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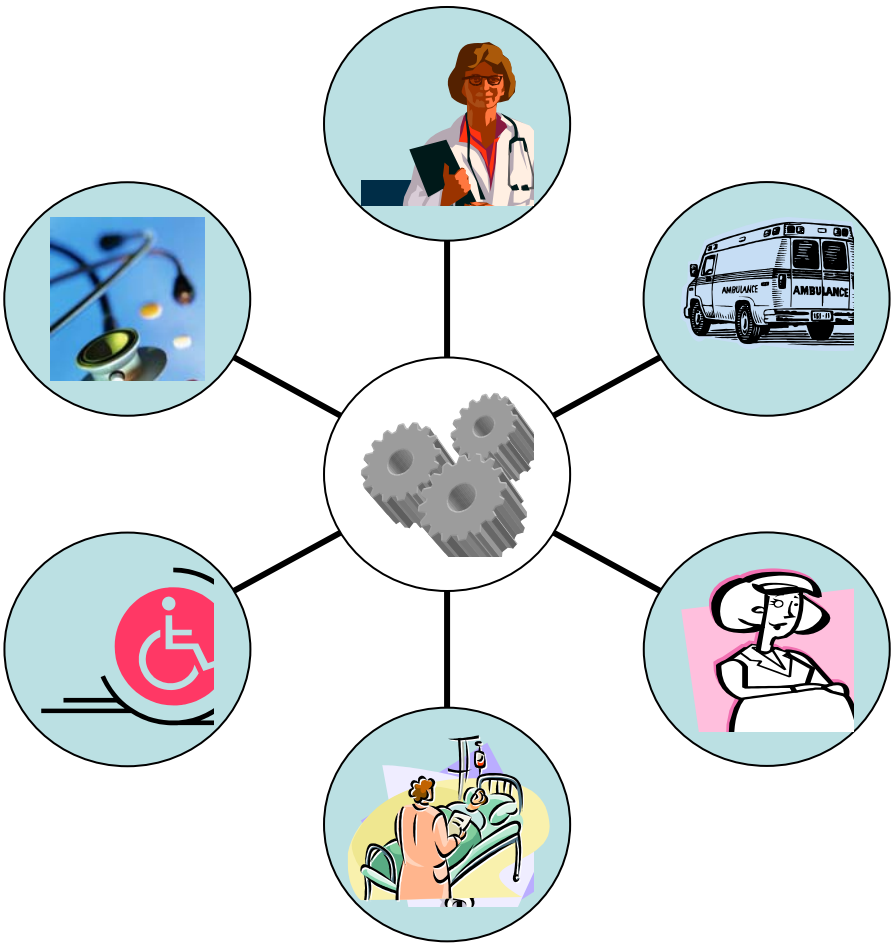
INDIA

HEALTH MICRO-INSURANCE SCHEMES: DIVERSITY, INNOVATIONS AND TRENDS

A NATIONAL REVIEW

2009

SUBREGIONAL OFFICE FOR SOUTH ASIA, NEW DELHI


AMBULANCE

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The Global Campaign on Social security and Coverage for All

Only one in five people in the world has adequate social security; half of the world's population is without any social security. Social security is a universal need and a basic human right. Based on the consensus reached by governments, employers and workers during the International Labour conference in 2001, the ILO launched the "Global Campaign on Social Security and Coverage for ALL" in June 2003. The Campaign is a concrete ILO contribution to the achievements of the Millenium Dvelopment Goals (MDG) and to a fair and inclusive globalization

A large variety of policies and institutions can be used to reach social security for all. Statutory social security schemes can extend existing or modified benefits to previously excluded groups or contingencies. They may also enhance their effectiveness through improved governance and design. New schemes may have to be developed. Another option may be to encourage and support the development of micro-insurance and innovative decentralized social security schemes to provide social protection through communities, social partners and civil society organizations. Within the context of a national policy framework sustainable linkages have to be developed between schemes that serve different parts of the population.

The Campaign uses three means of action. First of all, it provides technical assistance, contributes to capacity building and supports the process of social dialogue. Secondly, it focuses on knowledge development i.e. on research, experimentation and the dissemination of good practices. Thirdly, it aims at raising awareness and at encouraging partnerships, so as to mobilize key actors at the local, national and international levels.

The Campaign publishes books as well as four working paper series: (i) ESS papers (Extension of Social Security); (ii) Documenting Community Social Protection Schemes; (iii) Fighting Social Exclusion; and (iv) Special Studies.

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Strategies and Tools against social Exclusion and Poverty (STEP)

The Strategy and Tools against social Exclusion and Poverty global programme (STEP) of the International Labour Organization (ILO) is active in two interdependent thematic areas: the extension of social protection to the excluded and integrated approaches to social inclusion.

STEP supports the design and implementation of innovative systems intended to extend social protection to excluded populations, particularly in the informal economy. It focuses in particular on systems based on the participation and organization of the excluded. STEP also contributes to strengthening links between these systems and other social protection mechanisms. In this way, STEP supports the establishment of coherent national social protection systems, based on the values of efficiency, equity and solidarity.

STEP's action in the field of social protection is placed in the broader framework of combating poverty and social exclusion. It gives special emphasis to improving understanding of the phenomena of social exclusion and to consolidating integrated approaches at the methodological level which endeavour to reduce this problem. STEP pays special attention to the relationship between the local and national levels, while at the same time contributing to international activities and agenda

STEP combines different types of activities: studies and research, the development of methodological tools an d reference documents, training, the execution of field projects, technical assistance for the definition and implementation of policies and the development of networking between the various actors.

The programme's activities are carried out within the Social Security Policy and Development Branch of the ILO, and particularly its Global Campaign on Social Security and Coverage for All.

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Asian Micro-Insurance Network (AMIN)

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According to the survey conducted by the National Sample Survey Organization (NSSO) during 1999-2000, the total number of workers in the unorganized sector was about 37 crore (93 per cent of the total workforce of the country). This number has increased to 43.4 crore (94 per cent) as per the recent survey conducted by the same organization during 2004-05.

The 61st Round Survey report on “Informal Sector and Conditions of Employment of India” published by the Ministry of Statistics & Programme Implementation, Government of India, reveals that nearly 55 per cent of regular wage / salaried employees and 96 per cent of casual labourers were not eligible for social security benefit.

The National Commission for Enterprises in the Unorganized Sector’s (NCEUS) report on Conditions of Work and Promotion of Livelihoods in the Unorganized Sector (2007) highlighted the progressive informalization of the formal sector. The Commission has estimated that between 1999-2000 and 2004-2005, employment in the organized sector had increased by 8.5 million. Over the same time, the number of *informal workers* operating in the organized sector increased by 8.6 million. This means that the entire net increase in the employment in the organized sector consisted of informal workers, left without job security or social security benefits. This indicates the increasing informalization of employment in the formal sector.

PREFACE

As poverty and social exclusion remain major problems today, the quest for solutions continues. The ILO's Strategies and Tools against social Exclusion and Poverty Programme (STEP.) keeps on exploring innovative methods that can contribute to these solutions. One of them is health micro-insurance.

To this day, there are only a few fully documented initiatives all over the world. India may become a new reference with the present work reviewing 100 on-going health micro-insurance schemes spread all over the country.

Though every effort has been made to reach out as many initiatives as possible, at no point one can claim that every scheme could be identified.

In spite of the painstaking and extensive efforts made to obtain detailed information from as many reliable sources as possible, STEP has not been able in all cases to check the data collected. Therefore, STEP is inot in a position to guarantee the quality and reliability of all the information gathered in this work. In addition, it should be noted that in some cases, it has proved impossible to obtain an updated information.

Time constraints restricted personal contacts and in-depth interviews with most of the micro-insurance representatives. Therefore, the present work is essentially based on responses provided to the questionnaire which was specifically designed for the purpose of the review carried in India. Although this questionnaire was sent to all identified schemes, very few indeed took the necessary time to provide all the requested answers.

Due to a lack of data or documentation on existing schemes and a lack of responses by some organizations, secondary data had to be used in many cases.

The present review is not a comprehensive guide to health micro-insurance schemes, nor does il include an analysis of the different schemes. Likewise, the content is not intended to promote a preferred model on how to design, implement and manage a health micro-insurance scheme.

Finally, one should not infer STEP's policy from the content of the present review.

This document is a preliminary version of a database, which will be accessible on the internet through the Asian Micro Insurance Network (AMIN) at http://.www.amin-net.org allowing even more people to have an easy access to information.

ACKNOWLEDGEMENTS

We wish to aknowledge the invaluable help we received from two ladies working as AMIN secretariat officers during the time it took to gather all information pertaining to health micro-insurance schemes operating in India. Without the unflinching commitment of Miss. Stanzin Dolkar and Miss. Ashita Abraham, to track dawn all existing schemes and to sort out through the maze of all information coming to them, the multiple elements worth being recorded, the present document could never have been prepared. We also wish to tank again all the marvellous people met in India, fully dedicated to the health micro-insurance cause, for all the information, views and assistance provided while carrying out the present work

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
AMIN	Asian Micro Insurance Network
APL	Above Poverty Line
BPL	Below Poverty Line
CASHE	Credit and Savings for Household Enterprises
CBO	Community Based Organization
CHC	Community Health Centre
CLASS	Communities Led Association for Social Security
EPFO	Employees Provident Fund Organization
ESIS	Employees' Social Insurance Scheme
FHPL	Family Health Plan Limited
FW	Family Welfare
GoI	Government of India
GTZ	German Technical Cooperation
HDFC	Housing Development Financial Corporation
HIV	Human Immuno.Deficiency Virus
HMIS	Health Micro-Insurance Scheme
HW	Health Worker
IAS	Indian Administration Service
IEC	Informaion, Education & Communication
IRDA	Insurance Regulatory and Development Authority
ISEC	Institute for Social and Economic Change
ISSA	International Social Security Association
LIC	Life Insurance Corporation of India
MCH	Medical College and Hospital
MIS	Management Information System
MoH&FW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
MoSJ&E	Ministry of Social Justice and Empowerment
MoT	Ministry of Textiles
NA	Information Not available
MFI	Micro-Finance Institution
NGO	Non Governmental Organization
NRMH	National Rural Health Mission
NUHM	National Urban Health Mission
NIC	National Insurance Company
NIAC	New India Assurance Company
NSAP	National Social Assistance Programme
NSS	National Sample Survey
NSSO	National Sample Survey Organization
OBC	Other Backward Castes
OIC	Oriental Insurance Company
PF	Planet Finance
PHC	Primary Health Centre
PLHA	People living with HIV/AIDS
PPP	Public Private Partnership
PREM	People's Rural Education Movement
PRI	Panchayati Raj Institutions
RCH	Reproductive Child Care
RSBY	Rashtriya Swasthya Bima Yojana
SBA	Skilled Birth Attendant
SC	Scheduled Caste
SEWA	Self-Employed Women's Association
SFS	Self Funding Scheme

SHG	Self Help Group
SSA	Social Security Association of India
ST	Scheduled Tribe
STEP	Strategies and Tools against social Exclusion and Poverty
TPA	Third Party Administrator
UHIS	Universal Health Insurance Scheme
UIIC	United India Insurance Company
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

INTRODUCTION

In 2001 during the International Labour Conference of the ILO, the representatives of governments, employers and workers' organizations reached a new consensus on social security. One of the major components of this consensus was that "the highest priority should be given to policies and initiatives which could bring social security to those who are not covered by existing systems".

At the same time, it was widely recognised that in many developing countries the social security schemes set in place, had been designed to address the needs of the formal economy workers. Consequently, only a small percentage of the population could benefit from social protection. ILO's recent estimates revealed that two third of the world population had no protection at all, and that for 80% the protection remained inadequate. The magnitude of this social protection gap called for more active involvement of all concerned actors in new strategies and mechanisms that could contribute to the rapid extension of social protection to all excluded groups.

