner.

For urban settings, scheme members would only be allowed to seek treatment at a pr-determined hospital. This would help distribution of patients across different government hospitals, preventing overcrowding, while ensuring a minimum quality of service and attempts to fleece patients, and thereby insurance companies, by prescribing excessive and expensive drugs for treatment (also a non-insurance regulatory issue for ensuring services of a minimum standard); if the scheme were to simply reimburse providers for services it is likely to result in excessive treatment and service charges, raising doubts about scheme sustainability. The insurance company would be responsible for reimbursing the hospital without scheme members engaging in any form of financial transaction with the hospital.

Problems could arise in the implementation of the scheme due to lack of capacity in government hospitals to handle the influx of patients, given that they receive patients from everywhere. This issue could be addressed in two ways. First, within a selected hospital some hospital beds could be reserved for the scheme members. This would ensure that in times of need the scheme members would have easy admittance into hospitals. Secondly, some private hospitals could also be included under the scheme. Adoption of selected private hospitals would increase the pool of hospitals that the insurance company can draw upon. However, private hospitals would only be used in cases of emergency (out of fear of potential abuse of over- charging) when a government hospital is unable to accommodate a scheme member who is a patient.

Experiences of community based schemes in other countries suggest that participants are at times unable to pay the premium either at all or on a timely basis. Therefore, before the project is launched, it may become important to tap societies and organizations which are capable of providing short term credit to insured families. *Microfinance* and rotating saving societies (‘committees’) present themselves as viable options. As regards those poor households within the community unable to fully pay the premium, the government could provide assistance in two

ways. First, as already proposed above, it could have a matching principle whereby for every rupee that an individual contributes, the government matches it. Secondly, institutions like the BISP could be tapped to cover the premium payments of a certain proportion of the poor within the community.