2006 | ASIAN DECENT
2015 | WORK DECADE

International Labour Organization

SERIES:

SOCIAL SECURITY EXTENSION
INNOVATIONS IN ASIA

INDIA:
YESHASVINI CO-OPERATIVE FARMERS HEALTH SCHEME
(KARNATAKA)

"BUILDING A PUBLIC-PRIVATE-COMMUNITY PARTNERSHIP MODEL"

ILO Subregional Office for South Asia

INTRODUCTION

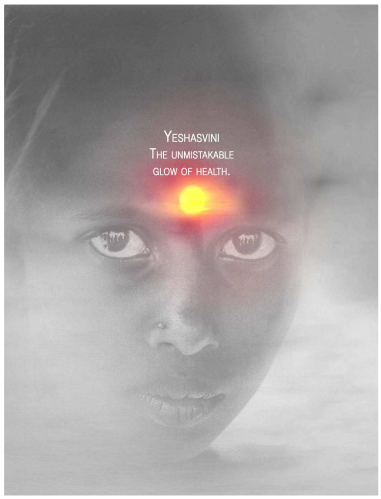
The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1st) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in India. In 2004, the United Progressive Alliance (UPA) Government pledged in its National Common Minimum Programme (NCMP) to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, and most particularly those operating in the informal economy who now account for 94 per cent of the workforce. In line with this commitment, several new initiatives were taken both at the Central and at the state level, focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, health micro-insurance schemes driven by a wide diversity of actors have proliferated across all India. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role had to rely on practical evidence, the ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative approaches that could contribute to the progressive extension of health protection to all. One such innovative and promising approach resulted from the multiple partnership approach already developed by the Yeshasvini scheme with both public and private actors.

BACKGROUND

The Yeshasvini scheme was conceived in 2002 by Dr. D. Shetty, a well-known heart surgeon and a group of private physicians who wanted to demonstrate that it was possible to extend access of the most sophisticated health care services to the poor. The concept relied on a preliminary survey conducted among various public and private hospitals operating in Karnataka which revealed that occupancy rates remained everywhere as low as 35%. The problem of access was therefore not due to the lack of infrastructure or professional staff, but to the impossibility for the poor to pay for the expected services.



To overcome this cash problem, a new insurance scheme targeting the poor rural communities and aiming to cover the most expensive segment of the health expenditure structure (surgical interventions) was designed in close collaboration with the Government of Karnataka and the Department of co-operatives.

A private Trust was set up, regrouping several prominent public and private individuals with the Principal Secretary of the Co-operative Department acting as chair of the Trust. The scheme targeted the poor farmers organized into co-operative societies that could play an active role, together with the Department of co-operatives staff operating at the field level, in distributing the insurance plan and collecting the premium. The Trust approached various insurance companies in order to get them

involved in the implementation of the scheme. These companies however, showed little interest for a scheme that seemed prone to low profitability and high risk. Having failed to enlist any support from that side, the Trust opted for a self-funding scheme.

TARGET POPULATION

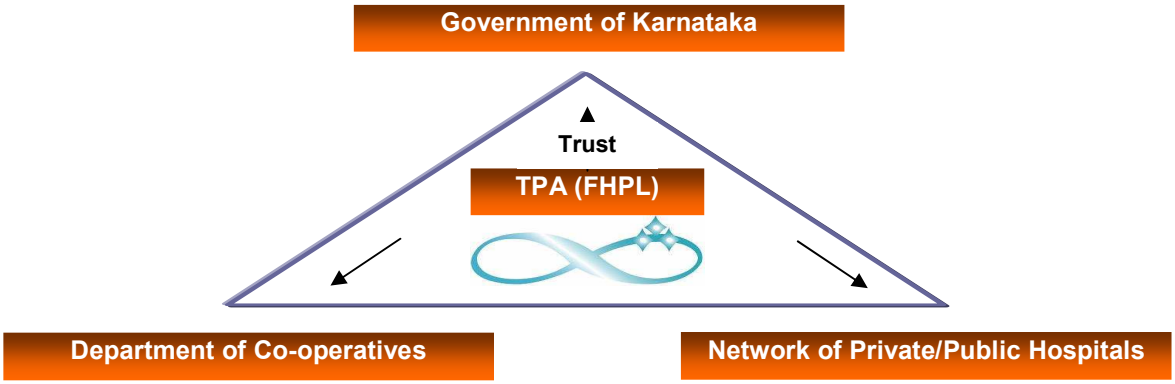
Built upon the insurance model, the scheme intended from the outset to achieve a wide coverage spread all over the state of Karnataka. The only institution organizing a broad movement in the state was represented by the cooperative societies.