As an integral part of ILO's Social Protection sector, the ILO/STEP programme has been actively engaged since 1998 in the identification, promotion and support of various innovative interventions that could effectively address the social protection needs of the poor and excluded groups. As part of this worldwide exercise, it has launched a series of studies to identify and document the various types of extension initiatives with a strong emphasisi on health, since health insurance is the first social protection priority for workers in the informal economy. This priority is also in line with ILO's interventions, medical care being regarded as the primary branch of social security since health is a concer to all groups and categories of workers.

As the largest democracy in the world, India is still striving to extend basic human rights, including social protection, to all its citizens.

Although there has been a persistent decline in the overall poverty ratio over the last two decades, the latest report published by the National Commission for the Enterprises in the Unorganized Sector estimated that 77% of the population lives on less than US$ 2 a day. That means that while the Indian economy is seen growing at historically high rates, 830 million people have hardly the resources to meet out of their meagre income all needs in time of illness, accident or other crises.

India accounts for a sixth of the world population but it is estimated that only 10% have access to affordable health care, meaning that to this day close to one billion people are still waiting for a health protection mechanism that can prevent them from being pushed at any time into the debt trap and into further deprivation and poverty.

While facing this unprecedented level of healthl exclusion phenomenon, there is growing evidence that India has already taken the lead in fostering and implementing innovative strategies and mechanisms aiming the extension of health protection to all. The Government of India, together with various State Governments, has recently demonstrated a wider awreness and stronger commitment to respond to the health protection needs of the presently excluded groups and engaged new widespread inititives. The various regulations issued by the Insurance Regulatory and Development Authority of In dia (IRDA) also converged to further encourage and facilitate a deeper penetration of health micro-insurance activities among all excluded groups.

Trade Unions, while increasingly extending their outreach to informal economy workers have also put health protection at the forefront of their social demands. The corporate sector is now expressing interest in the extension of health protection as a part of the corporate social responsibility principle, while numerous actors from the civil society (community-based organizations, women's groups, informal economy trade unions, NGOs, micro finance institutions, etc.) are already supporting different types of health micro-insurance schemes that are now found proliferating all across India.

The diversity and scope of these initiatives in a country as big as India already represent a unique experience. This uniqueness is further ehanced since, while trying to bridge the health exclusion gap, India has also experimented with various ways allowing the excluded groups to benefit from some redistribution

mechanisms that contribute under the national responsibility principle to the achievement of the over-arching g oals of social justice and human-rights promotion.

Put together, this wide array of new experiences can make an enormous contribution to achieving the first Millenium Development Goal of halving poverty by 2015. New evidence-based knowledge on this experience could also contribute in a big way to ILO's Global Campaign for Social Security for All. Hence, the need to carry out a comprehensive review of the various health micro-insurance schemes currently being operated in India.

OBJECTIVES

The overall objective of the present document is to provide an across-the-country review of the various on-going health micro-insurance schemes targeting the disadvantaged groups of the society Specific objectives were to:

1. Assess the overall development of the health micro-insurance sub-sector over the last five years;

2. Capture the diversity of approaches, actors, products and operational mechanisms while looking at the schemes' achievements and present and potential impact;

3. Identify the main innovations and best practices that can be used for the provision of appropriate health insurance benefits to the various disadvantaged groups;

4. Examine how today's achievements fit into the current health development policies and social security extension strategies both at the Central and State Government level;

5. Using all evidence-based information gathered, recognize the major trends that are likely to shape the future sub-sector landscape;

6. Highlight the key elements conditioning the successful implementation of present major initiatives as well as the further development of the whole sub-sector;

7. Formulate relevant recommendations pertaining to the design, implementation, monitoring and evaluation of health micro-insurance schemes aiming at improving their relevance, effectiveness and performance;

8. Analyze how the Indian health micro-insurance experience is likely to provide any guidance to policy makers of other countries having evinced some interest in initiating health insurance schemes while facing a similar health protection gap;

METHODOLOGY

The methodology used for this national review is mostly derived from similar exercises carried out by the STEP programme in recent years. To gather all relevant information, a context-specific comprehensive questionnaire was first developed and submitted to some health insurance schemes in order to get their feedback. The final version of the questionnaire, together with a briefing note and some technical explanations was then sent to the various organizations already known to be involved in the development of health micro-insurance schemes.

The identification process had to be iterative since no comprehensive information concerning health information activities was yet to be found in India. A contact list was to be built up through the snowball technique. The first contacted schemes were asked to provide information on other schemes, which could in

turn refer to other on-going initiatives.

Informal contacts were also established with a wide variety of organizations such as NGOs, Micro-Finance Institutions, Self-Help Group Federations, insurance companies, research centres, micro-insurance resource centres and development agencies in order to identify additional schemes.

This identification process was further extended to a newsclippings review spanning over a two-year period, to a comprehensive internet search. On two occasions, queries were also posted on the Solution Exchange – Micro-Finance virtual community, aiming at triggering the reaction of other health micro-insurance practitioners. Various reports and studies pertaining to health policies, health protection mechanisms, social security and insurance activities were finally screened in search of any additional useful information.

A list of some 130 “potential schemes” was put together as a result of this preparatory work. Information on the operational status of each scheme registered on this contact list was first verified through telephone interviews. Given timeframe constraints, this list could not be further extended, leading to some geographical gaps in the national review which originally intended to cover the interventions in each and every State.

All listed organizations were contacted and requested to fill in the questionnaire which was sent either by conventional or electronic mail. Several reminders and additional phone calls were often necessary to gather all relevant information. In many cases, organizations requested additional explanations on some technical terms used in the questionnaire which caused further delay in gathering all relevant information. In many instances, the information flow could take various weeks or even months before being completed.

Various organizations were found not willing to share information under the pretence this should remain confidential. In some other cases the information which was provided remained too scanty to allow for the concerned organization to be included in the national. As observed in most cases, the major constraint in providing the requested information seems more likely to be related to the many weaknesses affecting the management information systems set in place.

All in all, the information pertaining to a total of 100 health micro-insurance schemes could be gathered and processed in the present document. While the main information on each scheme could be collated, many elements pertaining to their features, achievements, impact and performance may still be found missing in the presentations to follow. Also, although no effort was spared to obtain more informationdetails and figures in order to check on the information that was provided, a long-distance contact could in no way verify all details and figures that were given. While these last words of caution reduce the overall information value expected from such a document, it remains however an invaluable contribution to the better understanding of the many developments currently witnessed in India in the health micro.insurance subsector.

EXECUTIVE SUMMARY

Nowhere but in India can one witness today so many efforts aiming to enhance effectiveness and coverage of health protection. Both public and private sector are found engaged in multiple health micro-insurance initiatives that have already brought India to the forefront of the development of this sector while recording an exponential growth in terms of both coverage and outreach. In today's India, the sheer number of interventions aiming at extending health protection benefits to the weakest segments of the population already defies any comprehensive identification attempt. This difficulty is even compounded due to the wide diversity of approaches and methodologies that require to be further investigated in order to be fully documented.

The key distinctive feature of the Indian experience for the provision of adequate health protection benefits to each and every citizen appears to be the diversity of actors, target groups, distribution channels, financing mechanisms and operational modalities. This wide diversity of initiatives is already responsible for some of the most innovative mechanisms that could serve as models for the wider replication in the Indian context as well as for the adaptation in other countries facing similar gaps in their overall health protection systems.

Pioneered by organizations such as RAHA and SEWA, the first health insurance initiatives had a strong social perspective while targeting low-income groups facing some worst forms of exclusion such as the tribal groups and poor self-employed women. To some extent, their example was followed by some NGOs already involved in various health programmes that needed to gradually rely on some cost-sharing mechanism.

The opening of the insurance market to private players in 1999 spurred the second wave of interventions. With the realization of a huge market left untapped, the most aggressive insurance companies although generally without any prior experience in this field, started to tie-up with organized groups, NGOs or MFIs, developing what soon came to be known as the partner-agent model to reach out to the disadvantaged groups.

As for the latter, the recent amazing multiplication of Self-Help Groups across the country, although located at the bottom of the micro-finance industry seemed to offer the best development avenue. For these entities, regrouping mostly women more sensitive to health risks (and also known for their superior financial discipline) and already engaged in both savings and loan activities, also providing health insurance services to their members was considered as a natural addition.

With all insurance companies encouraged by the Insurance Regulatory and Development Authority (IRDA) to venture into this sector, technical expertise became available and very soon showed its effects in terms of constant products improvements and innovations. With these very unique features, there is no arguing that India had already taken the lead and deserved to be seen at that stage of development as the "health micro-insurance" laboratory of the world.

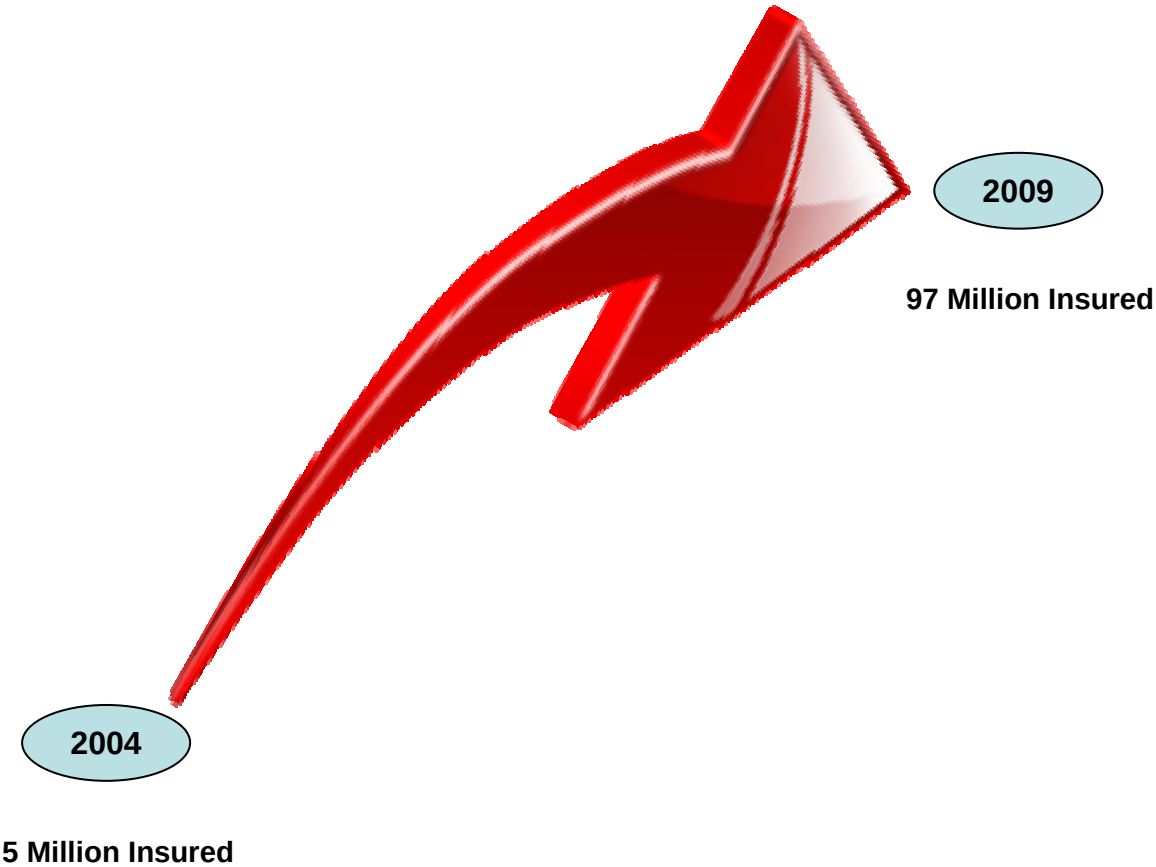
Although these new interventons could already lead to a dramatic increase in termes of enrolment, they often failed to achieve a significant impact over time for a variety of reasons. Among these, a still weak awareness of insurance principles and mechanisms, the difficulty to customize products and services to a heterogeneous public and the high level of transaction costs played a role in curtailing the growth expectations of insurance companies. The overall "one size-fits-all" strategy of the insurance companies didn't change much over time and the coverage of hospitalization costs still remained predominant. Both public and private companies were reluctant to venture beyond this type of benefit. The addition of a whole battery of age bars, exclusion clauses, benefit limitations and service caps often accounted for benefits found too narrow to attract huge numbers.

A far wider development effect resulted from the very first health insurance initiatives taken by various state governments. Including a subsidy component aiming to allow the broad BPL population to access some level of health protection, these interventions, in essence, removed the major difficulty to adjust the premium to the very limited contributory capacity of the various target groups. First one to cover 1.6 million in its first year of operation, the Yeashasvini scheme launched in Karnataka elicited an immediate strong interest among other State Governments, conveying the new certitude that efficient health insurance mechanisms could be brought to the mases. In its wake, the scheme initiated in Andhra Pradesh achieved even better results, succeeding to cover 36 million over a two-year time span.

But the best was yet to come. Akin to the interest evinced by many state governments in their health policies and initiatives, the Central Government had also been stressing the need for and importance of health insurance for the weakest segments of the population. Starting first with various schemes targeting some specific groups of workers, sponsored by various Ministries, the Central Government major initiative soon looked at the health protection needs of the entire Below Poverty Line population.

In October 2007, the Ministry of Labour and Employment, Government of India, released the Guidelines pertaining to the implementation of the new health insurance scheme called Rashtriya Swasthya Bima Yojana (RSBY), targeting in the first phase the Below Poverty Line workers and their families – about 300 million people. Since then, the Ministry of Labour and Employment has actively encouraged the various State Governments to implement this scheme planned to reach its full target population over a five-year period. Responding positively, almost all State Governments are now committed to be part of this Central Government sponsored initiative which strated its implementation phase in early 2008.

As a result of these successive developments, the number of health micro-insurance schemes operating in India increased dramatically and the total number of people covered reached a new amazing peak, as compared to the findings of a first inventory of health micro-insurance schemes in India undertaken five years ago by the ILO/STEP programmem which at that time identified only 28 health micro-insurance schemes.



The following presentation provides on overview of the last decade main developments witnessed in the health micro-insurance subsector.

Health Micro-Insurance in the Making: A Decade's Highlights

1999

- The Insurance Regulatory and Development Authority of India (IRDA) issues regulations allowing for private insurance companies to enter the national market

2002

- IRDA issues new regulations making it an obligation for private insurance companies to reach specific targets while working in the rural and social sectors

2003

- Under a very first Public Private Partnership arrangement, the state-wide Yeshasvini scheme is launched in Karnataka. Having succeeded to enrol 1.6 million people in its first year of operation, it triggers a broad interest among other States willing to take a similar initiative
- The Central Government launches the first "Universal Health Insurance Scheme" (UHIS) including a subsidy component restricted to Below Poverty Line families

2004

- The National Common Minimum Programme (NCMP) prepared by the new Government refers in its preamble to the welfare of farmers, agricultural workers and weaker sections of the society and strongly states a commitment to ensure through social security, health insurance and other schemes, the welfare and well-being of all workers, particularly in the unorganized sector which now represents 94% of the labour force
- To follow up this commitment, the Government establishes a National Commission to examine the major problems facing the various enterprises operating in the informal economy
- SEWA and other organizations launch a "National Campaign for social security for unorganized sector workers" as a rallying cry to ensure the provision of appropriate social security benefits to all excluded groups

2005

- The National Rural Health Mission (NRHM) is launched by the Ministry of Health and Family Wefare, Government of India, outlining a framework for developing health insurance programmes across the country
- IRDA issue the Micro-Insurance Regulations providing a detailed framework to insurance companies for their interventios in the rural and social sectors

2006

- The National Commission releases its report on Social Security for workers in the unorganized sector aiming to provide social protection benefits – including health insurance – to some 60 million workers and their families. This proposal could be viewed as paving the way towards a nation-wide comprehensive social security system based on the national social solidarity principle

2007

- The Ministry of Labour and Employment (MoLE), Government of India, releases its plan to provide a health insurance cover to 300 million people belonging to the Below Poverty Line population
- IRDA raises the rural and social targets that should be reached by all insurance companies over a five-year period
- In the spirit of the NRHM, the Government of Andhra Pradesh launches a broad health insurance scheme targeting the BPL population and aiming to cover 70 million people across the State

2008

- In close collaboration with various State Governments, the Ministry of Labour and Employment, Government of India, launches the new insurance scheme called "Rashtriya Swasthya Bima Yojana" (RSBY) aiming to cover 300 million people over a five-year period
- The Unorganized Sector Workers' Social Security Bill is adopted by the Parliament. It includes, among various other schemes, the RSBY scheme which has already been initiated in many states

2009	• The Government of Tamil Nadu launches a first health insurance scheme targeting both the BPL and – up to some income level – the APL families, fully subsidized by the State • VimoSEWA, the insurance branch of the Trade Union, turns into a licensed insurance company fully owned by its women members

In a nutshell, the following major components contributed to these spectacular achievements:

- The pioneering role played by some leading organizations like SEWA, RAHA and at a later stage, Yeshasvini, encouraging more civil society organizations and public departments to play an active role in new health micro-insurance initiatives
- The various regulations pertaining to micro-insurance issued by the Insurance Regulatory and Development Authority making it a social oblibation for all insurance companies to devote part of their portfolio to activities in the rural and social setor
- The strong commitment of the Central Government as well as of the State Governments to provide some level of health protection to the weakest segments of the population through various micro-insurance schemes including a subsidy component
- The existence and parallel development of various community-based organizations such as the self help groups and cooperative movement that may serve as effective channels to reach and serve the various target groups

INSURANCE COMPANIES SOCIAL OBLIGATIONS

(ISSUED in 2002 -year 1-5- and 2007-year 6-10)

	From Year 1 to Year 5	From Year 6 to Year 10
General Insurance Sector	Rural Sector: 5% of total Gross Premium Social sector: 20,000 lives	Rural Sector: 10% of total Gross Premium Social Sector: 55,000 lives
Life Insurance Sector	Rural Sector: 7% of total Policies Social Sector: 20,000 lives	Rural Sector: 16% of total Policies Social Sector: 55,000 lives

At the center of the present review, the Central Government RSBY sheme already spreads over 21 states and covers close to 34 million people.

The sheer magnitude of this unique health micro-insurance initiative clearly expose the new scheme to huge new implementation challenges. Having already adopted quite innovative features – such as the generalization of a smart card – the scheme is poised to deal with unprecedented operational issues. Opting for the most appropriate solutions, will no doubt require the active participation of all concerned actors such as those acting as social aggregators at the field level. Although benefiting from both the technical and financial assistance provided by the Central Government, the respective State Governments are to retain key responsibilities for the planning and implementation of the scheme and may decide to tie up with such intermediary organizations. At the same time, the associated insurance companies, using a model already tested in other health insurance plans, could also choose to rely heavily on similar partnership arrangements.

All 100 schemes reviewed in the present document, contribute through their diversity to a wider understanding of the various mechanisms that can be used to provide efficient health protection benefits to the most disadvantaged groups. This multi-faceted Indian experience could also more easily benefit other countries willing to move forward their own health protection extension agenda.

Being still at a nascent stage, it was not to be expected that health micro-nsurance could evolve so soon into a fully-developed experience having overcome all hurdles and pitfalls met at an early hour. Health insurance proved everywhere to be one of the most daunting lines of insurance activities. Much more time is still needed to stabilize membership, manage inherent risks, check and contain health costs and administration expenditures and secure long-term operational sustainability. But if a clear-cut model to achieve attractiveness, sustainability and scalability did not emerge so far, diversity of interventions is definitely present, bringing about a fastest pace of development and constant innovations, ranging from the design to the implementation, management and monitoring of the many schemes that now proliferate across all India.

Over the last few years, for instance, some of the most important changes found in the present review better contribute to give a human face to health micro-insurance, with an increasing concern towards some key issues such as maternity protection, inclusiveness, equity and accessibility:

Another major development bred by diversity is illustrated by the recent intervention of various micro-insurance resource centres that are expected to join hands with the multiple health micro-insurance actors, in order to enhance the practitioners' technical capacities, to contribute to the production of much-needed management and monitoring tools and to participate in advocacy activities towards policy-makers at all levels.

However, diversity also brings its load of challenges and predominantly the huge information gap that still affects most health micro-insurance interventions. Due to segmented approaches, many schemes are still operating in complete isolation and are left unaware of others' experiences. Hence, there is a reduced ability to overcome some common constraints and analyze development options and opportunities. This general lack of information makes also more difficult to look into the specific details of their activities which may delude any attempt to asses their relevance, effectiveness and sustainability. When looking at the broader picture, it also makes it much more difficult to measure their real contribution in terms of reduction of vulnerability and poverty, the very specific objectives they were supposed to achieve.

The end result of this shortage of information is to hinder the overall knowledge development process which also comes at a cost - some mistakes may still be repeated, and sound – if not best yet – practices may go unnoticed and are not allowed to be replicated. Hence, the need for new tools and processes aimed at enhancing the overall transparency, efficiency and sustainability of health insurance activities

Looking at the experience already developed by these 100 schemes, it was also felt that information gaps related to the broader social protection issue remain pervasive in the country. The very concept and principles of social protection as well as the systems and mechanisms that can be used to ensure a widespread coverage continue to be neglected by many.

This lack of basic understanding, while trying to respond to the needs of such a huge segment of the population, could lead towards more market-oriented approaches and individual behaviours and choices that go contrary to the very concept of social protection, whose provision should remain a core responsibility of the State. At this point of time, India could be seen standing right now at a crossroads where both social insurance and commercial insurance could be considered as the path for the future. Clearly, much more still needs to be done in order to convey the appropriate rights-based approach message to the many actors involved in the provision of health micro-insurance services to the Indian population.

A first look at these "hundred flowers to bloom" already shed some light on innovations and trends that will shape the future of health micro-insurance in India and change millions of lives in the process. Aiming at looking under the surface phenomenon, the present document should allow for a better understanding of the most important developments experienced in the health micro-insurance sub-sector which is to be recognized as vibrant and unique. As such, as in many other fields, India seems poised to provide the world with appropriate solutions to address the health protection needs of the excluded groups.