According to the National Cooperative Union of India (NCUI), the State of Karnataka ranks 6th in terms of total cooperative membership. More than 12 million people are registered in cooperative societies with a stronger representation in the rural sector where Primary Agriculture Cooperative Societies (PACS), rural credit and savings cooperatives, sugarcane production and dairy cooperatives already regroup about 8.2 million. The existence of regular financial transactions between the societies and their members, such as in the case of regular milk supply or savings and credit operations was an additional advantage allowing for the adoption of various easy payment mechanisms.

An ILO survey aiming at identifying social protection priority needs of cooperatives members in Karnataka was carried out in two milk cooperatives and two credit cooperative societies operating in rural areas in 2004. Most members were poor farmers belonging to Scheduled Castes, Scheduled Tribes or “Other Backward Castes” (OBC). They usually had to rely on different occupations to generate the scarce resources they are living with. Some common patterns emerging from the survey were their heavy dependence on loans that are needed not only in time of crisis, but also to cover their regular expenditures, their need for social protection mechanisms to cope with these risks as well as their still weak understanding of insurance principles due to the very limited intervention of insurance companies in these areas.

ORGANIZATION

The scheme is presently organized in the following manner:



THE INSURANCE PLAN

Eligibility

Initiated in early 2003, the Yeshasvini scheme targets all co-operative society members in rural areas having a minimum 6-month membership. Ages of insured are from newborn to 75. The plan is open to members on a voluntary basis.

Exclusions

The insurance plan excludes coverage for prosthesis, implants, joint replacement surgeries, transplants, chemiotherapy, cosmetic surgery, burn cases, joint replacements surgeries, dental surgeries and several other events.

Plan Benefits

The Yeshasvini plan covers about 1,600 surgeries available at approved hospitals on cashless benefits to members. The plan pays all associated hospitals a fixed tariff for each of these defined benefits. Tariffs have been set up for approximately 800 procedures. It is stated that the tariff is 40-50 per cent off the "regular" tariff applied by private hospitals. In addition, Out of Patient Diagnosis is provided free of cost and some diagnostic tests are performed at discount rates. Some network hospitals are also providing discounts on medical stay. The maximum benefit available per insured is Rs 100,000 per procedure (US 2,200) or Rs 200,000 (US 4,400) annually.

There were no changes in benefits during the first three years of operation. In Year IV, the following benefits were included under the plan in order to encourage a broader adhesion:

- Stabilization of defined medical emergencies requiring outdoor treatment (dog bite, snake bite, drowning, accidental poisoning, electrical shock, road traffic accident…)
- Normal deliveries;
- Paediatric care during the first five days after birth

Premium Rate

Over the first two years, members paid Rs 60 per year for each person insured. In Year III, the premium was set at Rs 120 for adults and Rs 60 for children below the age of 18. In addition, the Government of Karnataka provided each year a subsidy directly allocated to the premium, thus increasing the level of benefits to the members.

General Overview	
Starting date	May 2003
Ownership profile	Trust (Public-private partnership)
Target group	Co-operative farmers
Outreach	Karnataka (whole State)
Intervention area	Rural
Risks covered	Single risk: Health
Premium	Rs 120 (adults)
Insured/Year	Rs 60 (child under 18)
Co-contribution	Rs 89 (GoK)
Total premium	Rs 209
No of insured	2,230,000
Percentage of women	38%
Operational Mechanisms	
Type of scheme	In-house
Insurance company	No
Insurance year	Fixed (June to May)
Insured unit	Individual
Type of enrolment	Voluntary/automatic
One-time enrolment fee	None
Premium payment	Yearly – upfront
Easy payment mechanisms	Pre-payment by co-op societies – soft loans
Scope of Health Benefits	
Tertiary health care	
Hospitalization	No
Deliveries	
Access to medicines	No
Primary health care	No
Level of Health Benefits	
Surgical intervention	Up to Rs 100,000
Linked OPD services	Free
Service Delivery	
Health prevent./educ. Programmes	No
Prior health check-up	No
Tie-up with H.P.	Yes
Type of health prov.	Private and public
Type of agreement	Formal agreement
No of associated HP	295
TPA intervention	Yes
Access to health care services	Pre-authorization required
Co-payment:	No
HC payment modality	Pure cashless