1. ANALYSIS OF SCHEMES' MAIN FEATURES

STATES CONCERNED BY THE NATIONAL REVIEW

ORGANIZATIONS INVOLVED IN HEALTH MICRO-INSURANCE

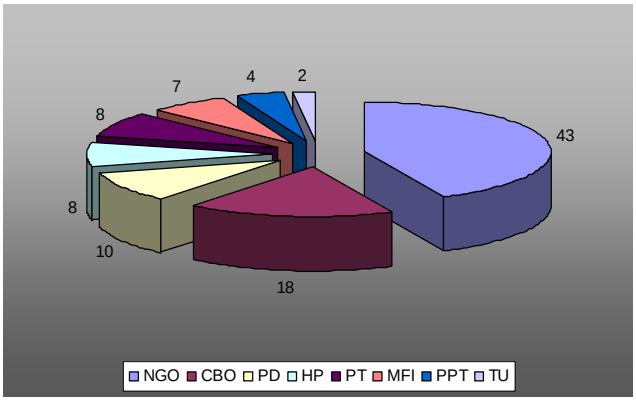
Sl.	Organization	N°of Schemes
1.	Accord – Ashwini	1
2.	Aga Khan Health Services (AKHS)	1
3	Andhra Pradesh State Police Trust	1
4.	Antodaya	1
5.	Aragonda Apollo Hospitals	1
6.	Arogya Roksha Yojana Trust (ARY)	1
7.	Arogyashree Yojana Trust	1
8.	Arthik Samata Mandal (ASM)	1
9.	Asha Kiran Society (AKS)	1
10.	Association of Serva Sewa Farms (ASSEFA)	1
11.	Awareness	1
12.	Bharatiya Agro Industries Foundation (BAIF)	1
13.	Bharatiya Samruddi Investments and Consultancy Services (BASIX)	1
14.	Bihar Milk Cooperatives Federation (BMCF)	1
15.	Bhartiya Integrated Social Welfare Agency (BISWA)	1
16.	Buldana Urban Credit Cooperative Society (BUCCS)	1
17.	Chaitanya	1
18.	Charotar Arogya Mandal (CAM)	1
19.	Community Aid & Sponsorship Programme (CASP)	1
20.	Community Health Assistance Project (CHAP)	1
21.	Centre for Overall Development (COD)	1
22.	Centre for Youth and Social Development (CYSD)	1
23.	Development of Humane Action (DHAN) Foundation	1
24.	Emmanuel Hospital Association – Uttarakhand (EHA-U)	1
25.	Emmanuel Hospital Association – Madhya Pradesh (EHA-MP)	1
26.	Evangelical Social Action Forum (ESAF)	1
27.	Freedom Foundation (FF)	1
28.	Gandhi Smaraka Grama Seva Kendram Karadka (GSGSKK)	1
29.	Grameen Kota (GK)	1
30.	Gram Niyojan Kendra (GNK)	1
31.	Gwalior Municipal Corporation Limited (GMC)	1
32.	Healing Fields Foundation (HFF)	1
33.	Health and Auto Learning Organization (HALO) Foundation	1
34.	Indore Municipal Corporation Limited (IMC)	1
35.	Kagad Kach Patra Kashtakari Panchayat (KKPKP)	1
36	Karnataka State Police Trust	1
37.	Karuna Trust	1
38.	Kas Foundation	1
39.	Katsurba Hospital	1
40.	Kodi Trust	1
41.	League for Education and Development (LEAD)	1
42.	Mahaseman Trust	1
43.	Mahashakti Foundation	1
44.	Mallur Health Cooperative	1
45.	Manndeshi Mahila Sahakari Bank (MMS)	1
46.	Manipal Academy of Higher Education (MAHE)	2
47.	Mayapur Trust/Sri Mayapur Vikas Sangha	1
48.	Ministry of Health – Madhya Pradesh	1
49.	Ministry of Labour and Employment – NSSS	1
50.	Ministry of Labour and Employment – RSBY	1
51.	Ministry of Social Justice and Empowerment	1
52.	Ministry of Textiles – Handloom	1
53.	Ministry of Textiles – Artisans	1
54.	Mitra Christian Hospital Bissamcuttak	1
55.	Modern Architects of Rural India (MARI)	1
56.	Myrada	1
57.	Naandi Foundation – Hyderabad	1
58.	Naandi Foundation – Udaipur	1
59.	Naandi Foundation – Jodhpur	1
60.	New Life	1
61.	Nidan	1
62.	Organization for Awareness of Integrated Social Security (OASIS)	1

63.	Organization for Development of People (ODP)	1
64.	Palmyrah Workers Development Society (PWDS)	1
65.	People's Rural Education Movement (PREM)	1
66.	Pragathi Gramin Bank – Chitradurga Unit (PGBCU)	1
67.	Pragati	1
68.	Raigarh Ambikapur Health Association (RAHA)	1
69.	Rajasthan Dairy Cooperative Federation (RDCF)	1
70.	Rinchi Hospital Trust (RHT)	1
71.	Rusha	1
72.	Sampoorna Kutumba Arogya Pathakam (SKAP)	1
73.	Samskar	1
74.	Seba Cooperative Health Society (SCHS)	1
75.	Self-Employed Women's Association (SEWA)	2
76.	Self Help Association for Development and Empowerment (SHADE)	4
77.	Self Help Promotion for Health and Rural Development (SHEPHERD)	1
78.	Self Help Groups Federation – Kerala	1
79.	Self Help Groups Federation (1) – Tamil Nadu	1
80.	Self Help Groups Federation (2) – Tamil Nadu	1
81.	Sevashram	1
82.	Seva Mandir	1
83.	Shanti Dhan	1
84.	Shree Kshetra Dharmasthala Rural Development Project (SKDRDP)	1
85.	Society for the Promotion of Area Resources (SPARC)	1
86.	Solapur Cooperative Federation	1
87.	Students Health Home (SHH)	1
88.	Symbiosis Centre for Health Care for Students (SCHCS)	1
89.	Swayam Krishi Sangam (SKS)	1
90.	Tamil Nadu AIDS Initiative (TAI)	1
91.	Tamil Nadu Health Insurance Trust (TNHIT)	1
92.	Tribhuvandas Foundation	1
93.	Uplift Health	2
94.	Vaatsalya Healthcare	1
95.	Village Welfare Society (VWS)	1
96.	Voluntary Health Services (VHS)	1
97.	Welfare Service Ernakulam (WSE)	2
98.	Working Women's Forum (WWF)	1
99.	Yeshasvini Trust	1
100.	Youth for Action (YFA)	2
Total Number of Schemes		**108**

1.1. Ownership Profile

With a great diversity of organizations being involved in the development of health micro-insurance schemes, the NGOs and CBOs still keep the upper hand, with a total of 61 schemes. It is noteworthy to mention the part already played at that stage by new actors such as the Public Departments and Public-Private Trusts

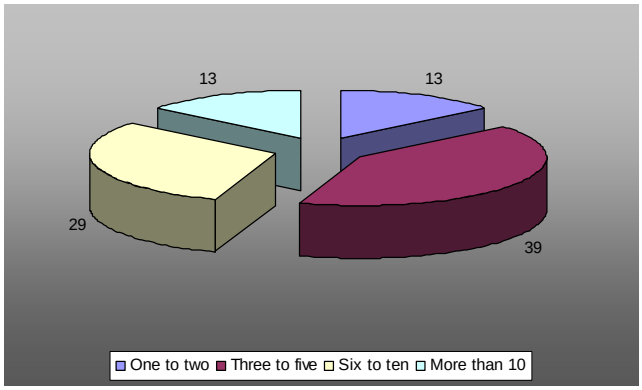
Type of Ownership	N°Schemes
Non-Governmental Organizations	43
Community-Based Organizations	18
Public Departments	10
Health Providers	8
Private Trusts	8
Micro-Finance Institutiona/Organizat.	7
Public-Private Trusts	4
Trade Unions	2
Total	**100**



1.2. Level of Experience

Most schemes are still very young, having started their operations in the last few years. The number of schemes (58) having less than 5 years experience comes to more than half the total

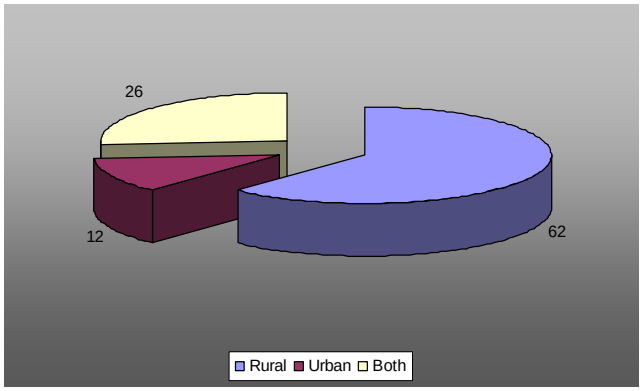
Number of Years	N°Schemes
One to two years	19
Three to five years	39
Six to ten years	29
More than ten years	13
Total	**100**



1.3. Area of Intervention

A majority of schemes (62) develop their activities in rural areas while very few (12) confine their operations to urban areas

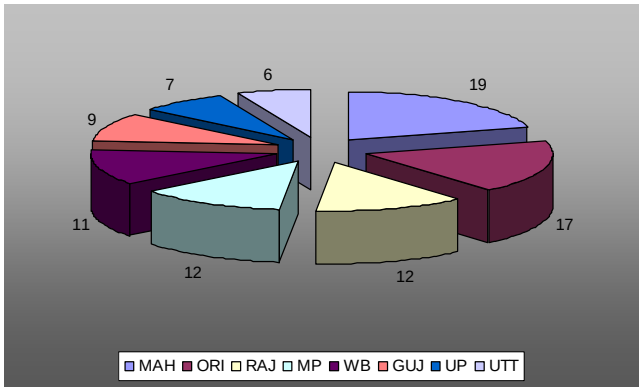
Area of Intervention	N°Schemes
Rural	62
Urban	12
Both	26
Total	**100**



1.4. Geographical Coverage

1.4.1. Northern States

States	N°Schemes	%
Bihar	8	8%
Chhattisgarh	7	7%
Gujarat	9	9%
Maharashtra	19	24%
Madhya Pradesh	12	12%
Orissa	17	17%
Rajasthan	12	12%
Uttar Pradesh	7	7%
Uttarakhand	6	6%
West Bengal	11	11%
Total	**98**	**100**

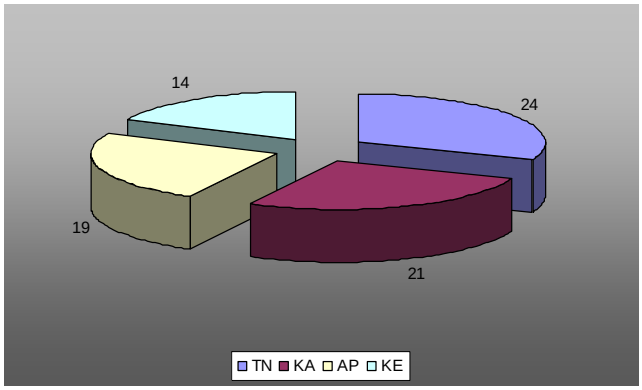


98 schemes are found operational in 10 Northern States as compared to the 78 schemes being operated in four Southern States only

1.4.2. Southern States

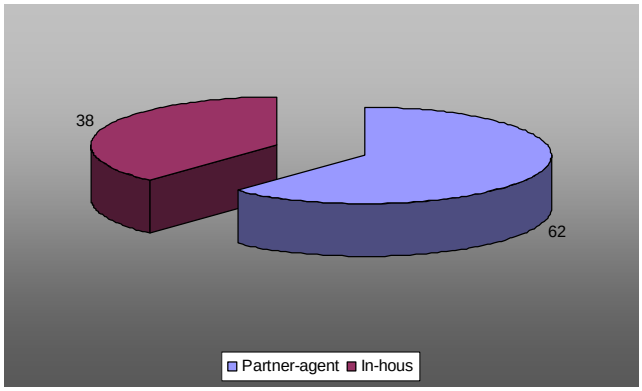
States	N°Schemes	%
Andhra Pradesh	19	24%
Karnataka	21	27%
Kerala	14	18%
Tamil Nadu	24	31%
Total	**78**	**100**

With 24 schemes already being implemented, the State of Tamil Nadu has the highest density in terms of health micro-insurance interventions



1.5. Type of Scheme

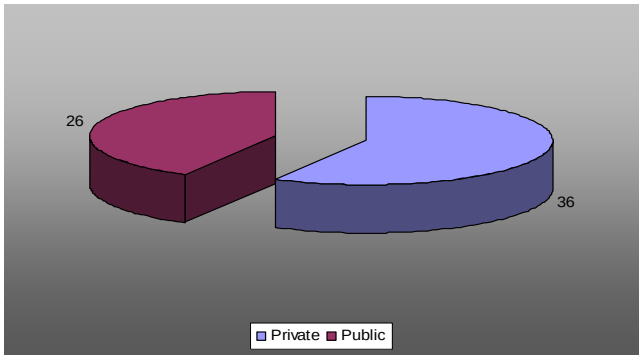
With sixty schemes having already opted for this model, the predominance of the partner-agent model has become more obvious. This percentage is expected to further increase as a result of the revised social obligations targets imposed by IRDA and the intervention of additional general insurance companies in the market. Conversely, while the number of in-house schemes has not shown any increase, their combined coverage accounts today only for a small share of the the total insured



1.6. Partnership with Insurance Companies

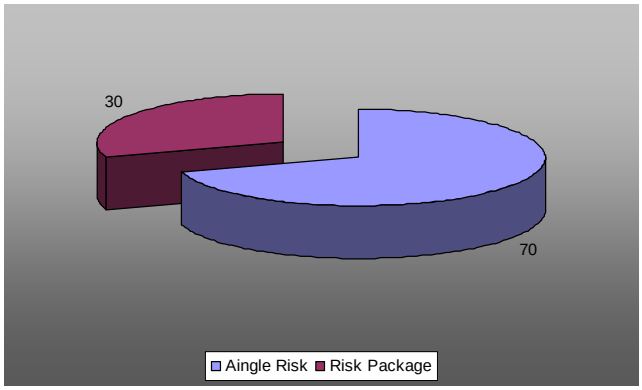
Spurred by the various IRDA regulations (social obligations an micro-insurance) both public and private insurance companies are now found busy competing while trying to find new channels and partnerships to reach out to the masses. This new mood could result in some cases in significant positive changes in terms of costs as well of the range of services provided under the schemes.

Although newcomers on the insurance scene, the private insurance companies already proved to more aggressive in their health insurance initiatives and marketing techniques. To this day, more schemes (36 out of a total of 62) choose to be linked with private insurance companies. This upwards trend is expected to move to higher levels with the growing imbalance between public and private insurance companies (now 4 public against 16 private)



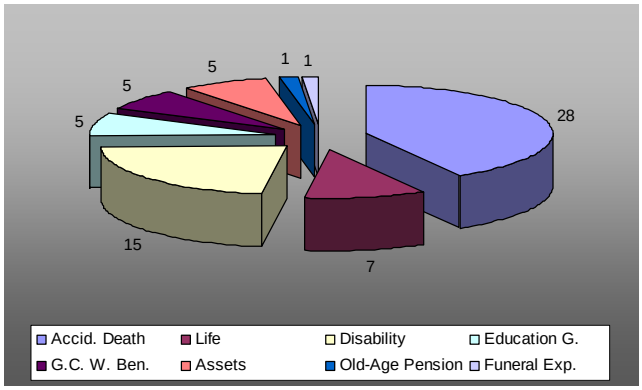
1.7. Type of Risk

The number of schemes offering a risk package is now limited at 30, confirming a general trend to focus on health insurance only. The additional risks (see table below) that came to be covered under different packages did not induce neither higher enrolment rates nor reduced drop-out rates in the various concerned schemes. Also, the largest schemes in terms of coverage today, all adopted the single risk type for their insurance plan



1.8. Distribution of Additional Risks

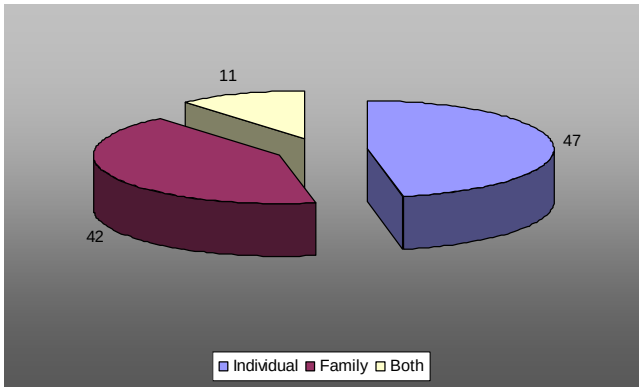
Aditional Risks	N°Schemes
Accidental death	28
Disability	15
Life	7
Assets	5
Education Grant	5
Girl Child Wedd. Benefit	5
Funeral Expenses	1
Old-Age Pension	1
Funeral Expenses	1



1.9. Enrolment Unit

States	N°Schemes
Individual	47
Family	42
Both	11
Total	**100**

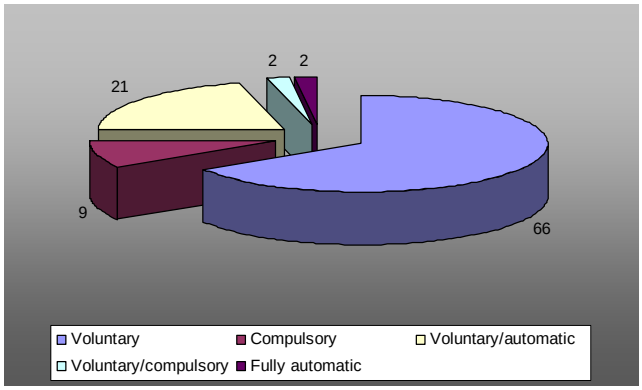
As compared to the information gathered among health insurance schemes found operational in 2004, there is a clear shift today towards family enrolment.



1.10. Type of Enrolment

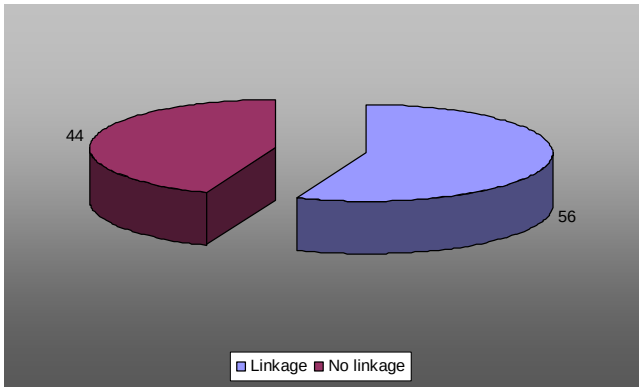
States	N°Schemes
Voluntary	66
Compulsory	9
Voluntary/automatic	21
Voluntary/compulsory	2
Fully atomatic	2
Total	**100**

Although most schemes (66) still rely on voluntary enrolment, the trend to shift to automatic/compulsory enrolment is already pretty much on the rise



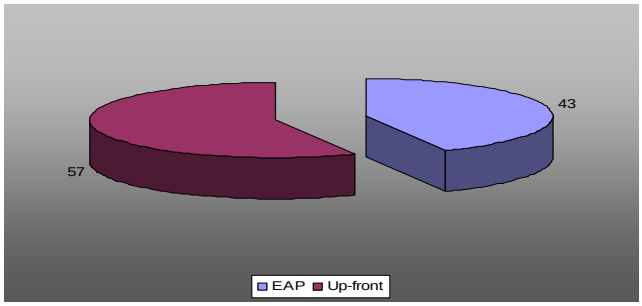
1.11. Linkage with Micro-Finance Institutions/Organizations

The natural linkage between micro-insurance and micro-finance is still reflected in the majority of the schemes (56). This linkage is expected to become stronger in the years to come due to the new importance attached to partnership arrangements developed within the widespread Self Help Group movement



1.12. Use of Easy Payment Mechanisms

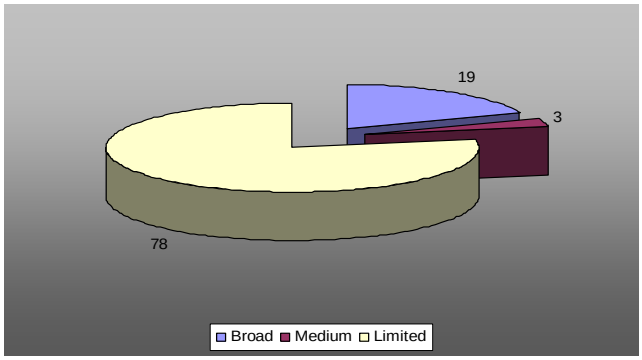
Most schemes (57) have already adopted various easy payment mechanisms in orer to reduce the burden of a one-time up-front premium payment for their members. Since various insurance companies are now found very active in trying to incorporate such mechanisms in their insurance plans, many more schemes are expected to adopt them in the near future



1.13. Scope of Health Benefits

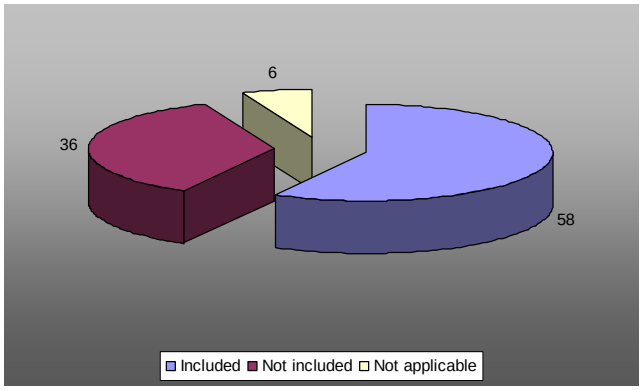
Scope	N°Schemes
Broad (OPD + Hosp +…)	19
Medium	3
Limited (OPD or Hosp. only)	78
Total	**100**

Most schemes still cover a limited scope of health benefits to their members, often restricting the cover to hospitalization costs along with various restrictions, exclusions and service caps



1.14. Inclusion of Maternity Protection

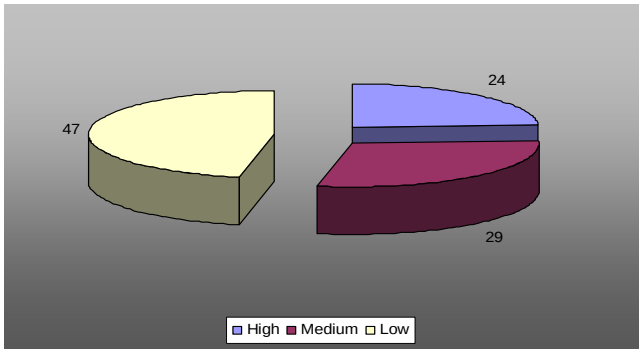
58 schemes already include a maternity protection component. This should be seen as a major achievement as compared to the situation observed in 2004 where maternity benefits were left excluded in almost all health insurance schemes



1.15. Level of Health Benefits

Level	%
High (Rs. 30,000 onwards)	24
Medium (Rs.10,001 - 29,000)	29
Low (Less than Rs. 10,000)	47
Total	**100**

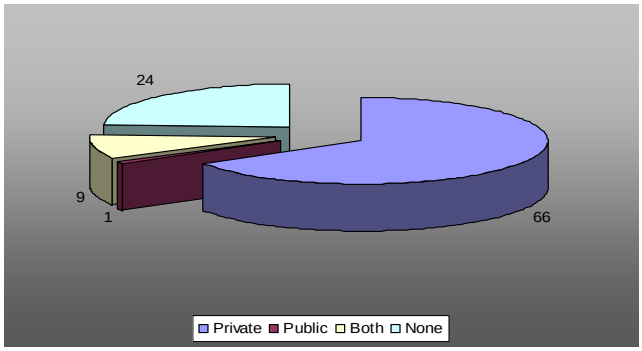
Most schemes still provide a low level of health protection with benefits ranging from Rs. 500 to Rs 10,000



1.16. Partnership with Health Providers

Health Facilities	N°Schemes
Private	66
Public	1
Both	9
None	24
Total	**100**

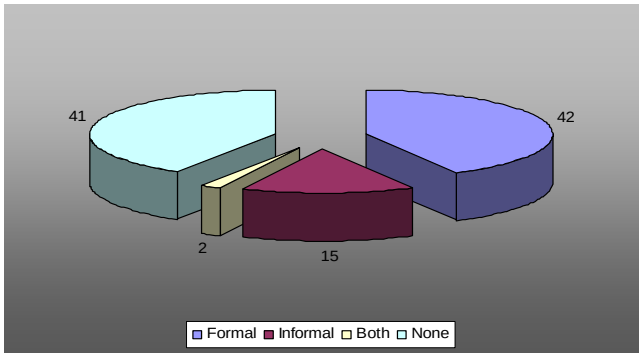
66 schemes only partner with private health providers. Attempts to include public facilities in the hospital networks remain so far very limited