Plan Distribution

The insurance plan covers a full year starting from June 1. The promotion campaign may start as early as February each year with the assistance of the Co-operative Department whose agents enroll members, issue receipts and deposit the premium with a local co-operative bank, prior to the start of the plan year. In year I, receipts plus a letter from the district Registrar of co-operatives, certifying authenticity, were required to receive the services at one of the network hospitals. From year II onwards, photo ID cards were issued to a majority of members via the co-operative societies.

Service Delivery

Pre-determined tariffs for the interventions covered under the plan were negotiated with various private hospitals and nursing homes operating across the state. Given the high level of expected membership, most health facilities were willing to be associated with the scheme and agreed to apply significant discounts on main interventions or complementary services. In Year I, the scheme had already tied up with enough health facilities to be present in all districts. Starting in Year II, an increasing number of public facilities whose services answered the eligibility criteria also joined the network.

Administration

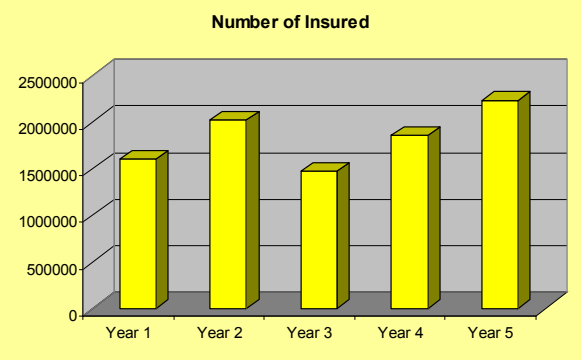
The Trust invited Family Health Plan Limited (FHPL) to administer the scheme. FHPL was one of the first Third Party Administrators to be licensed under IRDA (Insurance Regulatory and Development Authority) regulations and one of the largest operating country-wide with in-depth experience in the administration of health insurance schemes. Under contractual arrangements, FHPL checks the eligibility of health facilities, manages the relations with associated hospitals and processes all claims.

MAIN ACHIEVEMENTS

Coverage

The scheme succeeded to enroll 1.6 million in its first year of operation and 2 million in Year II. The decline in Year III was due to the premium increase (from Rs 60 to Rs 120). Since then, the enrolment figure steadily increased, giving some indication that the scheme may now rely on a more secured membership allowing it to lay out its long-term development vision and business plan.

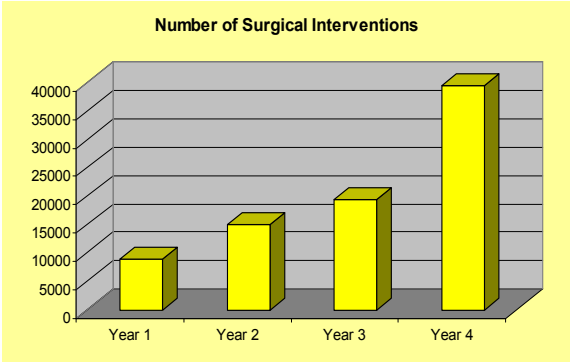
	Y1	Y2	Y3	Y4	Y5
			X 1000		
N° Insured	1.601	2.021	1.473	1.854	2.230



Services Provided

Over its first four years, the scheme could already perform 82,000 surgical interventions, many of these life-saving. The scheme also covered some 345,000 OPD interventions provided through an extensive network of health facilities. Each associated hospital provides a help desk staffed 24 hours to receive and assist the policyholders, while some also extend discounts to other services.

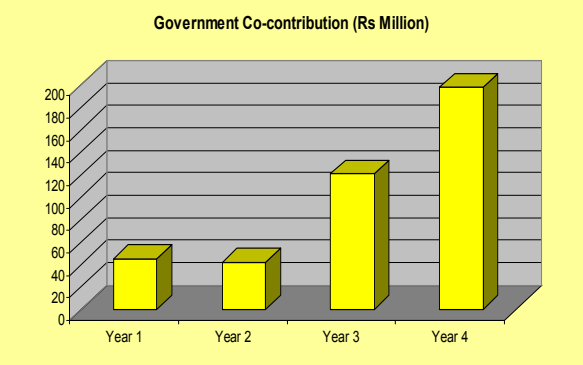
	Y1	Y2	Y3	Y4
N° Surg. Int.	9,008	14,963	19,439	39,441
N° OPD Treat.	35,814	50,174	52,892	206,977



Co-contribution

From Year I onwards, the Government of Karnataka supported the scheme through a contribution to the premium which increased over time and amounted to Rs 89 per insured in Year IV. However, the resources to be allocated to the scheme are still not pre-defined nor directly related to any prior policy cost estimate.

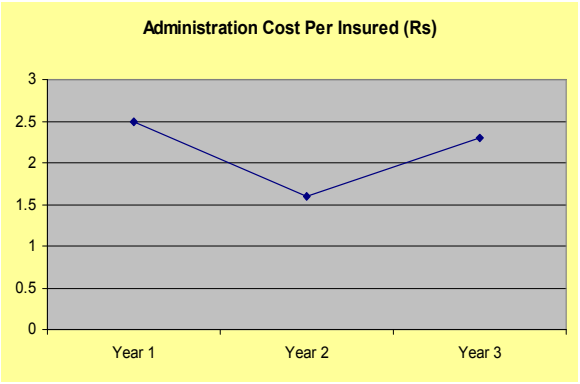
	Y1	Y2	Y3	Y4
		X Million		
Total co-contrib.	45	42	121	198
N° of Insured	1.6	2.0	1.4	2.2
Co-contr/Insured	28	21	82	89



Administration Costs

The Yeshasvini insurance scheme may rightly claim to be one of the most cost-effective insurance schemes throughout the world. In Year III, the Administration Cost Ratio (ACR) was 1.5% only, while the Administration Cost per Insured (ACI) was kept at the amazingly low level of Rs 2.3.

	Y 1	Y 2	Y 3
		X 1000	
Total Admin. Costs	4,002	1,278	4,361
N" of Insured	1,601	2,021	1,473
Adm. Cost/Insured	2.5	1.6	2.3



CHALLENGES

The insurance plan has still to address the following main challenges:

- Restricted scope of benefits: Being not limited on the supply side, the scheme is now looking for ways to expand the benefits it currently provides (surgical procedures). However, due to the lack of date relating to the health status of the target population, this required a cautious approach. A wider benefit package was first to be tested in a parent scheme initiated as a pilot in one division of Bangalore district (Arogya Roksha Yojana, now covering 150,000 in its third year);
- Overall coverage: The scheme is still seeking to cover more co-operative members in order to reach its target set at 3 million;
- Membership instability: Average renewal rate still stands at a low 50-55% with huge discrepancies between districts;
- Increasing adverse selection phenomenon:
  - Claim incidence was: 5.6 per thousand in Year I and reached 25 per thousand in Year IV
  - Claim incidence was unexpectedly found far higher for the first age group (0 to 2 years) than for any other (including the oldest age group: 73 to 77 years) and is still increasing
  - Claims cost was Rs 69 per insured in Year I and reached Rs 253 per insured in Year IV.
- Uncertainty attached to government subsidy;
- Gaps in the management information system;
- Absence of a professional managerial function.

THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme targeting the disadvantaged groups. Evidence also suggests that building efficient linkages between community-based initiatives and governmental programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.

Scope of Linkages

Financing:	
Operations:	
Service Delivery:	
Governance:	
Policy Planning:	
Legal framework:	No

The Yeshasvini scheme was the first to develop a far-fledged linkage experience, proving to be successful enough to become, as early as in Year I, India's largest health micro-insurance scheme. This could not fail to elicit a wide interest amongst other states also committed to take similar health protection initiatives for the poor. Some new government-sponsored schemes already surpassed Yeshasvini on some accounts, including coverage. However, none so far succeeded to take the full measure and the best advantage of Yeshasvini's unique features in terms of building a broad linkage model.