1.17. Type of Agreement with Health Providers

Type of Access	N°Schemes
Fornal agreements	42
Informal agreements	15
Both	2
None	41
Total	**100**

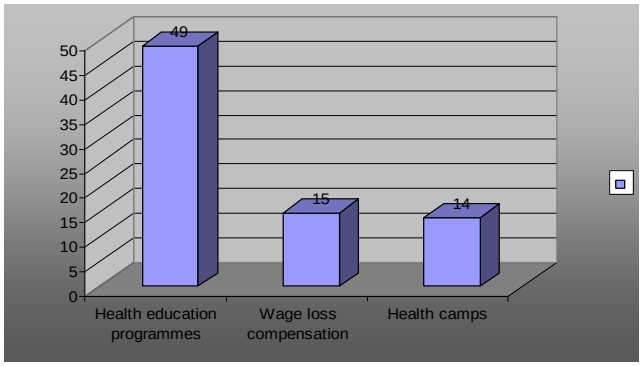
Although the number of schemes concluding formal agreements has sharply increased, many schemes still rely on informal relations with health providers



1.18. Health-Related Additional Activities/Services

Activities/services	N°Schemes
Health Camps	14
Health Education/Prom. Programmes	49
Wage Loss Compensation	15

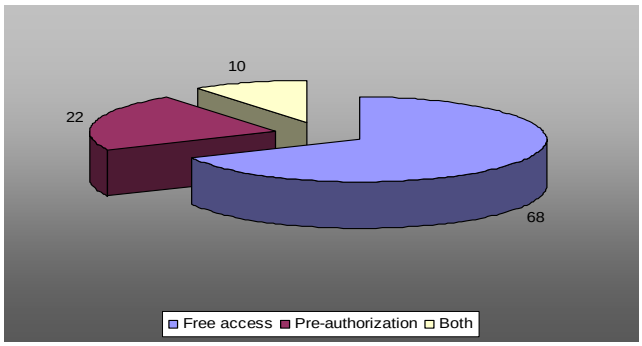
49 schemes are involved today in the organization of regular health education/promotion campaigns complementing their insurance activities. This may be seen as a major progress over the last few years



1.19. Access to Health Services

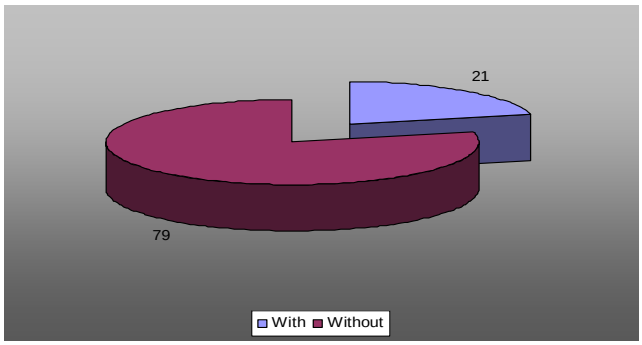
Type of Access	N°Schemes
Free Access	68
Pre-authorization	22
Both	10
Total	**100**

68 schemes allow for a free access of their members to heath services. The schemes that have opted for a pre-authorization mechanism often rely on the intervention of a TPA



1.20. Existence of Co-payment Mechanism

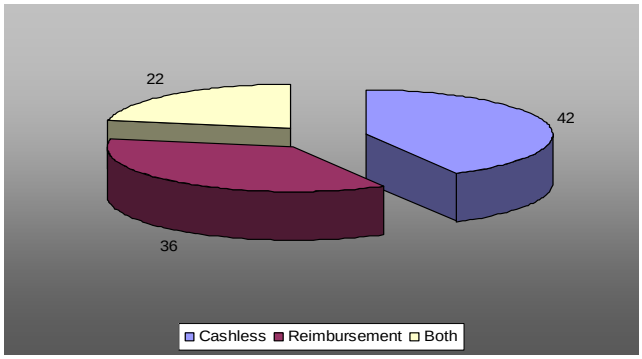
Most schemes (79) do not include a co-payment modality. However, the number of schemes that require such co-payment is found steadily increasing



1.21. Health Services Payment Mechanism

Payment Mechanism	N°Schemes
Cashless	42
Reimbursement	36
Both	22
Total	**100**

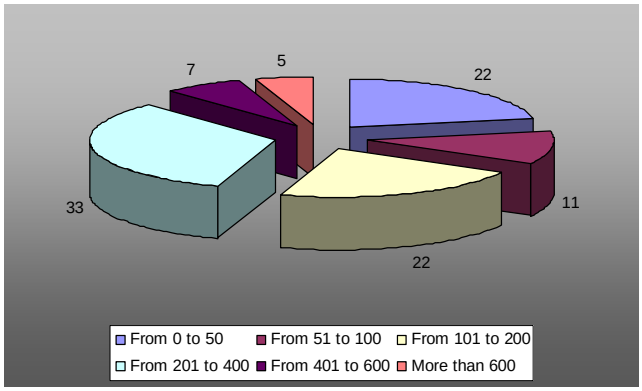
Cashless schemes are slowly gaining ground since it does not put any burden of payment on the beneficiaries and as such may induce more people to join the scheme



1.22. Level of Yearly Premium

Premium/year	N°Schemes
Rs. 0 to Rs. 50	22
Rs. 51 to Rs. 100	11
Rs. 101 to Rs. 200	22
Rs. 201 to Rs. 400	33
Rs. 401 to Rs. 600	7
More than Rs. 600	5
Total	**100**

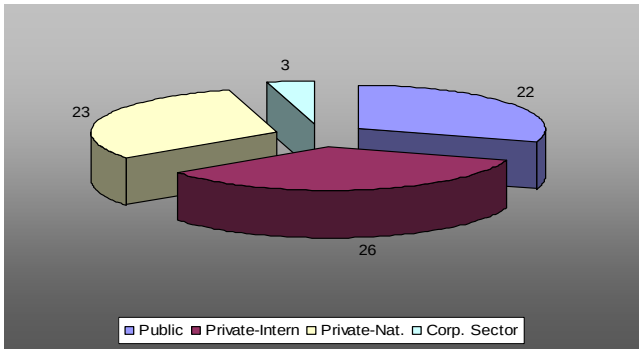
The average premium level remains low in most schemes. The above figures also seem to confirm a maximum contributory capacity around Rs. 400



1.23. Origin of Subsidies

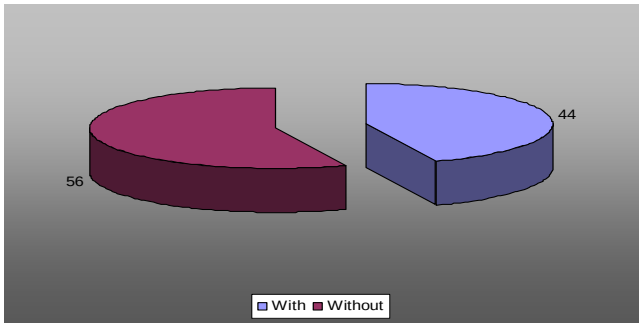
Origin	N°Schemes	%
Public	22	30%
Private (International)	26	35%
Private (National)	23	31%
Corporate sector	3	4%
Total	**74**	**100**

Most schemes still rely on some subsidy wether direct or indirect. The share of public subsidies increased dramatically over the last few years



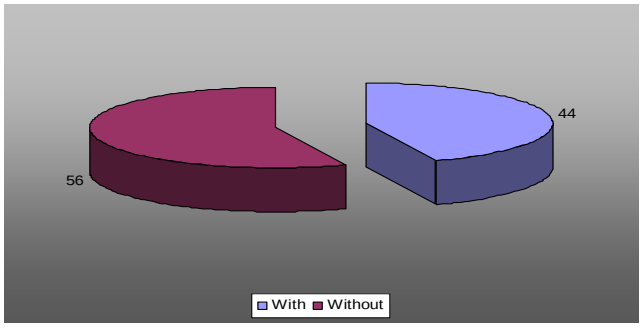
1.24. Current Spread of Direct Subsidies

44 schemes already benefit from a direct subsidy – co-contribution – allowing for more health benefits to be provided to the insured. In some cases, this subsidy covers the full premium amount In case of a partial subsidy, it may take the form either of a fixed cost-sharing mechanism or a flexible contribution mechanism



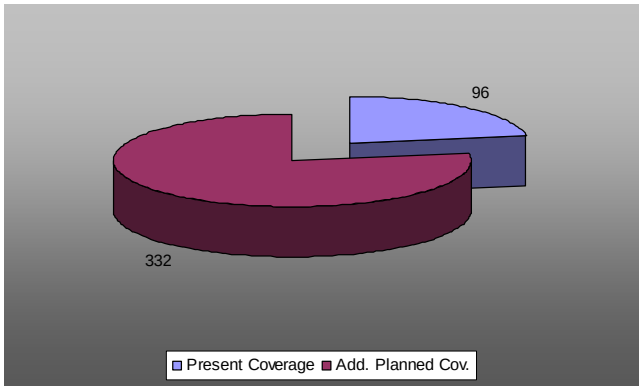
1.25. Current Spread of Indirect Subsidies

44 schemes still rely on an indirect subsidy aiming at supporting the overall administration costs or a component of the various activities developed by the scheme. While indirect subsidies may play a critical role at the initial stage, they are expected to be withdrawn in due time in order for the scheme to achieve its full operational sustainability



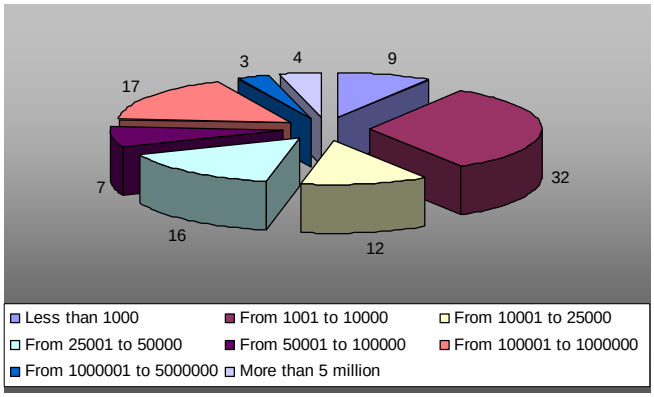
1.26. Overall Present and Potential Coverage

At present, the 100 schemes under review already cover some 97 milliom people across the country. At the same time, and according to estmates provided by the schemes' representatives, an additional 332 million people could still be covered once the schemes have reached their full operational outreach. While this last figure may appear somehow inflated, the targets set by the largest schemes benefiting from government subsidies may well be on the way to come close to this figure



1.27. Coverage-Wise Distribution of Schemes

Number of Insured	N°Schemes
Less than 1,000	9
From 1,001 to 10,000	32
From 10,001 to 25,000	12
From 25,001 to 50,000	16
From 50,001 to 100,000	7
From 100,000 to 1,000,000	17
From 1,000,001 to 5,000,000	3
More than 5 million	4
Total	**100**



These figures already show the impressive impact of many on-going schemes, with 4 schemes covering more than 5 million insured and 20 schemes reaching an insured population ranging between 100,000 and 5 million

1.28. Coverage Top Twenty Schemes

Organization	Geograph. Outreach	Ownership	Number Insured X 1000	Pot. Target X 1000
1 Aarogyashree Yojana Trust (8)	Andhra Pradesh	Public-Private Trust	36,700	70,000
2 Ministry of Labour & Employment RSBY (50)	All India	Public Department	33,997	300,000
3 Ministry of Textiles – Handloom (52)	All India	Public Department	6,120	6,480
4 Ministry of Health & Family Welfare (47)	Madhya Pradesh	Public Department	5,490	5,490
5 Yeshasvini Trust (99)	Karnataka	Public-Private Trust	3,047	6,000
6 Ministry of Textiles – Handicraft (53)	All India	Public Department	2,700	2,970
7 Students Health Home (87)	West Bengal	Public Department	1,587	5,600
8 Village Welfare Society (95)	West Bengal	MFI	766	1,500
9 Shree Keshtra Dahramsthala RDP (84)	Karnataka	NGO	721	800
10 Bharatiya Samruddi Inv. & Cons. S. (13)	Andhra Pradesh+	MFI	525	2,000
11 Swayam Krishi Sangam (89)	Andhra Pradesh+	MFI	472	2,700
12 Andhra Pradesh – State Police Trust (3)	Andhra Pradesh	Public Department	400	400
13 Rajasthan Dairy Cooperat. Federation (69)	Rajasthan	Public Private Trust	384	600

14 Karnataka – State Police Trust (36)	Karnataka	Public Department	350	350
15 Self-help Group Federation – Kerala (78)	Kerala	CBO	225	425
16 Self-Employed Women's Associatiob (75)	Gujarat+	Trade Union	195	300
17 Bhartiya Integr. Social Welfare Agency (15)	Orissa	MFI	183	1,000
18 Grameen Kota (29)	Karnataka	MFI	175	300
19 Sampoorna Kutmba Arogya Patlakam (72)	Andhra Pradesh	CBO	170	250
20 Solapur Cooperative Federation (86)	Maharashtra	CBO	170	300
Total Top Twenty			**94,377**	**398,895**
Total Top Ten			**91,653**	**392,270**

All together, the 20 largest schemes already cover 94 million people, which is about 98% of the total insured tabulated for the 100 schemes under review. Looking at the impact of the first ten top schemes, total coverage would only be slightly less: 91 million, representing 95% of total insured, thus reflecting the huge disparities in terms of size and impact between the schemes under review

2. REVIEW MAIN FINDINGS

2.1. Diversity

The wide diversity of experiences could already lead to the integration of key issues such as maternity protection (now included under various forms in many schemes) as well as some other social aspects:

Participation: Full ownership of the health micro-insurance scheme, close involvement in overall management and claims processing, participation in regular monitoring and evaluation

Women-friendly: Inclusion of maternity protection benefits, coverage of complicated deliveries, cash benefits, maternity vouchers, post-natal care, baby care…

Inclusiveness: Extension of health coverage to most disadvantaged groups: senior citizens, poor young children, primitive tribal groups, people living with disabilities, persons living with HIV/AIDS…

Equity: Income-rated premium scale, premium level ranging according to the production of milk, compulsory co-contribution made by all micro-finance borrowers…

Accessibility: Dedicated registration desks, networks of empanelled hospitals, homeopathic and ayurvedic treatment, use of herbal remedies, telehealth technology, availability of low cost generic drugs…

Individual Support: Professional advise prior to treatment, personal assistance at the time of hospital discharge, transportation costs, wage loss compensation during the time of hospitalization, transportation costs, post-hospitalization care, regular home visits by health workers…

Diversity also allowed for new actors to step in. Various specialized resource centres are now found active joining hands with the schemes operating in the field in order to provide the additional technical services that they require.

Resource Centers

- Planet Finance Micro-Insurance Awards
- Sa-Dhan Core Group on Social Security
- Centre for Insurance and Risk Management
- CARE International Micro-Insurance Centre
- Communities-Led Association for Social Security
- Micro-Insurance Academy

INDIA
PLANET FINANCE
www.planetfinance.org
The Microfinance Platform

PlaNet Finance is an international network of non-profit organizations, dedicated to the development of microfinance as a strategy against poverty. Recognizing the need for insurance to become as easily available to the poor as credit, PFI recently joined hands with ING Insurance Company to institute the Micro-insurance Awards which aim to support the development of a stronger micro-insurance platform as an extension of microfinance in order to offer a better protection to the poor against the various risks they face on a daily basis. Through the MI Awards, PFI and ING plan to build a comprehensive inventory and identify the best practices in needs assessment, product design and delivery channels implemented by the various micro-insurance schemes already being operated in the country and to generate a market-oriented enthusiasm towards micro-insurance.

Established in 1998, the Association of Community Development Finance Institutions (Sa-Dhan) helps its members and associate institutions to better serve low income households, particularly women, in both rural and urban India, in their quest for establishing stable livelihoods and improving their quality of life. In October 2006, Sa-Dhan established a core group on social security whose objective is to guide and facilitate the greater outreach of social security services to the poor and marginalized segments of the society with a major focus on the multiple ideas to facilitate innovations for the micro-insurance sector. As a first item on its operational agenda, the core group initiated a discussion on the strategies and mechanisms that can be used to improve the quality of the delivery mechanisms of micro-insurance products and services.

The Institute for Financial Management and Research (IFMR) is a leading school with strengths in both research and training founded in 1970 in Chennai with backing from ICICI and other major corporates. While the micro-finance sector has been growing rapidly in India with a focus largely on expanding outreach, there was an urgent need to fill some gaps in the practice and in the understanding of micro-finance in order to maximize and accelerate the impact of this growth. Observing that poor households face multiple critical risks that impact their earning capacity and could further push them into poverty and indebtedness, IFMR also set up a sectoral infrastructure, the Centre for Insurance and Risk Management (CIRM) to focus on developing capabilities for insurance and other risk mitigating instruments. The Centre was to collaborate with all micro-insurance actors to develop efficient insurance programmes and products and build an enabling environment fostering further growth of the micro-insurance sub-sector.

As an international NGO, CARE's vision is a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. CARE's first foray into micro-finance in 1996 rapidly evolved towards the implementation of a full scale programme called Credit and Savings for Household Enterprises (CASHE) currently spread over three states. As part of its effort to promote innovations, CASHE has actively promoted micro-insurance and other social protection schemes that could be associated with micro-finance activities. One major priority was to address the health protection needs of poor women through the availability of appropriate client focused insurance products. In October 2006, CARE India partnered with Bajaj Allianz Insurance Company to open a micro-insurance centre in Chennai, aiming to design and promote innovative products and mechanisms that could provide an appropriate level of protection to the tsunami affected communities.

Realizing that better awareness on social security mechanisms still needed to be built along with the capacities that would allow them to better serve their members, various organizations from different states came together to list the actions required in order to see a people led social protection movement emerging out of the various community based health insurance schemes. This event set the first corner stone of a national platform called Communities Led Association for Social security (CLASS) to coordinate resources existing all over the country towards the support of concrete new social health insurance projects. Scaling up together became the motto of the group while preparing its plan of action which includes the development of an active advocacy role with various Public Departments at the central and state level. For this, experience-based evidence needed to be gathered and analyzed. To create together a Data Warehouse would be a one stop resource solution (online) for products, tools, forms, softwares, MOU specimens and any other relevant information

The Micro Insurance Academy (MIA) is a Delhi-based Charitable Trust (NGO) dedicated to providing technical assistance in insurance domain-knowledge to organizations that focus on grassroots communities. MIA also carries out the research needed for data collection & analysis underlying effective interventions, and impact evaluation. The unique features of the MIA model of empowering poor people to obtain insurance that suits their needs and their ability to pay is based on the following: *i)* Enabling resource-poor communities to design health insurance packages that reflect an optimal match between local needs, supply and solvent demand, *ii)* The development of innovative, interactive, and practical training and insurance education modules that provide communities with the necessary knowledge and skills to establish and govern their own mutual micro health insurance units, *iii)* Collecting and analysing data: baseline surveys, impact assessments, qualitative and quantitative inquiries; production of high quality research and training materials, *iv)* The design and implementation of essential support tools, such as the IT system and access to reinsurance and *v)* Monitoring, evaluation and feedback

Finally, and since health is a matter of State, diversity is also illustrated in the various policies and strategies that were adopted by the State Governments with regard to health protection (See Annexure 2). Most State Governments are already committed to support the development of health micro-insurance schemes whether through their participation in the RSBY implementation, or by launching their own separate initiative.

2.2. Innovations

The many innovations found in the present review may be grouped under the following headings:

2.2.1. Design and Setting Up

Scheme Design

- Full participation and ownership of community based organizations
  - Uplift Health (93) – Maharashtra
- Resulting from a broad consultation process
  - Ministry of Labour and Employment – RSBY (50) – All India
  - Aarogyashree Yojana Trust (7) – Andhra Pradesh
- Through a direct collaboration developed by a TPA with a Municipal Corporation
  - Indore Municipal Corporation (34) – Madhya Pradesh
- Through a partnership arrangement developed by an NGO with two public departments (Health & Family Welfare and Education)
  - Nandi Foundation Hyderabad (57) – Andhra Pradesh
- Through a partnership agreement developed by the Ministry of Health & Family Welfare with private physicians
  - Ministry of Health & Family Welfare (48) – Madhya Pradesh

Coverage Extension

- Extending health insurance cover to senior citizens
  - Gwalior Municipal Corporation (31) – Madhya Pradesh
  - Indore Municipal Corporation (33) – Madhya Pradesh
- Extending health insurance cover to poor children enlisted in public schools
  - Naandi Foundation – Hyderabad (57) – Andhra Pradesh
  - Naandi Foundation – Udaipur and Jodhpur (58-59) – Rajasthan
- Extending health insurance cover to a Primitive Tribes Group
  - Asha Kiran Society (9) – Orissa
- Extending health insurance cover to marginalized people and transgendered
  - Tamil Nadu AIDS Initiative (90) – Tamil Nadu
- Extending health insurance cover to people living with autism, mental retardation and multiple disabilities
  - Ministry of Social Justice and Empowerment (51) – All India
- Extension of coverage to HIV/AIDS

- Naandi Foundation - Hyderabad (57) – Andhra Pradesh
- Karuna Trust (37) – Karnataka
- Freedom Foundation (27) – Karnataka

Benefit Package

- Comprehensive health package (low ceiling)
  - Accord – Ashwini (1) – Tamil Nadu
  - Raigarh Ambikapur Health Association (68) – Chhattisgarh
- Comprehensive health package (high ceiling)
  - Sampoorna Kutumba Arogya Pathakam (72) – Andhra Pradesh
  - Arogya Roksha Yojana Trust (6) - Karnataka
- Whole care package (no ceiling)
  - Nandi Foundation - Hyderabad (57) – Andhra Pradesh
  - Naandi foundation – Udaipur and Jodhpur (58-59) – Rajasthan

Additional Benefits

- Education grant and girl child benefit
  - Healing Fields Foundation (32) – Andhra Pradesh
  - Raigarh Ambikapur Health Association (68) – Chhattisgarh
- Funeral expenses
  - Evangelical Social Action Forum (26) – Kerala
- Old-age pension
  - Ministry of Labour and Employment – NSSS (49) – All India

Co-contribution

- From the corporate sector
  - Naandi Foundation – Hyderabad (57) – Andhra Pradesh
- From pharmaceutical companies
  - Arogya Roksha Yojana Trust (6) – Karnataka
- From local governments
  - Indore Municipal Corporation (34) – Madhya Pradesh
  - Gwalior Municipal Corporationj (31) – Madhy Pradesh
  - Kagad Kach Patra Kashtakari Panchayat (35) – Maharashtra
- From private physicians
  - Naandi Foundation - Hyderabad (57) – Andhra Pradesh
- From Central Government to provide health coverage to specific groups
  - Ministry of Social Justice & Empowerment (51) – All India
  - Ministry of Textiles – Handlooms (52) – All India
  - Ministry of Textiles – Handicraft Artisans (53 – All India
- From State Governments to provide special assistance to some population groups
  - Self Help Groups Federation (78) – Kerala
  - Self Help Groups federation (79) – Tamil Nadu
  - Tamil Nadu AIDS Initiative (90) – Tamil Nadu
  - Tamil Nadu Health Insurance Trust (91) – Tamil Nadu