1. Financing

From the outset, the Government of Karnataka committed itself to support the scheme, being wise enough to allocate its financial support where it ought to go: as a co-contribution to the premium to be paid by each policyholder that resulted in enhancing the benefits provided under the scheme. Over a four-year period, these co-contributions amounted to a total of some Rs. 406 million.

Being the first of its kind and as such having to rely on a lot of guesswork, no proper guidelines were laid down at inception point to organize the Government's financial support. To this day (Year V), co-contributions are not yet regulated nor planned ahead and continue to materialize only once the resources raised by the scheme appear to be depleted. With regard to this missing element, the scheme is expected to make headway in Year V.

2. Operations

The partnership developed with the Department of Co-operatives was a key factor in the implementation machinery. It also allowed for one of the most striking achievements of the scheme: the setting up of cost-free premium collection mechanism. Since marketing costs generally cut into the budget in a major way, more value could accordingly be given to the payment of benefits to members.

Another advantage resulted from the partnership developed with a public department. An official tender was launched in order to identify a suitable TPA. The whole procedure could end up in selecting the least expensive offer, which in turn translated into a further increase of benefits provided to members. Termed as a two-year contract, the agreement concluded with the TPA is still subject to regular bidding procedures which also add to other cost-containment measures applied by the scheme.

3. Service Delivery

The scheme registered a similar success in trying to solve the second half of the health insurance equation. Even under stringent eligibility conditions, it could enlist the active support of private health facilities to provide sophisticated healthcare services to low-income groups.

The scheme could organize and maintain over the years a state-wide hospital network already regrouping 295 health facilities. It also succeeded to ensure the progressive integration into the network of government run healthcare facilities having up-graded their services to match the accreditation standards set by the scheme.

4. Governance

Chairing the Trust, the Department of Co-operatives is directly involved in any decision pertaining to the functioning of the scheme. Being part of the Trust facilitated the active involvement of the staff at all levels and broadened the partnership arrangements to other officials such as the District Collectors (overseeing premium collection and transfers) and District Health Officers/District Surgeon (checking the scheme's efficiency both at demand-side (client's satisfaction) and supply-side (quality of services provided by network hospitals).

Owing to this participation in the decision-making process and also to the active role played at the grassroots level when distributing the insurance plan, the scheme soon came to be known as a "Government's" initiative, which generated more credibility and trust, especially among the poor farmer community.

5. Policy Planning

The Yeshasvini scheme triggered a broad wave of health insurance initiatives all across India. Some new State-sponsored initiatives choose to provide the same benefits (critical illnesses only), as evidenced in the following cases:

- Assam: Covering the entire population (scheme interrupted at the end of Year I)
- Andhra Pradesh: Covering the BPL population in selected districts (8,5 million)
- Madhya Pradesh: Covering the BPL population of the whole State (20 million)
- Madhya Pradesh: Covering co-operative members in one district (101,000)

The Central Government which had pledged since 2004 to provide various social protection benefits – including a health insurance component – to the unorganized sector workers also kept an eye on the development of the Yeshasvini scheme. The Ministry of Health and Family Welfare, Government of India, organized on July 13, 2007, a national workshop regrouping all Health Secretaries. Aiming at encouraging new health insurance initiatives, the proceedings relied on three presentations of on-going experiences that could serve as models: one being the Yeshasvini scheme while the two others had adopted the same basic benefit package. During this event, the Yeshasvini Trust representatives advocated for the setting up of State Health Trusts that should rely on a similar multiple partnership approach, including the active involvement of community-based organizations such as co-operatives, Self-Help Groups and other organized groups.

6. Legal Framework

Being a self-funded scheme, without any tie-up with an insurance company, the Yeshasvini scheme remains out of the purview of the micro-insurance regulations issued in November 2005 by the Insurance Regulatory and Development Agency (IRDA) of India.

CONCLUSION

As of today, the Yeshasvini scheme remains confronted with major challenges such as finding appropriate ways to reduce the adverse selection phenomenon and broadening the scope of benefits provided to its members. Although still not the perfect working model to be used for replication in other States, it already demonstrates how effective a broad linkage model proves to be in applying practical solutions to the implementation of a very large health insurance scheme.