Premium Payment Mechanisms

- Allow for in-kind payment
  - Raigarh Ambikapur Health Association (68) – Chhattisgarh
  - Tribhuvandas Foundation (92) – Gujarat
  - Katsurba Hospital (39) – Maharashtra
  - Pragati (67) – Orissa
- Develop various easy payment mechanism (soft loans, accumulated savings, use of fixed account interests, use of health emergency funds
  - Self Employed Women's Association (75) – Gujarat
  - Self Help Promotion for Health and Rural Development (79) – Tamil Nadu
- Use of an income-rated premium scale
  - Voluntary Health Services (96) – Tamil Nadu

Service Delivery

- Setting up a broad hospitals network
  - Ministry of Labour & Employment – RSBY (50) – 2,000 hospitals – All India
  - Ministry of Textiles – Handlooms (52) - 1,650 hospitals – All india
  - Ministry of Textiles – Handicraft Artisans (53) - 1,650 hospitals – All

India
    - Yeshasvini Trust (99) - 352 hospitals – Karnataka
    - Ministry of Social Justice and Empowerment (51) – 300 hospitals – All India
    - Grameen Kota (29) – 69 hospitals – Karnataka
    - Shree Keshtra Dharmasthala Rural Development Project – 69 hospitals (84) – Karnataka
    - Aarogyashree Yojana Trust (7) – 68 hospitals – Karnataka
    - Kas Foundation (38) – 62 hospitals – Orissa
- Partnering with public hospitals
    - Karuna Trust (37) – Karnataka
    - People's Rural Education Programme (65) – Tamil Nadu
- Empanelling public hospitals in a private network
    - Yeshasvini Trust (99) – Karnataka
- Relying on its own health facilities
    - Raigarh Ambikapur Health Association (68) – Chhattisgarh
    - Asha Kiran Society (AKS) – Orissa
    - Manipal Academy of Higher Education (46) – Karnataka
- Establishing its own health facilities in order to deliver the services covered under the scheme
    - Naandi Foundation – Hyderabad (57) – Andhra Pradesh
    - Naandi Foundation – Udaipur and Jodhpur (58-59) – Rajasthan
- Use of telehealth technology
    - Arogya Roksha Yojana (6) – Karnataka

Access to Medicines

- Through 500 Village Medicine Depots
    - People's Rural Education Movement (65) – Orissa
- Through Village Model Clinics
    - Arogya Roksha Yojana Trust (6) – Karnataka
- Through Mobile Schoold Clinics
    - Naandi Foundation - Hyderabad (57) – Andhra Pradesh
- Through associated public Primary Health Centres
    - Karuna Trust (37) – Karnataka
- Provision of herbal remedies
    - Raigarh Ambikapur Health Association (68) – Chhattisgarh

2.2.2. Operations

Prior Check-Ups and Additional Services

- Prior health check-up of insured
    - Naandi Foundation – Hyderabad (57) – Andhra Pradesh
    - Aarogyashree Yojana Trust (7) – Andhra Pradesh
    - Tamil Nadu Health Insurance Trust (91) – Tamil Nadu
- Regular health camps and health education programmes with the support of network hospitals
    - Self Help Promotion for Health and Rural Development (77) – Tamil Nadu

Plan Distribution

- Through the cooperative movement
    - Yeshasvini Trust (99) – Karnataka
    - Rajasthan Dairy Cooperative Federation (69) – Rajasthan
    - Bihar Milk Cooperative Federation (14) – Bihar
    - Solapur Cooperative federation (86) – Maharashtra
    - Sampoorna Kutumba Arogya Pathakam (72) – Andhra Pradesh
- Through SHG federations
    - Palmyrah Workers Development Society (64) – Tamil Nadu
    - Gandhi Smaraka Grama Seva Kendram Karadka (28) – Kerala
- Through schools
    - Naandi Foundation - Hyderabad (57) – Andhra Pradesh
    - Naandi Foundation – Udaipur and Jodhpur (58-59) - Rajasthan

- Raigarh Ambikapur Health Association (68) – Chhattisgarh
- Through trade unions
  - Self Employed Women's Association (75) – Gujarat
  - Kagad Kach Patra Kahtakari Panchayat (35) – Maharashtra
- Through education centres
  - Students Health Home (87) – West Bengal
  - Symbiosis Centre for Health Care for Students (88) – Maharashtra

Enrolment

- Compulsory enrolment through agreements concluded with the target population
  - Each village community willing to join has to convince all its members to enroll in the scheme: People's Rural Education Programme (65) – Orissa
- Compulsory enrolment linked to loans provided by micro-finance institutions/organizations
  - Bharatiya Samruddi Investmenst and Consultancy Services (13) – Andhra Pradesh
  - Bhartiya Integrated Social Welfare Agency (15) – Orissa
  - Village Welfare Society (95) – West Bengal
- Shifting from voluntary to compulsory enrolment
  - Swayam Krishi Sangam (89) – Karnataka
  - Karnataka – State Police Trust (3) – Karnataka
  - Bhartiya Integrated Social Welfare Agency (15) – Orissa
- Automatic enrolment through agreements concluded with CBO federations representatives
  - Rajasthan Dairy Cooperative Federation (69) – Rajasthan
  - Bihar Milk Cooperative Federation (14) – Bihar
  - Solapur Cooperative Federation (86) – Maharashtra
  - Sampoorna Kutumba Arogya Pathakhan (72) – Andhra Pradesh
  - Self Help Groups Federations (78) - Kerala
  - Tamil Nadu Health Insurance Trust (90) – Tamil Nadu
- Semi-automatic enrolment (some cooperative societies pay the premium on behalf of their members out of their yearly surplus)
  - Yeshasvini Trust (99) - Karnataka
  - Rajasthan Dairy Cooperative Federation (69) – Rajasthan
  - Sampoorna Kutumba Arogya Pathakam (72) – Andhra Pradesh

Individual Support Services

- Prior counselling (24/7 professional helpline)
  - Yeshasvini Trust (99) – Karnataka
  - Uplift Health (93) – Maharashtra
  - Healing Fields Foundation (91) – Andhra Pradesh
  - Indore Municipal Corporation (34) – Madhya Pradesh
- Individual support before discharge
  - Self Employed Women's Association (77) – Gujarat
  - Bharatiya Samruddi Investments and Consultancy Services (13) – Andhra Pradesh

Family Support Services

- Support to accompanying families during hospitalization period
  - Naandi Foundation - Hyderabad (57) – Andhra Pradesh
- Free transportation of accompanying families
  - Self Help Promotion for Health and Rural development (77) – Tamil Nadu

2.2.3. Management

Management Information System

- Use of smart cards for all health services provided under the scheme
  - Ministry of Labour and Employment – RSBY (50) – All India
- Fully computerized and customized Management Information Systems
  - Self Employed Women's Association (77) – Gujarat
  - Uplift Health (93) – Maharashtra
  - Healing Fields Foundation (32) – Andhra Pradesh

- Yeshasvini Trust (99) – Karnataka
- Online comprehensive Information Management System
  - Aaragyashree Yojana Trust (7) – Andhra Pradesh

2.3. Trends

Resulting from the review exercise, some major trends that are susceptible to shape up the future of the whole subsector could already be identified:

From supply to demand-driven products

Facing the ground reality over the last few years was already enough for many actors to revise the first products that they had designed in isolation and to initiate a broad consultation process in order to make them more enticing and more affordable to the various target groups

From voluntary to automatic enrolment

There is a growing recognition that voluntary enrolment goes together with a dramatic increase in terms of promotion and insurance plan distribution costs. In order to keep the costs low and so provide inexpensive products to the target groups, many organizations are looking for maws allowing for atomatic enrolment

From rare to whole care

Health benefit packages are slowly moving away from the conventional hospitalization expenses to cover a wider spectrum of health needs including out-patient care, maternity cover, post-hospitalization expenses and wage loss compensation during hospitalization

From subsidies to cost-sharing

The typically unspecified subsidies that were first allocated to various schemes to make them viable are now gradually abandoned in favour of real cost-sharing mechanisms whereby a well-defined co-contribution is committed by the Central, State or local Government

From risk-package to single risk

The previous move towards providing a composite benefit package has now come to a stall point. The new trend is to focus on more comprehensive health benefits while trying to develop a convergence with other schemes taking care of other non-health protection needs

From safe to glass house

More and more organizations now feel the need to share information and experience as well as for the setting up of a collective organization of data warehouses and information hubs to facilitate all interventions at the grass roots level

From local to national

The experience gained by various organizations first involved in the provision of health insurance benefits to the poor clearly contributed to the design and implementation of new schemes by the Central and State Governements and plans are already afoot to extend this subsequently as well as to cover other unorganized workers who do not fall under the BPL cap

From separate action to multiple public-private partnership arrangements

There is growing recognition of the emphasis that should be placed for any health insurance initiative on arrangements for ensuring interface with the beneficiary population. This would require effective multiple partnerships between the co-contributors, insurers, health providers as well as with intermediary organizations with grassroots presence, such as NGOs, cooperatives, SHG federations, trade unions and other organizations that can play a critical role at all stages of the implementation process

2.4. The Way Ahead

Based on all information gathered through this across-the-country review of the various health micro-insurance schemes targeting the disadvantaged groups of the society, the following recommendations can be made:

1. The Insurance Regulatory and Development Authority should gather and collate more information related to health micro-insurance activities and achievements under the partner-agent model and put them in the public domain;

2. The Insurance Regulatory and Development Authority should encourage and provide the appropriate support to activities that would aim at producing to the benefit of of the target groups the much-needed pedagogical tools pertaining to the principles, mechanisms and advantages of health micro-insurance;

3. One of the micro-insurance resource centres should invest some time and effort to build up a partnership arrangement with one State Government allowing it to undertake a detailed analysis on the implementation of the RSBY scheme;

4. One of the micro-insurance resource centres should invest some time and effort to build up a partnership arrangement with ICICI Lombard General Insurance Company in order to gather more information and statistical date with regard to the inmplementation of the RSBY scheme in various states;

5. Based on all evidence-based information gathered in these various states, the same resource centre should try to develop a collaboration with the Ministry of Labour and Employment aiming at designing and implementing efficient monitoring processes and instruments as well as reporting tools on regular activities and achievements of the scheme;

6. One of the micro-insurance resources centres should invest some time and effort to carry out a study on the quality of care provided under the two largest schemes run separately by the Ministry of Labour and Employment (RSBY scheme) and the Ministry of Health & Family Welfare (Aarogyashree Yojana in Andhra Pradesh);

7. One of the resource centres should invest some time and effort to develop a collaboration with the Yeshasvini scheme, which does not operate under the same partner-agent model (self funded scheme) in order to gather and report all relevant information pertaining to the activities and development potential of this type of scheme;

8. One of the resource centres should invest some time and effort to carry out additional studies focusing on the following issues that condition the future development of the whole health micro-insurance subsector:

- The possible convergence between the two flagship programmes: the RSBY scheme (hospitalization only) and the Janani Suraksha Yojana scheme (maternity protection only)
- The implementation process and development potential with regard to the future extension of health protection of the first scheme covering both the BPL and APL populationj (Tamil Nadu Health Insurance Trust)
- The present status and development potential of the revised version of the Universal Health Insurance Scheme now promoted through the United India Insurance Company (Public)
- The present status and the implementation arrangements planned for the launch of the next flagship programme: the National Urban Health Mission (Ministry of Health and Family Welfare – Government of India)